Statewide Primary Prevention Plan

2014-2016

From Planning...

To Practice

Preventing Intimate Partner Violence in Connecticut

CCADV
Connecticut Coalition Against Domestic Violence

From Planning to Practice
Preventing Intimate Partner Violence in Connecticut

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Preface

Acknowledgements

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Introduction

Nearly one in three women and men in Connecticut have experienced rape, physical violence and/or stalking by an intimate partner during their lifetime.[1] Nationally, about one in four women and one in seven men in the U.S. have experienced severe violence by an intimate partner, defined as being hit with a fist or hard object, beaten or slammed against something.[1] The negative impact of this violence on public health, economic productivity, and the wellbeing of children in the U.S. is huge. In addition to the immediate harm it causes in the form of injuries and sometimes death, those who have experienced intimate partner violence (IPV) are also more likely to report having frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health compared to those who have not.[1] Victims of IPV in the U.S. lose a total of nearly 8 million days of paid work and nearly 5.6 million days of household productivity each year as a result of the violence.[2] Researchers report that children who witness IPV are at greater risk of having psychiatric disorders, developmental problems, school failure, and low self-esteem.[3] Children who experience IPV in their family are also more likely to become victims or perpetrators of IPV themselves in young adulthood.[4]

Each year in Connecticut, 55,000-60,000 people reach out to local domestic violence agencies for help to cope with the effects of intimate partner violence. Organized services for survivors have existed in Connecticut for more than three decades. These services are life-saving, hope-inspiring and vital to the well-being of the citizens of the state.

Equally critical is the need to define the underlying causes that prompt and perpetuate this violence and to implement strategies to impact those underlying causes. Experts agree that prevention efforts should promote healthy, respectful relationships in couples and families, and also counter the beliefs, attitudes and norms condoning violence that are deeply embedded in our social structures.

This plan represents the first effort of this scale in Connecticut to tackle the factors that increase risk for the perpetration of intimate partner violence and to promote factors that create healthy, sustainable relationships, families and communities. The structure of this document reflects our core commitment—to reach out to every citizen of Connecticut to help foster the attitudes, skills,

behaviors, and norms leading to healthy relationships, with special attention to those groups, which carry the heaviest burden of risk for being affected by this violence.

Plan Overview

Our Vision

We envision a Connecticut that promotes healthy relationships for all ages that are violence free.

Definition of Intimate Partner Violence

Intimate Partner Violence (IPV) is a behavior used by one person in a relationship to control or harm the other. These behaviors may include physical or sexual assault, emotional and/or financial abuse, threats, stalking, or intimidation. This violence can happen once or repeatedly between same-sex or heterosexual couples and can be deadly. IPV knows no boundaries of age or income, race or culture, abilities, religion, or ethnicity.

This plan has goals targeting five key areas: 1) youth engagement in IPV primary prevention, 2) reinforcing the role of men and boys in IPV primary prevention, 3) public awareness of IPV and IPV primary prevention, 4) strengthening and increasing IPV primary prevention programs, and 5) results based accountability.[5*] It is our sincere hope that the implementation of this plan will bring about the changes needed to develop solid evidence about the root causes and prevalence of intimate partner violence and will produce measurable change in reducing its magnitude and impact in Connecticut.

The statewide plan is presented in the following order. First, we present a detailed overview of the history of the plan and the planning process, highlighting our efforts to apply best practices in IPV primary prevention planning recommended by the Centers for Disease Control and Prevention (CDC) and other states that have produced similar plans under the CDC's DELTA initiative.

[*] The approach to results based accountability for this plan uses Getting to Outcomes®, a framework that incorporates traditional evaluation, empowerment evaluation, results-based accountability, and continuous quality improvement.

Next, we present the findings from our needs and resource assessment pertaining to the incidence and prevalence of intimate partner violence in Connecticut. This includes data from various state agencies as well as a brief summary of the findings from a survey that was developed to assess primary prevention activities and select strategies to strengthen IPV primary prevention in Connecticut.

Following these findings, the five main strategic directions for expanding and strengthening IPV primary prevention efforts in Connecticut are introduced in order, with a description of the needs, resources, and opportunities identified in each area. Included in the overview of each strategic direction are three to four major goals for that area, activities that will be carried out toward accomplishing these goals and measurable outputs and outcomes that will be the basis for the evaluation of the plan's implementation over the next three years.

A logic model for the entire plan and logic models for each of the five strategic directions are provided in the final section of this report. Lastly, appendices are included that provide more detailed information about the data and resources referenced in this plan.

Part One:
Background of Statewide Plan

History of Domestic Violence Prevention in Connecticut

In April 2008, the Connecticut Coalition Against Domestic Violence (CCADV) was awarded one of nineteen agreements to work with the Centers for Disease Control and Prevention (CDC) on a primary prevention initiative called the Domestic Violence Prevention Enhancement and Leadership Through Alliances, Preparing and Raising Expectations for Prevention (DELTA PREP). The DELTA PREP was funded in a four-year collaborative effort between the CDC, the CDC Foundation, and the Robert Wood Johnson Foundation. DELTA PREP built on the successes and lessons of the CDC's DELTA Program and focused on strategies to prevent first time occurrences of IPV.

DELTA PREP funded CCADV to build their organizational capacity for IPV primary prevention work. Through participation in DELTA PREP, CCADV has integrated primary prevention into their organizational structures and practices. They have expanded and enhanced their organization's ability to lead and support efforts to stop IPV before it begins and to facilitate and promote primary prevention capacity at the state and community levels. The following table describes the key organization changes and prevention efforts that CCADV undertook:

Table 1: CCADV Delta Prep Implementation

Documented Organizational Change	Date Occurred:
All CCADV staff trained in primary prevention.	January 2010
CCADV worked with state legislature to pass new law regarding teacher in-service training on domestic/dating violence prevention.	April 2010
Legislation passes mandating the Department of Public Health to develop a public service announcement by June 2012 on domestic violence/teen dating violence prevention.	May 2010

Documented Organizational Change	Date Occurred:
CCADV holds "Purple Tie Tuesday" to promote men's commitment to preventing domestic violence.	October 2010
CCADV and the State Department of Social Services co-sponsor "Domestic Violence Across Communities: Prevention to Partnerships" conference.	October 2010
The new strategic plan, with primary prevention goals, was approved by the Board of Directors and the CCADV membership.	November 2010
CCADV holds 12-month comprehensive statewide Prevention Capacity Building Training with our 18 local domestic violence agencies. The training provided participants with basic principles of prevention, the Social Ecological and Getting to Outcomes®[4] models of prevention, theories of change, the logic model for organizing prevention activities, facilitative leadership, youth engagement strategies, program planning and evaluation, and tools for coordinating a community response.	January 2011
CCADV unveils new teen dating APP with back-up micro website.	April 2011
CCADV adds prevention section to their website and develops a primary prevention training manual.	August 2011
CCADV holds "First 100 Men" event to recognize male leaders from across Connecticut who have worked to raise awareness about domestic violence. Speaker of the House Christopher Donovan pushes for prevention of domestic violence.	September 2011
CCADV member agencies develop initial action plans for the prevention of domestic violence in their communities.	October 2011
Steering committee formed to develop statewide primary prevention plan.	February 2012

Initiation of State-Level Planning Process

In 2012, the focus of the prevention initiative broadened. In addition to building local capacity for primary prevention, attention also focused on statewide IPV primary prevention capacity building. In February 2012, CCADV convened key Connecticut stakeholders to create an Intimate Partner Violence Prevention Steering Committee ("the IPVPSC").

The IPVPSC's purpose is to guide the scope and direction of state-level IPV prevention work and expand the reach of CCADV by engaging multiple partners in IPV prevention efforts. The IPVPSC members represent geographic distribution and a variety of focus areas in IPV prevention work. The IPVPSC includes representation from the State Department of Public Health (DPH), the Governor's Prevention Partnership, the State Office of the Child Advocate, the Community Health Center, Inc., EASTCONN, CCADV, law enforcement and Verizon, as a business partner. The IPVPSC is co-led by CCADV's Training and Prevention Coordinator along with a contracted Empowerment Evaluator.

Getting to Outcomes®: A Results-Based Approach to Accountability[5]

The Getting to Outcomes® (GTO) framework has served as a guide in the planning process. This approach involves ten steps that occur in sequence, but are also iterative as the process unfolds. Step One involves conducting a needs assessment. This is followed by Step Two, establishing a set of goals or objectives. Step Three is to identify best practices to reach these goals. Step Four is to determine the fit of a selected program to its setting. Step Five entails assessing organizational capacities and resources required toward this goal. Step Six is to develop the program plan. Step Seven is to conduct a process evaluation and Step Eight is to assess how well the program is working by conducting an outcome evaluation. Step Nine is to invest in improvements to the program and Step Ten is to establish a plan for sustaining the program. As part of this framework, empowerment evaluation principles are applied to help ensure that the planning process is participatory, inclusive, data-informed, utilizes knowledge of best-practices combined with community knowledge, and establishes a set of measurable goals and outcomes toward achieving the desired results.[6]

Figure 1. The Getting to Outcomes® framework[5†]

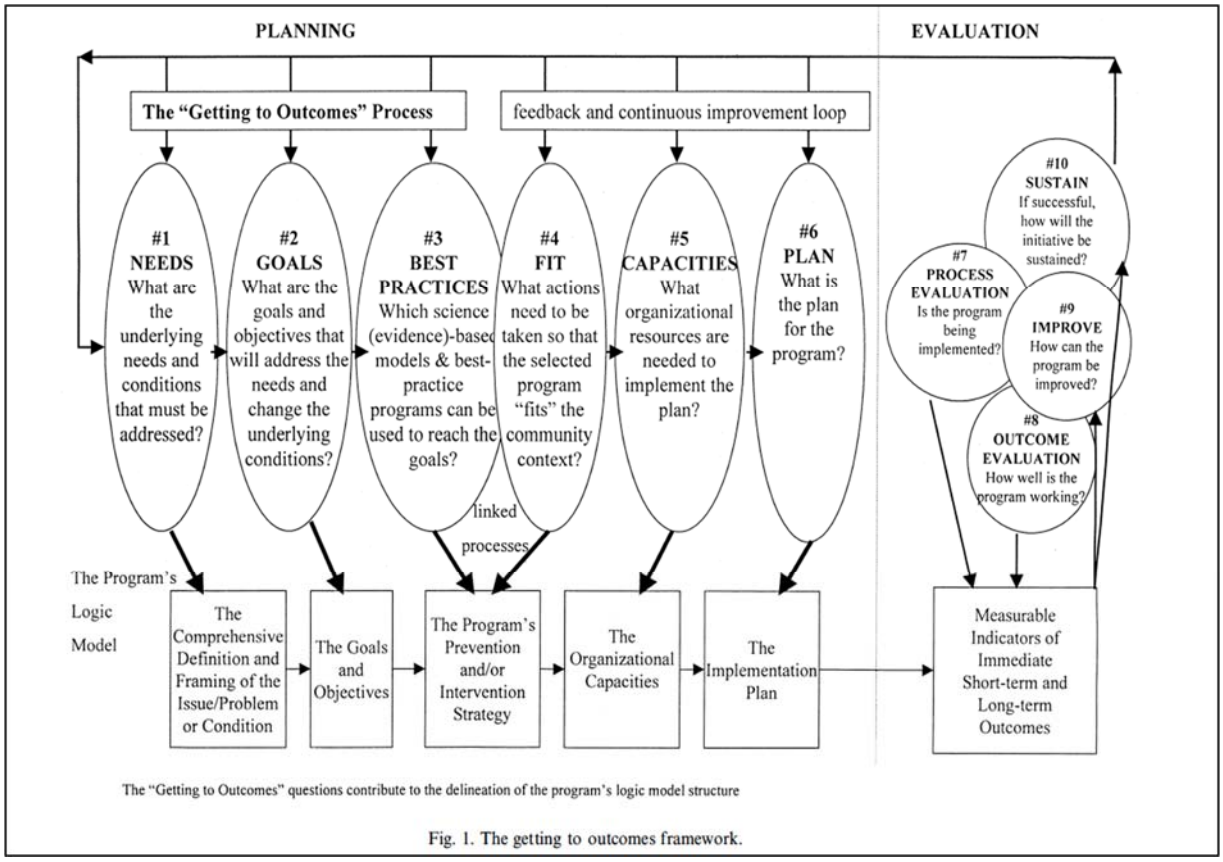


Fig. 1. The getting to outcomes framework.

While GTO® is an apt model for community-level planning, it had to be slightly adapted towards the goal of developing a state-level plan that can serve as a useful guide in multiple and diverse regions across Connecticut. Specifically, Steps 3 and 4 in the planning process were kept at a general level of identifying evidence-based practices (EBP) and best practices in IPV primary prevention for universal or select populations across Connecticut. In the course of the planning, a regional coalition in Fairfield County was established that has begun implementing GTO® at a local level to identify and select specific EBP for use in their communities. One goal that developed out of our planning process is to establish other regional coalitions in communities at high risk for IPV.

† Figure republished with permission from authors.

Strategic Planning Process from April 2012-June 2013

One of the first undertakings of the IPVPSC was to develop and agree upon a working definition of Intimate Partner Violence, as well as a shared IPV Prevention Vision. The definition was drafted by the IPVPSC with further revision facilitated over the course of two meetings. The final version was accepted in April 2012.

Empowerment Evaluation

In May, a very basic introduction to empowerment evaluation was provided to the IPVPSC. In August, the empowerment evaluation principles were reviewed in more depth with an opportunity for the IPVPSC to reflect on how they had been applying the principles in the planning process. The chart below was used in this discussion and has been updated to reflect areas included in this plan.

Table Two: Empowerment Evaluation Principles[5] used in Planning

EMPOWERMENT EVALUATION PRINCIPLE	DEFINITION	OUR APPROACH
IMPROVEMENT	• Improve process and performance • Use data to inform decision making • Monitor change over time	• The ongoing IPVPSC meetings will continue to ensure that changes and new data are considered in updating the plan. • IPVPSC conducts "rapid needs assessment."
COMMUNITY OWNERSHIP	• Stakeholders have control of process • Evaluator is coach/facilitator offering tools, training, and technical assistance • Stakeholders have oversight	• Creation of the IPVPSC Steering Committee. • Stakeholders were committee chairs. • Evaluator provided tools and resources.

EMPOWERMENT EVALUATION PRINCIPLE	DEFINITION	OUR APPROACH
INCLUSION	• Stakeholders represent communities they serve • Empowerment Evaluator facilitates participation by all	• Stakeholders were diverse in terms of gender, age, geography, profession, but less diverse in terms of socio-economic status and education level. • Need to bring more representatives of the faith community to the table. • Need to increase diversity in work groups.
EVIDENCE-BASED PRACTICES	• Identify evidence-based strategies that can lead to goals • Adapt evidence-based strategies within community context	• Emphasis was placed on identifying evidence-based practices that fit with the populations and contexts. • Developed risk and protective factors charts. • Researched other DELTA models.
SOCIAL JUSTICE	• Think through potential implications of evaluation results • Aim is to make a difference toward the larger social good • Base programmatic decisions on a social justice framework • Work should facilitate social change and address social inequalities	• We aim to change social norms and conditions that increase the likelihood of intimate partner violence. • Looking at inequalities in underserved, underrepresented, and not served individuals.
COMMUNITY KNOWLEDGE	• Respect and value knowledge that is within the organization/community • Use and validate community knowledge • Combine local/state-specific knowledge with evidence-based strategies	• Community knowledge used to inform the decision-making process, alongside local and state data.

EMPOWERMENT EVALUATION PRINCIPLE	DEFINITION	OUR APPROACH
CAPACITY-BUILDING	• Empowerment Evaluator provides training and technical assistance • Stakeholders guide training/TA needs	• Several members of the IPVPSC sought support for evaluating programs at their agencies from the empowerment evaluator and others involved in the planning process. • Plan includes efforts to build the evaluation capacity of organizations providing IPV prevention services.
ORGANIZATIONAL LEARNING	• Empowerment Evaluator and stakeholders foster a culture of learning • Stakeholders involved in interpretation of results and forming recommendations	• Resources, information, and knowledge were shared during the planning process. • Dropbox was used to share meeting notes and other relevant documents. • Other state's toolkits, coalition planning guides and research literature were shared with everyone.
ACCOUNTABILITY	• Use appropriate tools, measures, and methods • Identify reasons that implementation differed from plan (process) • Identify reasons why desired outcomes were and were not reached (outcome)	• Developed charter documents to account for IPVPSC activities. • Outputs and outcomes in the plan are measurable. • A plan is in place for process evaluation and for assessing whether outcomes are reached.

Ecological Model of Risk and Protective Factors

In July, the IPVPSC identified and compared risk and protective factors for IPV in Connecticut, drawing upon research findings on IPV etiology in the U.S. combined with community knowledge. The IPVPSC explored these risk and protective factors according to the ecological model.[7] The ecological model considers factors at the level of the individual, relationship, community and society (see Figure 2 below). It represents the complex interplay of factors for IPV across multiple societal levels. According to the CDC, prevention strategies should include a

continuum of activities across all four levels that are developmentally appropriate and conducted across the lifespan.[8]

Figure 2: Ecological Model[7]

A table was created with the hypothesized risk and protective factors for IPV, citing scientific research, to inform our strategic planning process. Portions of the table are presented below (see also appendix A).

IPV Risk and Protective Factors in an Ecological Framework

Individual Level

The individual level refers to factors having to do with biological and personal history that increase the likelihood of becoming a victim or perpetrator of IPV. Factors can include age, education, income, substance use, or history of abuse. Prevention strategies at this level are generally designed to promote pro-social attitudes, beliefs, and behaviors.[8]

Table Three: Individual Risk and Protective Factors for IPV

Risk Factors	**Protective Factors**
• Generational IPV/ early trauma • Witnessing or experiencing violence as a child • Low income • Substance abuse • Mental health problems: low self-esteem, poor impulse control, anxiety, depression, anger • Young age • Unemployment • Social isolation • Prior relationship aggression	• Education • Healthy self-esteem • Respect for self and others • Healthy communication skills • Ability to make healthy choices about partner • High income • Social support

Relationship Level

The relationship level considers social influences that may increase the risk of experiencing intimate partner violence as a victim or perpetrator. These factors may include the influences of a person's closest social circle-peers, partners or family members. Prevention strategies at this level are typically designed to reduce conflict, foster problem solving skills, and promote healthy relationships.[8]

Table Four: Relationship Risk and Protective Factors for IPV

Risk Factors	**Protective Factors**
• Financial strain in relationship • Marital conflict • Gender inequality in relationship • Desire for power and control in relationship • Status incompatibilities (income, education, relationship expectations) • Unmarried or cohabitating	• Healthy relationships • Healthy male role models • Egalitarian partnership • Financial security

Community Level

The community level seeks to identify the characteristics of settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level are typically designed to impact the climate, processes, and policies in a given setting or institution. Social norm and social marketing campaigns can be used to create community settings that promote healthy relationships.[8]

Table Five: Community Risk and Protective Factors for IPV

Risk Factors	**Protective Factors**
• Lack of sanctions or ineffective sanctions • Disadvantaged neighborhood • Poverty	• Community awareness • After school programs for kids • Cohesive communities w/ low tolerance for IPV

Societal Level

The societal level looks at the broad societal factors that either support or prevent intimate partner violence from occurring. These factors include the governmental and institutional policies that may help to maintain economic or social inequalities between groups in society, as well as social and cultural norms.[8]

Table Six: Societal Risk and Protective Factors for IPV

Risk Factors	**Protective Factors**
• Widespread electronic communication • Perception that domestic violence is not a crime • Societal gender inequality	• Stricter laws and public policy • Gender equality • Women's economic independence

IPV Planning Process Following the GTO® Framework

GTO® Step One: Statewide Needs and Resource Assessment

The next step carried out by the IPVPSC in July-August was to develop and administer the "Strategic Directions Survey," a rapid needs assessment of IPV and prevention-related resources in Connecticut.

In September, based on results from our Strategic Directions Survey, IPVPSC members identified four key strategic directions for the statewide plan: 1) youth engagement, 2) involving men and boys, 3) IPV public awareness and 4) capacity building/strengthening prevention programs.

In September and October, Work Teams were established for each of the strategic areas to further develop the goals, activities, outputs and outcomes to be accomplished over the next three years. IPVPSC members were given the option to co-chair one of the Work Teams or continue as a IPVPSC member without co-chairing. Five IPVPSC members volunteered to serve as co-chairs. Two new IPVPSC members were invited to co-chair the Capacity Building Work Team by the CCADV Training and Prevention Coordinator. During the next month, 5-15 new members per team were recruited whose work or interests aligned with each of the areas. These

volunteers were identified from those individuals who had reported on the Strategic Directions Survey that they might be interested in serving on a Work Team and through the professional networks of CCADV and IPVPSC members. A charter document was distributed outlining collaborative and data-informed processes and deadlines for deliverables towards completion of the plan. Each of the co-chairs signed the charter document to formalize their agreement with CCADV and the rest of the IPVPSC.

The Work Team chairs, with support from either the CCADV Training and Prevention Coordinator or the Empowerment Evaluator, oriented the new members to the Getting to Outcomes® framework, empowerment evaluation principles, and the planning process to date. Most of the Work Teams agreed to meet independently on a monthly basis for approximately 1½ to 2 hours; one work team decided to hold three, three-hour meetings. Each team began engaging their new members by conducting their own assessment of community readiness for change in the area they were responsible for using the SWOT analysis method, or a more detailed community readiness assessment (GTO® worksheet 4.1).[9 (pp.113)] Work Teams were also given a coalition relationship inventory tool to use in identifying key stakeholders who they might wish to reach out to for additional input or participation in the planning.

The next meeting of the Work Teams focused on reviewing the risk and protective factors for IPV for the particular target population(s) appropriate for their strategic direction. The teams were also encouraged to review the sources of data available to them and determine gaps in data that would be useful to guide their decision-making (GTO® Worksheet 1.3).[9 (pp.41)] They each came up with their own data collection plans to conduct a survey, interviews with key informants, a focus group or other means of gathering information from other key stakeholders including providers and/or the community members they serve.

Consistent with Step One of GTO®, the IPVPSC also began the process of assessing patterns of IPV in Connecticut. Information was derived from published reports of Connecticut state agencies and from CCADV reports. Limitations of these data sources and gaps in the data were identified and plans began to be formulated as to how we might fill in these gaps.

GTO® Step Two: Goals

The data on IPV, findings from the Work Team's research, and community knowledge informed the development of goals for each of the Strategic Directions. Information was also exchanged among Work Team members about current initiatives that were underway that could be expanded or built upon to include a focus on IPV primary prevention. The Work Teams then brainstormed ways to address the needs in their strategic area and best utilization of available resources. A consensus process was used to arrive at a measurable set of goals under each of the strategic areas for each Work Team. The goals were reviewed by the Empowerment Evaluator and CCADV Training and Prevention Coordinator according to SMART criteria—namely that the goals were Specific, Measurable, Achievable, Results-Focused and Time Bound and recommended revisions were provided to the committee chairs.

GTO® Step Three: Best Practices

Evidence-based primary prevention practices, specifically programs that were known to already be in use in Connecticut and that had strong scientific evidence in support of their effectiveness (randomized or quasi-experimental design studies), were identified through the strategic planning process. Due to the growing emphasis in some parts of Connecticut on the use of school resource officers to prevent violence in schools, research regarding the DARE program's lack of effectiveness informed committee members' consideration of different intervention models for IPV prevention in schools.[10]

GTO® Step Four: Fit

Emphasis in the strategic plan is on guiding agencies and organizations to assess the fit of evidence based practices (EBP) to their communities. The statewide planning process has begun to assess the cultural fit of evidence-based prevention programs for youth, as well as specifically designed programs for boys and men, based on existing literature measuring effectiveness with diverse populations and "practice-based knowledge." This process will continue as a tool kit is developed and the programs are assessed in different community contexts over the next three years.

GTO® Step Five: Capacity

Since the fiscal climate is not very conducive to increased government funding due to the economic recession, extra attention has been given to maximizing existing resources of agencies and programs that can be leveraged in support of evidence-based IPV prevention practices. Several organizations involved in the planning process have committed to incorporating primary prevention programs and activities into their plans with existing budgets for the upcoming years. Other discussions have focused on ways to strengthen and build upon IPV primary prevention activities associated with existing legislation.

GTO® Step Six: The Plan

In developing goals and activities for each strategic direction for the plan, it was decided that a fifth strategic direction needed to be added that focused on data and evaluation and ensuring accountability towards achieving the outcome goals in the plan. (This strategic direction was initially included as part Capacity Building Work Team). The five strategic directions agreed upon for the plan are as follows:

- Engage youth in IPV primary prevention
- Reinforce men and boys role in IPV primary prevention
- Raise public awareness of IPV and IPV primary prevention
- Strengthen and increase the number of IPV primary prevention programs
- Results-based accountability

Part Two:
IPV Prevention Needs and Resource Assessment for Connecticut

Introduction

The IPVPSC collected and interpreted data from a variety of sources with the goal of identifying the needs and conditions that must be addressed in Connecticut to prevent intimate partner violence, and determining what are the indicators we can use to measure our progress in preventing IPV.

The specific goals of the needs assessment were to:

- Describe the socio-demographic characteristics of the population of Connecticut
- Identify socio-demographic and economic trends that might influence IPV perpetration, victimization, or implementation of prevention programming
- Examine existing data sources that describe the incidence and prevalence of IPV in Connecticut
- Explore data revealing the impact of IPV in Connecticut

The needs portion of the assessment utilizes publically-accessible data and reports from the following Connecticut state agencies: the Department of Emergency Services and Public Protection (DESPP), Department of Public Health, Department of Education (SDE), Department of Children and Families, U.S. Department of Justice, and The Connecticut State Data Center. Additional secondary analyses were performed for the plan regarding rates of assault per population using the data from the DESPP Detailed Family Violence reports and population statistics at the town level from the Department of Health. The resource portion of the assessment draws upon data from CCADV Strategic Directions Survey and CCADV's quarterly reporting form for member agencies.

<u>Connecticut State Profile</u>

A brief state profile is provided describing the people, conditions, and resources of Connecticut, as well as highlights of regional differences within the state.

Geography

Connecticut is located in the Northeastern United States, sharing borders with Massachusetts to the north, Massachusetts and Rhode Island to the east, the Long Island Sound to the south, and

New York to the west. Connecticut is one of the smallest states geographically, covering 5,544 square miles.

Connecticut consists of 169 towns, divided into 8 counties, as shown in Figure 3. The county divisions are not reflective of the governance structure, since towns, not counties, are the units of local government. Each State agency divides the state into separate yet inconsistent regions for the purpose of service delivery.

Figure 3: Connecticut Counties

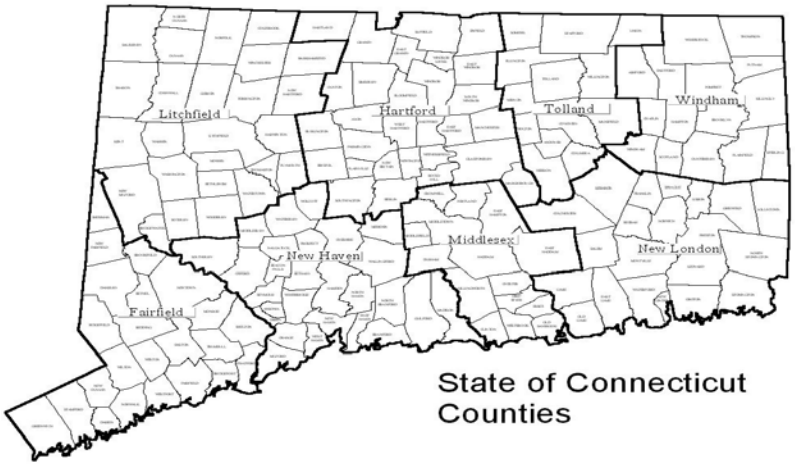


Table 7: Population density by county.[11]

Population per square mile, 2010 – (No. of people per square mile)	
County	**Value**
Fairfield	1,467.2
Hartford	1,216.2
Litchfield	206.3
Middlesex	448.6
New Haven	1,426.7
New London	412.2
Tolland	372.2
Windham	230.9

Demographics

The U.S. Census Bureau 2011 American Community Survey[12] estimate for the population of Connecticut is 3,580,709, with 48.7% males and 51.3% females, and a median age of 40.3 years old. Residents in Connecticut are primarily White, comprising 78% of the total population, followed by Hispanic or Latino (13%), Black or African American (10%), and Asian (4%)[‡]. Just over 20% of households speak a language other than English in the home and 13.3% of the population was born in a foreign country. Of residents 25 and older, 88.6% are high school graduates and 35.7% hold a bachelor's degree or higher.

Of the 1,487,891 housing units available in Connecticut 67.5% are owner-occupied and 32.5% are renter-occupied. Families (66.8%) make up the majority of households, with children under the age of 18 comprising 33.4% of households, and households with individuals over the age of 65 make up 25.9% of households.

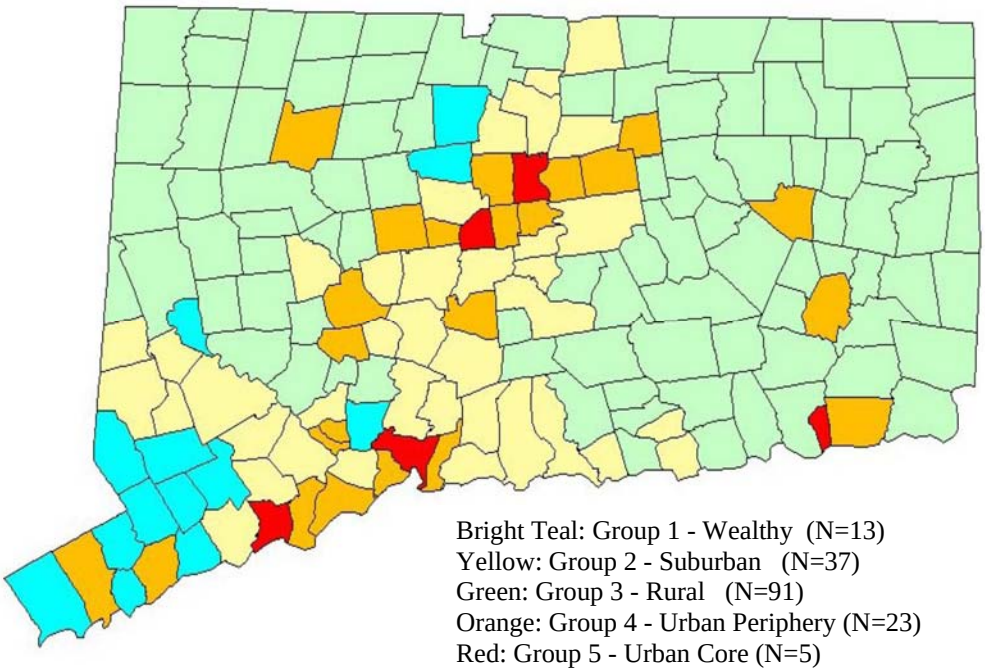
Connecticut's Economy

Although IPV knows no boundaries of class, research shows that living in poverty is a significant risk factor for IPV.[13] Connecticut has the highest personal per capita income, third highest median household income, and third lowest poverty rate in the U.S. The median household income is $69,243, with 9.5% of the population living below the poverty level.[12] Yet there are marked differences in socioeconomic status across towns in each county.

The Connecticut State Data Center has categorized Connecticut towns based on the median income, poverty level, and population density. Known as the "Five Connecticuts", the categories include: Wealthy, Suburban, Rural, Urban Periphery, and Urban Core.[14] Mapping of the "five Connecticuts" shows how one of the wealthiest states in the nation also has pockets of concentrated poverty.

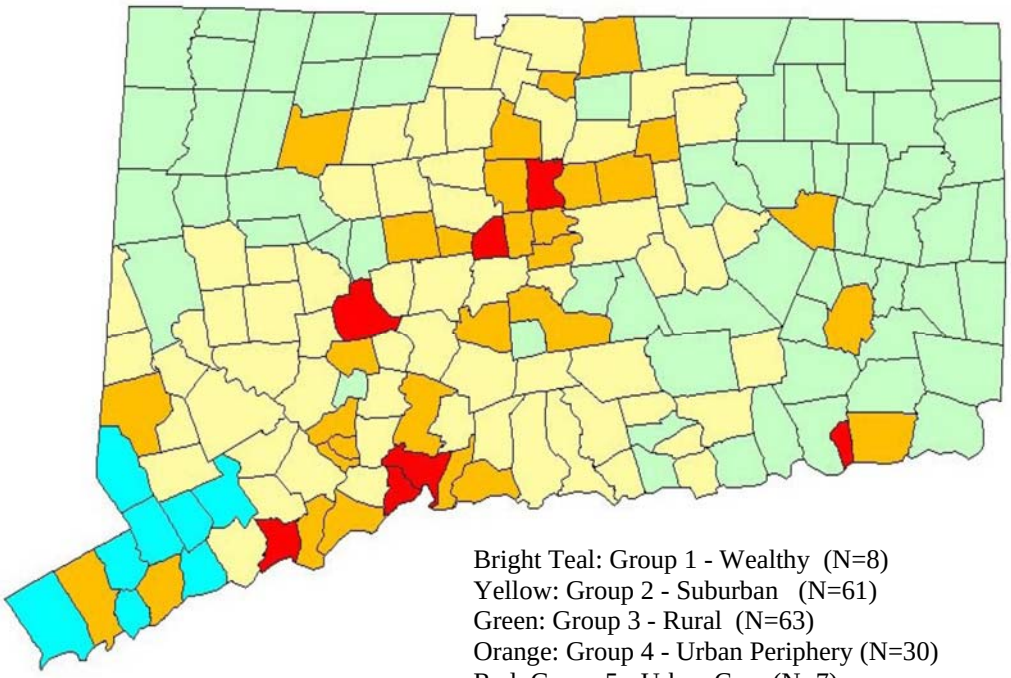
[‡] These percentages account for individuals with more than one race category.

Figure 4: Map of 1990 Town Groups[14]



Bright Teal: Group 1 - Wealthy (N=13)
Yellow: Group 2 - Suburban (N=37)
Green: Group 3 - Rural (N=91)
Orange: Group 4 - Urban Periphery (N=23)
Red: Group 5 - Urban Core (N=5)

Figure 5: Map of 2000 Town Groups[14]



Bright Teal: Group 1 - Wealthy (N=8)
Yellow: Group 2 - Suburban (N=61)
Green: Group 3 - Rural (N=63)
Orange: Group 4 - Urban Periphery (N=30)
Red: Group 5 - Urban Core (N=7)

The Connecticut State Data Center has reported economic and demographic trends for Connecticut from 1990 to 2000. During this period, gains in income were concentrated in Wealthy Connecticut towns, however the number of wealthy towns decreased and their population decreased from 6.8% to 5.4% of the state's total population. This was in part due to the reclassification of five towns from Wealthy to Suburban. [14]

During this same period the population of the Urban Core grew by 125,643 or 24%. Connecticut's racial and ethnic minorities are concentrated in Urban Core towns. By 2000, the Urban Core accounted for only 19% of the state's population, yet 54% of all Hispanics and 55% of all Blacks in Connecticut resided in the Urban Core. Also in 2000, 55% of all Whites lived in towns that were at least 90% white. Furthermore, 78% (132 of 169) of towns were at least 90% White. [14]

Those living in the Urban Core have been economically distressed since at least the 1990s and up through the present. In 1990, 217,300 Connecticut residents were living below the Federal Poverty Line, making up 6.8% of the state's population. Throughout the 1990s the level of poverty grew 19%, accounting for 7.9% of all state residents. In 2000, the poverty rate in the Urban Core was 19.4% as compared with the statewide average of 7.6% and a national average of 12.1%. Also in 2000, 29% of all children in the Urban Core lived in poverty.[14] In the 2000s, the level of extreme poverty continued to rise 21%, for a total of 314,000 people, accounting for 9.2% of Connecticut's population.[15] Educational attainment in the Urban Core was below the national average. Teen pregnancy is another issue in poor communities. In the six poorest cities, as many as 58% of births to Latinas were to women 17 and younger, compared with 27% among Black women and 7% among White women.[15]

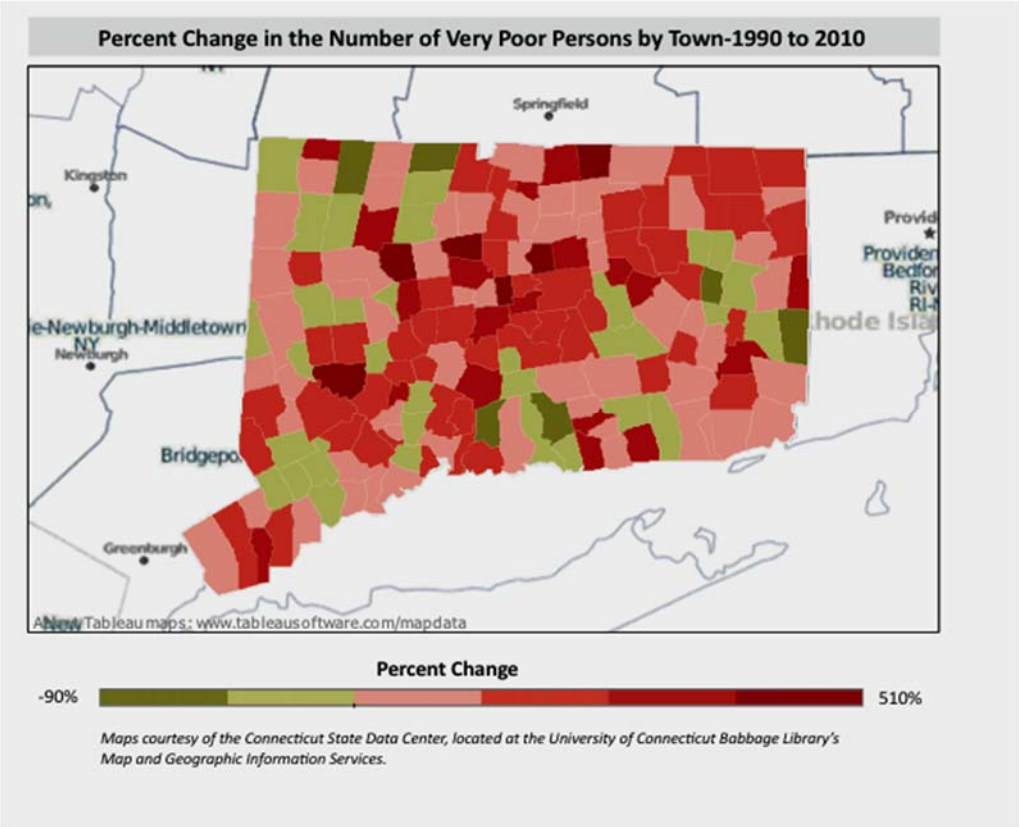
Current Economic Status in Connecticut

Research findings presented in the report titled: *Meeting the Challenge: The Dynamics of Poverty in Connecticut* demonstrate that unlike other states, Connecticut has been slow to recover from the economic downturn and poverty has grown in almost all parts of the state.[15] As of 2010, there were more than 720,000 people living at or double the poverty rate in Connecticut, which represented 21% of all residents in the state, an increase of 17% from two decades earlier.

From 1990-2010, out of the 169 towns in Connecticut, 131 towns saw an increase in their poverty rate, while just 38 towns saw a decrease. The number of people who struggled with insufficient income grew sharply in the most populous cities.

The figure below depicts the increase in the number of persons classified as "Very Poor" by Connecticut town during the period of 1990 to 2010. "Very Poor" are those individuals with incomes below $11,000 and families of four with incomes below $21,000.

Figure 6: Percent Change in the Number of Very Poor Persons by Town 1990-2010.[§15]



Poverty and education levels for people living in Connecticut are strongly correlated, especially for males. Both men and women with a B.A. or advanced degree are significantly more likely to earn above the state median income (78% and 68%, respectively). Conversely, without a high school diploma or GED a person is much more likely to be classified as very poor (72% for males and 62% for females).[15]

[§]Reprinted with permission from authors.

The report states that between 1990 and 2010, "there have been only eleven months during which the number of employed Connecticut residents exceeded the number employed in 1990. …Connecticut has the worst job creation record in the nation over the 1990-2010 period."[15 (pp.4)] In manufacturing, Connecticut lost 69,000 jobs between 1999 and 2011. The decline in manufacturing has hurt not only the middle-class, but also people living at or near poverty. Of the lost jobs, 25,000 paid under $40,000, which is less than double the poverty rate for a family of four. Connecticut residents living in or near poverty have experienced a significant reduction in the number of lower wage jobs.[16]

In May 2013, the Connecticut Economic Outlook,[17] a quarterly report by the University of Connecticut Center for Economic Analysis, announced that the state's economy is recovering very slowly and is lagging the performance of the overall U.S economy. Connecticut has regained only a quarter of the jobs it lost since 2007. Unemployment in April 2013 was 8% compared with 7.5% for the U.S, which is the lowest it has been in four years. Connecticut's slower growth has led to declines in state tax revenue that are even lower than forecasted.[17] This may have ramifications for IPV primary prevention efforts, as attempts to close the state budget gap may lead to additional funding cuts to state agencies and programs in public health and social services.

National Intimate Partner and Sexual Violence Survey (NISVS) [18]

The Centers for Disease Control and Prevention's National Intimate Partner and Sexual Violence Survey is an ongoing, nationally representative, random digit dial (RDD) telephone survey that collects information about experiences of sexual violence, stalking, and intimate partner violence among non-institutionalized English and/or Spanish-speaking women and men aged 18 or older in the United States. [18]

Findings include a prevalence estimate of IPV, the estimated number of victims, and 95% confidence intervals. Prevalence estimates are based on a sample and not a census of the U.S.

population.[**] Readers are *cautioned* against comparing estimates across states, with the U.S. as a whole or by gender. Estimates that have overlapping confidence intervals might not be meaningfully different from each other and additional statistical analyses are needed to test for significant differences.

Connecticut findings from the 2010 NISVS[18] were as follows:

- The lifetime prevalence of rape, physical violence and/or stalking by any intimate partner for females was 32.9% (N=442,000) and for males was 33.9% (N=462,000).

- The lifetime prevalence of rape, physical violence and/or stalking by any intimate partner with *any IPV-related impact* was 23.2% (N=327,000).
- The lifetime prevalence of rape, physical violence and/or stalking by any intimate partner with *fear or concern for safety* was 21.8% (N=306,000).
- The lifetime prevalence of rape, physical violence and/or stalking by any intimate partner with *PTSD symptoms* was 19.8% (N=278,000 victims).
- The lifetime prevalence of rape, physical violence and/or stalking by any intimate partner with *injuries or in need of medical care* was 17.9% (N=252,000).
- An estimated 22.1% reported having been raped in their lifetime.
- The prevalence of victims of other types of sexual violence other than rape was 48.6% (N=683,000).

The Connecticut Department of Public Health

The Connecticut Department of Public Health (DPH) is designated by Connecticut law as the lead agency for statewide health planning activities. Responsibility for overseeing the public's health in the state rests with the Commissioner of Public Health and Directors of Local Health Departments are considered agents of the Commissioner. They engage in public health activities at the local level and receive training, certification, technical assistance, and specialty services from DPH. There are 73 local health departments, of which 51 are full-time and 22 are part-time. The full-time health departments, which serve approximately 95% of Connecticut's

[**] Estimates that are based on a sample always include some error. This uncertainty or error is estimated with a 95% confidence interval. The confidence interval provides a range of values that likely include the true prevalence estimate. The 95% confidence interval means that we can be 95% confident that the true prevalence is within the interval.

population, include 30 municipal health departments and 21 health districts (serving 2 to 18 towns). There are also 2 tribal health departments within the state.

Connecticut is ranked 28th in the nation for state funding of public health for fiscal year 2011-2012, despite the critical need to invest in disease prevention and health promotion.[19] Beyond financial support, Connecticut's DPH is well positioned to emerge as a collaborative statewide leader in regard to IPV primary prevention initiatives. The key entity within the agency that could offer guidance and leadership is the Injury Prevention Unit of the Community Health and Prevention Section (CHAPS).

Connecticut School Health Survey: Teen Dating Violence

The Connecticut School Health Survey (CSHS)[20] includes a Youth Behavior Component (YBC) derived from the Centers for Disease Control and Prevention Youth Risk Behavior Survey. Several items on the survey address IPV. The survey has been administered in Connecticut every two years since 2005.†† The survey is anonymous and confidential and is randomly distributed to classrooms within selected schools comprising youth in grades 9-12.

In 2011, Connecticut high schools had a 60% response rate for the YBC section. A total of 2,058 students completed the survey. The percentage breakdown by grade level was as follows: 26.3% in 9th grade, 25.2% in 10th grade, 24.4% in 11th grade, and 23.7% in 12th grade. The breakdown by ethnicity/race was: 13.1% Black (Non-Hispanic), 16.4 Hispanic/Latino, 65.4% White, 2.7% All other races, and 2.4% Multiple races. [20]

Findings pertaining to intimate partner violence

As many as 8.2% of teens reported being hit, slapped or physically hurt on purpose by a boyfriend or girlfriend (9.9% of males and 7% of females). Almost twice as many students (16.7%) reported that their boyfriend or girlfriend had verbally abused them (for example, called them names, made fun of then in front of other, made fun of their body or looks, or told them that they are no good or worthless) during the past 12 months. A total of 7.3% of youth (4.4% of males and 10.2% of females) reported they had been physically forced to have sexual intercourse when they did not want to.[20]

Table 8: Percentage of students who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months for CT and the U.S.[a]

	2005		2007		2009		2011	
Survey Year	CT	U.S.	CT	U.S.	CT	U.S.	CT	U.S.
Total	16.0	9.2	13.4	9.9	9.9	9.8	8.2	9.4
Male	17.8	9.0	13.8	11.0	10.7	10.3	9.3	9.5
Female	14.1	9.3	12.7	8.8	9.1	9.3	7.0	9.3

a. CDC, YRBSS [21]

Table 9: Percentage of students who had ever been physically forced to have sexual intercourse when they did not want to for CT and the U.S.[a]

Survey Year	2005		2007		2009		2011	
	CT	U.S.	CT	U.S.	CT	U.S.	CT	U.S.
Total	N/A	7.5	9.7	7.8	7.4	7.4	7.3	8.0
Male	N/A	4.2	7.9	4.5	6.3	4.5	4.4	4.5
Female	N/A	10.9	11.5	11.3	8.4	10.5	10.2	11.8

a CDC, YRBSS [21]

Limitations and Survey Changes

One is cautioned against comparing rates of teen dating violence between Connecticut and the U.S. without further statistical analyses to take into account confidence intervals. For the 2013 version of the YBC some of the IPV-related questions have been revised; instead of boyfriend/girlfriend, the survey now reads “someone you were dating or going out with” and the answer format was changed from yes/no to an open frequency format such as “I did not date” and options ranging from 0 times up to 6 or more times.

Pregnancy Risk Assessment Tracking System

Being pregnant is a known risk factor for experiencing IPV among women and this risk may be even greater for women living poverty.[56] According to findings of the "Connecticut Pregnancy Risk Assessment Tracking System (PRATS) Survey-Round Two" report, approximately 43,000 live births occur in Connecticut annually.[22] The majority of infants that are born in Connecticut are healthy and the mothers do not experience health complications, however a small percentage of them experience adverse health outcomes during pregnancy or at birth. It is well understood that exposure to any physical violence prior to pregnancy places a women's health and safety at risk as well as that of her infant. Experiencing physical violence also can lead a woman to engage in other risky behaviors such substance abuse, or to experience increased stress, a poor diet, and perhaps to delay or forgo essential prenatal medical care.

To determine the prevalence of maternal risk behaviors and experiences during the perinatal period and their association with adverse pregnancy and infant health outcomes, the Connecticut Department of Public Health (DPH) conducted two point-in-time surveys modeled after PRAMS1, called the Pregnancy Risk Assessment Tracking System (PRATS) survey.

The first round of the PRATS survey was conducted between February and May 2002. The second round was conducted between September 2003 and January 2004. A random sample of birth records (n=4,480) was selected from the November 2002 to June 2003 birth cohort. The sample was stratified by a dichotomous risk category, where low birth weight (<2500 grams) or early gestational age (<37 weeks) was selected as the high-risk category. Non-resident births, multiple births, and births without birth weight recorded were excluded from the sampling frame. A packet consisting of a cover letter and the survey (available in English and Spanish) was mailed to the sample of mothers, inviting them to respond either by mail or by telephone. The response rate was 44.2% (n=1982). The age and race/ethnic composition of the survey respondents generally mirrored that of the maternal demographics seen in the birth cohort from which the sample was derived.[22]

Select findings from the PRATS survey included the following related to intimate partner violence:

Teenage Births

Historically, teenage mothers have experienced poorer outcomes and engaged in risk behaviors more often than older age groups. Several key findings pertaining to teen mothers and IPV were as follows:

- Eighty-seven percent (87.4%) of teens were not trying to become pregnant at the time they did.
- One-fourth (26.3%) of teens that were not trying to become pregnant reported they were doing something to prevent pregnancy.
- One-third (33.0%) of teens were on Medicaid prior to pregnancy.
- Eighteen percent (18.2%) of teens reported experiencing physical violence during the 12 months before getting pregnant, much higher than women ages 25 and older.

Family Planning

- Almost 44% of women reported that they were not trying to become pregnant at the time they did; of these, 39% reported they had been doing something to prevent pregnancy.
- Almost 80% of Blacks and more than half of Hispanics (58%) reported they were not trying to become pregnant at the time they did, whereas 35% of Whites were not trying to become pregnant.
- Race/ethnic differences were not seen among those not trying to become pregnant who were also doing something to prevent pregnancy (each approximately 40%).

Physical Violence

- Approximately 6% of women reported they were pushed, hit, slapped, kicked, choked, or physically hurt some way by someone during the 12 months before getting pregnant.
- Blacks (13.4%) were more likely to have experienced some form of physical violence in the 12 months prior to getting pregnant compared to Hispanics (7.0%) and Whites (4.5%).

Health Education

- In addition to addressing the medical needs of the mother during perinatal care visits, there are also opportunities to provide health education about a number of critical risk factors. Survey results showed that only 33.8% of providers talked about physical abuse to the women by their husbands or partners.

Based on these findings the authors of the April 2006 PRAT report remarked that, "Efforts to reduce violence against women and to identify women experiencing domestic or intimate partner violence are critical."[22 (pp.8)] The results of the survey also pointed to the need for providers to integrate 'less traditional topics such as perinatal depression, physical abuse, and injury prevention into prenatal care visits so as to provide providing a comprehensive approach to care.' Findings from the survey also indicate racial and ethnic disparities in IPV risk during pregnancy for Black and Hispanic women compared with White women.

Connecticut Department of Children and Families (DCF)

Research has shown that there is a strong correlation between experiencing family violence as a child and becoming either a victim or perpetrator of domestic violence. Children's well-being, safety, and stability are at risk when their parents experience IPV. Children who live with domestic violence face increased risks of neglect, of being directly abused, and of losing one or both of their parents among other risks.[23,24]

Over the course of a year, the Department of Children and Families receives about 95,000 calls for assistance, including about 47,000 calls alleging the abuse or neglect of children and youth.[25] On any given day, about 30,000 youngsters receive services provided or funded by DCF across its child welfare, children's mental health, juvenile justice and prevention mandates. DCF recently examined disproportionality and disparity by race and ethnicity in the child welfare cases that they serve. The following data, which was compiled and analyzed in 2010, revealed significant disparities. The report identified the following disparities:

- While children of color[‡‡] make up about 37% of the total number of children in Connecticut, they comprise 58% of children referred as alleged victims of abuse or neglect, 61% of all

[‡‡] Defined as those across all races and ethnicities who did not report being white/non-Hispanic.

children where abuse or neglect has been substantiated and 60% of children in cases opened for DCF services.

- Children of color constitute 67% of all children in a DCF funded placement, whether a foster family or a congregate setting.
- African American children constitute about 11% of the total child population in Connecticut, but they constitute 21% of all child welfare referrals and 22% of substantiations and cases opened for DCF services. They constitute approximately 27% of all placements, whether a foster family or a congregate setting.
- Latino children constitute about 19% of the total child population in Connecticut, but 28% of all referrals and 30% of all substantiations and open cases. Among all children in placement, Latino children account for 32%.
- The category of other race includes American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other, Multi-Racial and Missing/Unknown. These children constitute about 7% of the total population of children in Connecticut and 9% of referrals, substantiations and open cases. They also constitute 6% of all children in placement.

Children in Placement: 2012

In early August 2012, 4,168 children and youth on the DCF caseload were placed either in congregate care or in foster family placement settings, excluding those in the three DCF facilities. These data represent a steady decline in the number of out-of-home placements over the past decade with a significant decline over the past 18 months. Placement data as of August 7, 2012 are shown below[25]:

Table 10: DCF Placements as of August 7, 2012[a]

Placement Type	Number of Youngsters
Foster Family Care	1947
Relative Care and Special Study Foster Families	1186
Residential Treatment, In and Out of State	360
Group Homes and SAFE Homes	427
Medical Placements	30
Shelters	87
Independent Living	123
[a.] Healthy, Safe, Smart and Strong report[25]	

Across all of the 4,278 children in placement, 1,631 or 38% were White/Not Hispanic and 62% were of various other races and ethnicities. These data confirm that disparities in placement by race and ethnicity revealed in 2010 findings has continued into 2012.

Table 11: DCF Numbers In Context[a]

What?	How Much?	In Context
Careline calls and reports	The Careline received approximately 93,000 calls in State Fiscal Year 2010. These included over 45,000 reports of suspected abuse or neglect, of which over 24,500 were accepted for investigation.	Approximately **6,800** reports were substantiated.
Intact families receiving services	As of March 2011, the Department provides treatment services to approximately 3,875 families whose children remain safely at home after an investigation of neglect or abuse.	The number of families whose children live at home and receive Department services has grown by 37 percent since 2002.
Abused and neglected children in care	Approximately 5,000 children in the Department's custody receive services because of abuse/neglect.	The number of children in state care has declined 18 percent since 2004 and 28 percent since 2000.

[a] DCF Fast Facts.[26]

Domestic Violence Estimates for Substantiated Child Abuse Cases in the Department of Children and Families

The Department of Children and Families (DCF) reports an estimated 60% (approximately 4,080) of substantiated cases of child abuse or neglect by their agency also involve incidents of domestic violence. Mary Painter, Director of Substance Abuse & Domestic Violence at DCF, has stated in an email correspondence (May 2013) that they do not track intimate partner violence incidence specifically in their database system, so these percentages are estimated based on different case sampling efforts. They are currently reviewing how and what data is collected specific to domestic violence, so as to improve their data collection system.

Family Violence: Uniform Crime Report

Connecticut has a comprehensive system for reporting family violence offenses, which provides information on the ages of victims and perpetrators as well as their relationship classification. The Family Violence Detailed Reports are published annually as part of the Uniform Crime Reporting System in Connecticut.[27]

"Family Violence" is defined in Connecticut statutes to mean an incident resulting in physical harm, bodily injury or assault, or an act of threatened violence that constitutes fear of imminent physical harm, bodily injury or assault between family or household members. Verbal abuse or argument shall not constitute family violence unless there is present danger and the likelihood that physical violence will occur.[28]

Findings from 2011 Detailed Family Violence Report[27]

This data shows us that in 2011, there were 20,990 family violence related offenses in Connecticut, comprising 1/3 of all criminal court cases. The number of victims and offenders totaled 42,982.

Of the 20,494 offenses, the most common charges were disorderly conduct (33%), assault (32%), breach of peace (22%), and other/court order violation (11%). Less common charges were criminal mischief (.06%), sexual assault (.05%), risk of injury (.05%), homicide (.01%), and kidnapping (.01%).

Out of the total offenses, 25.6% did not involve weapons, while the majority (64.2%) involved weapons of hands, fists, feet, etc. Only 3.2% involved a knife, 0.7% involved a gun, and 6.3% involved other dangerous weapons.

Out of the total offenses 59.3% did not involve a physical injury, 39.7% involved a minor physical injury, 0.9% involved a serious physical injury, and less than 0.01% involved a fatality. At least one third (33.3%) involved drugs or alcohol and at least 19.4% involved individuals with prior court orders.

Demographics of Offenders and Victims

> "Family or household member" means (A) spouses, former spouses; (B) parents and their children; (C) persons eighteen years of age or older related by blood or marriage; (D) persons sixteen years of age or older other than those persons in subparagraph (C) presently residing together or who have resided together; (E) persons who have a child in common regardless of whether they are or have been married or have lived together at any time; and (F) persons in, or have recently been in, a dating relationship."[28]

Out of the 42,982 total family violence offense victims and perpetrators for 2011, 30% were live-in or companions, 20% were boyfriends/girlfriends, 16% were spouses, and 32% involved relatives. 19.0% had a child present during the offense, and 14.5% involved children. Of the 18,132 victims**,** 74% were female and 26% were male.

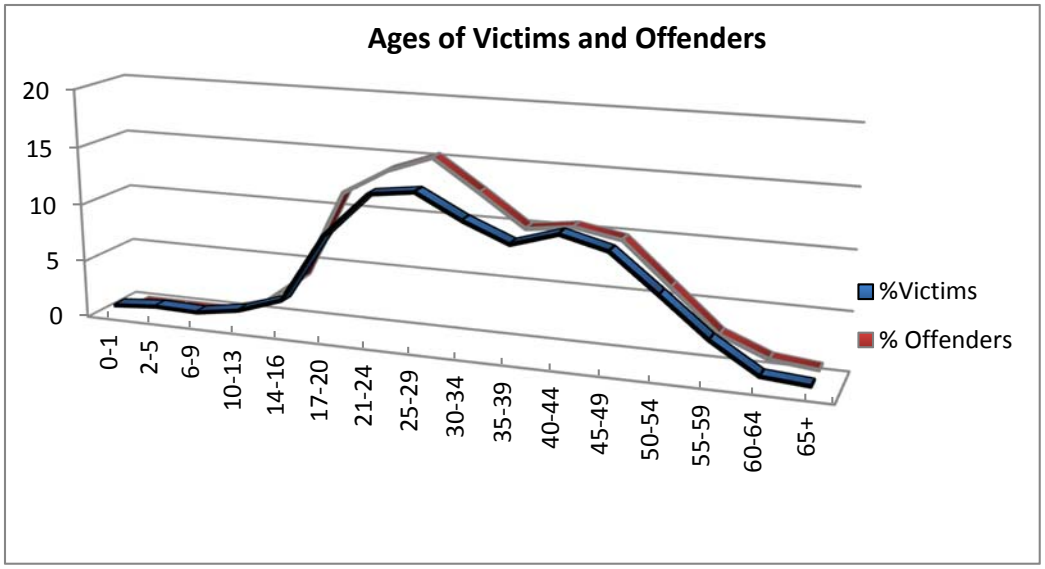
The ages of victims were as follows:

- 7.9% were under age 17
- 13.7% were between ages 17 and 24
- 24.6% were between ages 25 and 34
- 20.6% were between ages 35 and 44
- 16.7% were between ages 45 and 54
- 5.5% were 55 and older

Out of the 16,644 offenders**,** 77% were male and 23% were female. The ages of these offenders were as follows:

- 4.9% were under age 17
- 25.6% were 17-24
- 28.0% were 25-34
- 20.5% were 35-44
- 16.1% were 45-54
- 4.8% were 55 and older

Figure 7: Ages of Victims and Offenders based on arrest data[27]



Rates of Family Violence Offenses per Population

Using data from the State of Connecticut's Family Violence Detailed Report (2011)[27] and the Department of Public Health estimated population data from 2011,[29] the authors of this report calculated that the average rate of family violence offenses per 1,000 population in Connecticut was 5.67. The highest rates of family violence offenses per population were in the following cities/towns: New London (18.32), followed by Putnam (15.1), Hartford (14.55), Norwich (11.48), New Britain (11.27), Torrington (10.70), Manchester (10.45), New Haven (10.33) and Windham (9.72). Of these towns with the highest rate of offenses per population, New Haven had the greatest percentage of arrests for assault (42%), followed by New Britain (41%), Hartford (40%), Norwich (36%), Torrington (26%), Manchester (26%), Windham (24%), New London (22%), and Putnam (21%).

Table 12: Connecticut Towns with the highest rate of Family Violence Offenses per population.

Town	**Estimated 2011 Population[a]**	**Family Violence Offenses 2011[b]**	**Family Violence Offenses 2010[c]**	**Family Violence Offenses per 1,000 population 2011[a]**	Assault[b]	Sexual Assault[b]	Breach of Peace[b]	Disorderly Conduct[b]	Other/Court Order Violation[b]
New London	27,569	505	452	18.32	22%	0%[d]	39%	24%	13%
Putnam	9,562	144	116	15.1	21%	0%[d]	26%	35%	17%
Hartford	124,867	1,817	1,825	14.55	40%	1%	21%	27%	11%
Norwich	40,408	464	465	11.48	36%	1%	11%	35%	17%
New Britain	73,261	826	989	11.27	41%	0%[d]	10%	37%	11%
Torrington	36,167	387	352	10.70	26%	1%[d]	40%	18%	14%
Manchester	58,287	609	620	10.45	26%	0%[d]	29%	33%	10%
New Haven	129,585	1,339	1,371	10.33	42%	0%[d]	43%	5%	6%
Windham[e]	25,214	245	286	9.72	24%	0%[d]	35%	26%	13%

a. Annual Town and County Population for Connecticut[29]
b. Family Violence Detailed Report 2011[27]
c. Family Violence Detailed Report 2010[27]
d. 0% does not mean that there were no sexual assaults, but the percent was below .01
e. The town of Windham includes Willimantic, South Windham, and North Windham.

Data Limitations

The number of family violence offenses per population does not tell us the incidence of those perpetrating or affected by intimate partner violence. Multiple offenses in a year can be perpetrated by a single repeat offender. Within research studies on family/domestic violence, re-arrest rates for family offenses in Connecticut have been found to be as high as 47% within an 18-month period.[30] Many family violence offenses go unreported. National research has found that about 46% of IPV victimizations were not reported to police between 2006 and 2010. The percentage of IPV victimizations not reported to police was about the same, regardless of whether the victimization was a simple assault (44%) or a serious violent crime (47%). Among the unreported IPV victimizations, 38% went unreported because the victim was afraid of reprisal or getting the offender in trouble.[31]

Domestic Violence Fatalities

In 2011, the Connecticut Domestic Violence Fatality Review Committee examined homicide/suicide cases that occurred from 2000 through 2009.[32] The total number of intimate partner fatalities for this timeframe was 146. The highest incidence of domestic violence fatalities occurred in 2004 (N=21), while the lowest number occurred in 2009 (N=10). From 2006-2009, there is an overall decline of 18.75%.

Victim's and offender's age and gender were as follows: 75% of all domestic violence homicide victims and 69% of those committing homicides were between 20 and 49 years old. Yet, 20-49 year olds make up only 40% of the overall population of Connecticut. Findings also show that 85% of homicide victims were female and 90% of those committing homicide were male. Whereas only 13% of victims were male and 10% of those committing homicide were female.

Relationship status was as follows: 35% of all homicide victims were married to their perpetrator at the time of their death, whereas 25% of victims were living with their partner, 27% were identified as a girlfriend or boyfriend, and 13% had a child in common.

CCADV Member Agencies and Domestic Violence Victim Services

CCADV, through its member agencies, provided services to over 57,785 victims in 2012, and on any given day served approximately 1,200 victims statewide. A total of 27,787 contacts with

victims in crisis were handled by the staff and volunteers of member agencies. There were 1,378 adults and 1,018 children who stayed in emergency safe homes because they were in serious physical danger and had no other safe options. Of those seeking services, there were 11,721 adults, 76 teens experiencing dating violence and 522 children that received support services. Another 42,923 individuals were court-referred domestic violence victims that received direct services from court-based advocates who act as liaison between the victim and the court system. These services also included counseling, court advocacy, assistance with orders of protection, information and referrals to community services and assistance with developing safety plans.[33]

Victim's age, gender and ethnicity were as follows: 92% of all victims receiving services were female while 8% were male; 88% were over the age of 18 while the remaining 12% were 17 years old and younger. 45% of those served identified as White, 24% Latino/Hispanic and 15% African American. There were 7% who identified as another ethnicity such as Asian, Native American or Hawaiian/Pacific Islander, while 9% chose not to self-identify.

Strategic Directions Survey: Brief Summary

In June 2012, CCADV and the Steering Committee conducted a rapid needs assessment to solicit input from a broad range of stakeholders working in the area of domestic violence in Connecticut, especially in regards to selecting 3-5 strategic directions. Its purpose was to:

- Determine who is currently involved in primary prevention work
- Determine potential partners for primary prevention efforts
- Identify barriers and opportunities that affect IPV primary prevention
- Identify gaps that must be addressed to adequately build capacity around IPV primary prevention

The assessment utilized an electronic survey and several follow-up calls with individuals to clarify some of the data regarding program numbers and expenditures. Respondents were given a list of strategic directions to rank into their top four priorities in the areas of prevention programming and prevention capacity building in Connecticut. The list of options was derived from DELTA IPV Primary Prevention plans from 14 other states. The survey also asked respondents to explain their rational for their top four priorities, using a qualitative response format. The survey also captured some information on existing primary prevention programs and the capacity and resources for primary prevention possessed by organizations in Connecticut.

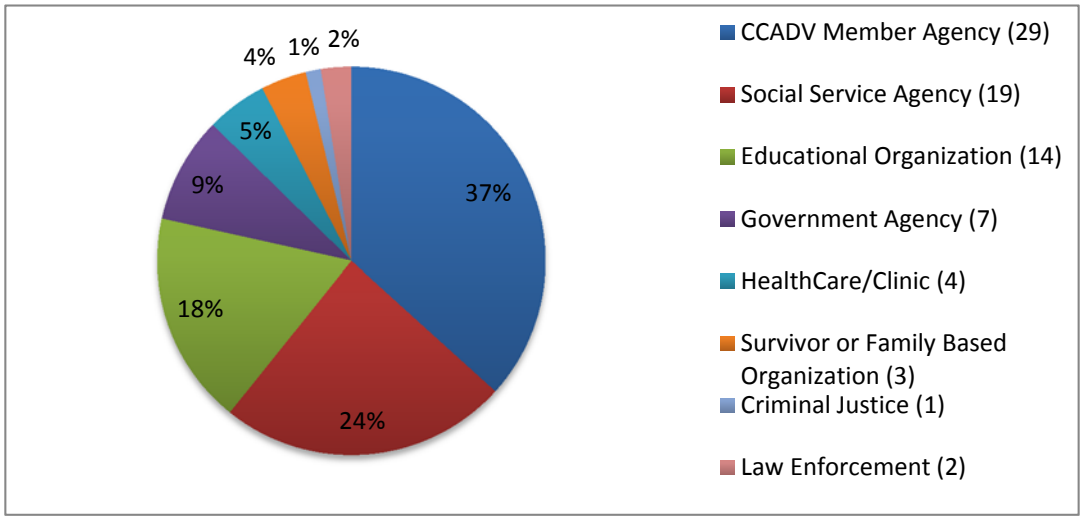
Methods

The survey link was sent electronically via SurveyMonkey.com to key organizational directors, staff, state and local entities, and community-based organizations working to eliminate intimate partner violence across the state. The survey was distributed via email to approximately 250 individuals in July and again in August of 2012. The response rate was approximately 63%. Analysis was conducted using SurveyMonkey.com and Excel statistical analysis software.

Respondent Demographics

There were 157 individuals who initiated taking the survey. Of these, 102 (65%) completed the survey. Respondents were from all eight counties in the state and belonged to a range of different types of organizations. A majority of them were CCADV member organizations. Faith-based organizations were not represented among survey respondents.

Figure 8: Agency Types selected by respondents to the Strategic Directions Survey (N=80)



- 80 of the respondents reported at what type of agency they worked. Of these 37% were employees of CCADV Member Agencies, another 24% were employees of social service agencies, 18% were from an educational organization, and 9% were from government. The remainder were from either a health care/clinic, a survivor or family based organization, law enforcement or criminal justice.
- 31% were Program Directors or Managers within their organizations,13% were Executive Directors of their organizations, and 28% were direct service staff.

Involvement and Organizational Supports for IPV Primary Prevention

- 49% (77/157) of respondents said that they were currently or had been recently involved in IPV primary prevention efforts. 51% (79/17) of respondents said they were not involved in IPV primary prevention.
- Of the 67 respondents who said that they were involved in IPV primary prevention, 63% have been involved for over 5 years, 16% have been involved for 2-3 years, 13% have been involved for 1 year, and 8% have been involved for less than a year.
- In total, 24 individuals (who indicated that they were either an executive director, program directors/manager or community leader) were asked to supply information on existing primary prevention programming in their agency or community group. They were from 21 different organizations throughout the state, 11 of these organizations were CCADV member agencies and the other 10 were governmental, law enforcement organizations, or community groups.
- They reported a total of 61 IPV primary prevention programs offered by their organizations/groups across the state [§§]. They reported organizational budgets for IPV primary prevention ranging from 0 to $240,000.

Results on Ranking Top Four Priorities for Primary Prevention Programming

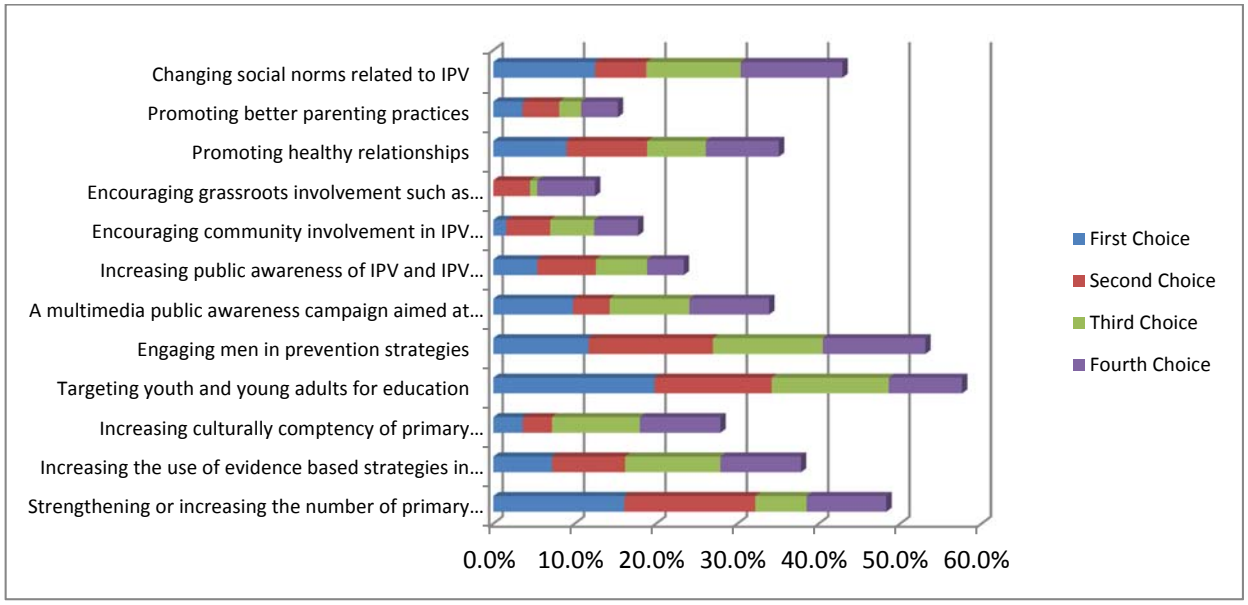
Respondents were asked to rank their top four priorities for future primary prevention programming and capacity building. In total 102 respondents provided rankings. In the diagrams below we provide the results of the ranking. More detailed information about the findings of the Strategic Directions Survey can be found in Appendix B.

The top four ranking strategic directions for primary prevention programming were:

1. Targeting youth and young adults for education and involvement
2. Engaging men in prevention strategies
3. Strengthening or increasing the number of primary prevention programs
4. Changing social norms related to IPV

[§§] This number was calculated from totaling the responses to the question "How many IPV prevention programs are offered at your agency?" Several individuals whose responses seemed excessively high were contacted by phone to confirm the accuracy of their responses and the numbers were revised with this new information. Also, the number was adjusted to account for several individuals who worked at the same agency.

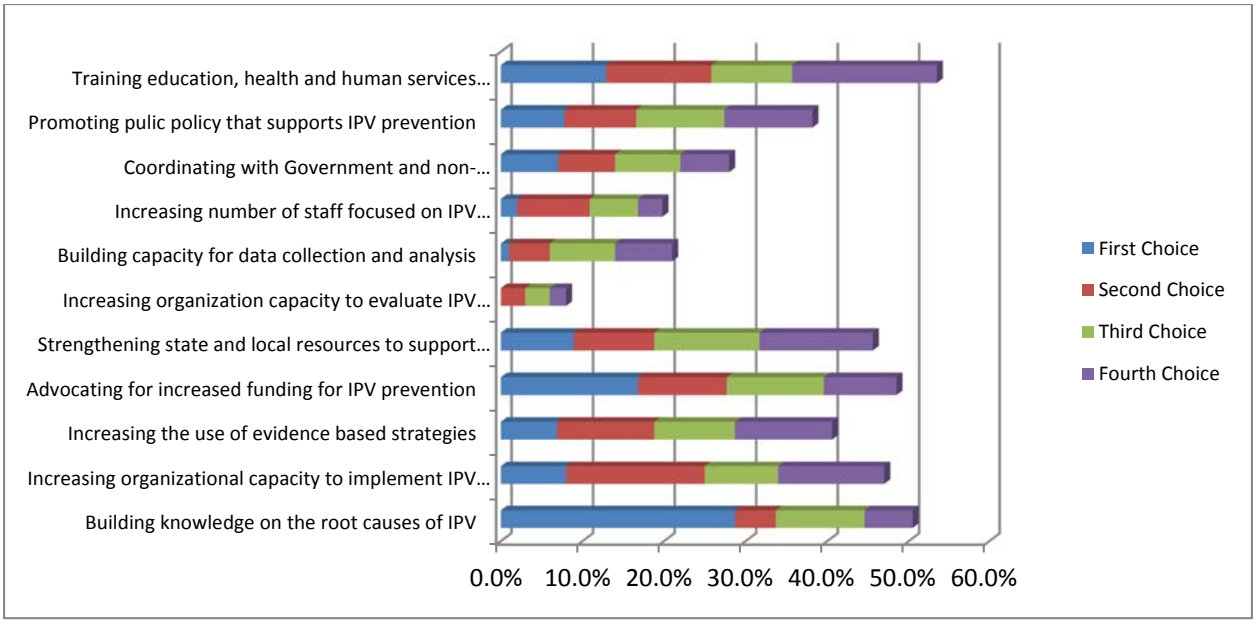
Figure 9: Ranked priorities for future prevention programs and activities.



The top four priorities for capacity building were:

1. Training education, health, and human services professionals on IPV primary prevention
2. Building knowledge on the root causes of IPV
3. Advocating for increased funding
4. Increase organizational capacity to implement programs

Figure 10: Ranked Priorities for Capacity Building



Part Three: Statewide IPV Primary Prevention Plan 2014-2017

Strategic Direction One: Engaging Youth in IPV Primary Prevention

Need Statement: Incidence and Prevalence of IPV among Connecticut Youth

In Connecticut, 8.2% of high school students who completed the School Health Survey in 2011 reported being physically abused by a boyfriend/girlfriend within the past 12 months, 16.7% reported being verbally abused by a boyfriend/girlfriend within the past 12 months, and 7.3% reported that they had ever been physically forced to have sexual intercourse when they did not want to.[20]

Research: Risk and Protective Factors for Youth

Individual level

Research has shown that the following factors correlate with teens who are victims of IPV: low self-esteem, disordered eating behaviors (dieting and binge-purging), suicidal ideation, and poor mental and physical health.[34,35] Depression seems to be more of a risk factor for females than males.[36] Use of alcohol, cigarettes, marijuana and other substances correlate with being both a victim and perpetrator of IPV for teens.[37,38,39] Low GPA is another risk factor for IPV victimization among female teens.[40,41] Based on national data, findings indicate that the prevalence of partner violence victimization may increase by a factor of 2 to 5 between adolescence and young adulthood, depending on the behavior examined.[40]

According to prior research, witnessing inter-parental violence[42,43] and experiencing child abuse[44,45,46] are factors in childhood that can put individuals at risk for becoming victims as well as perpetrators of IPV in adolescence or adulthood. One prominent theory is that IPV is a learned behavior that can be transmitted across generations through a child's witnessing it in their family. As Boivin et al (2012) notes, "some studies have found evidence that supports this theory for boys only or for girls only, while other studies find it applies to both genders, and some have failed to identify any link."[47]

Insecure attachments, parental divorce or living in a single-parent household also place females and males at risk for becoming victims of IPV.[43,48] An absent or rejecting father is hypothesized to be another risk factor for males becoming perpetrators of IPV.[49] Violence with a parent or sibling and parental divorce are other risk factors for being a perpetrator.[43,50]

Generally having a higher socioeconomic status, a higher education level, high social capital are factors that lower the probability of females being victims of IPV.[51]

Relationship Level

The following relationship factors place teens at risk for being victims of IPV: having a friend who is a dating violence victim and having ever been hit by an adult with the intention of inflicting harm.[52,53] Past sexual behavior, early age of sexual initiation, sexual attitudes, sexual risk taking, higher number of dating partners, or sexual abuse history have also been shown to correlate with IPV for teens.[36,37,41,54]

The frequency of verbal disagreements and high levels of conflict in relationships are strong predictors of physical violence in relationships.[55,56] Kaukinen found that status differentials favoring females can increase the likelihood for their experiencing emotional abuse from their partners.[57] Girls in grade eleven involved in relationships where there was mutual violence had lower levels of school connectedness and community involvement and the highest levels of delinquency, aggressive behaviors, distress and suicidal thoughts.[58]

According to Heise's social-ecological framework, delinquent peer associates are a risk factor for males committing acts of violence against women.[49] Having been bullied is hypothesized to be another risk factor for being a perpetrator of IPV.[59] Belief that violence against the opposite sex is justifiable is a known risk factor for being a perpetrator of IPV.[60] Reyes et al. found that heavy alcohol use in adolescence was associated with dating violence perpetration and that this association increased as levels of family conflict and friend involvement in dating violence increased.[39]

Having a close relationship with a caring parent figure and socio-economic advantages are generally protective factors for children.[61] Having a positive relationship with one's mother is

another resilience factor that may protect female teens from becoming victims of IPV.[41] The availability of someone to turn to for emotional support and having positive peer and sibling relationships and friendships are other potential protective factors.[62,63]

Community Level

To offer strategies to decrease IPV at the community level there must be an assessment and understanding of the composition of the community and how such risk and protective factors influence youth within the community. School environments with weak sanctions against disrespectful behavior, bullying, sexual harassment, and peer aggression may contribute to IPV.[64,65] Analysis of data from the National Longitudinal Study of Adolescent health found the odds of experiencing psychological violence were 1.5 times higher for males who attended large schools than for those who attended small schools.[40]

Where one lives and one's work conditions can correlate with different levels of risk for IPV and with different risk and protective factors. In one study, lack of social support and social isolation were found to correlate with IPV victimization among rural women in the U.S., but not urban women.[66] Neighborhood poverty and living in a disadvantaged neighborhood or where there is perceived neighborhood disorder are factors that correlate with increased prevalence of IPV.[67,68,69] For Mexican-American women, living in an urban area correlated with experiencing IPV.[70] Negative work conditions were strongly correlated with IPV among migrant farm workers in California.[71]

Involvement in the community and having connections to pro-social organizations are protective factors for teens mental health that may apply to preventing IPV.[72,73]

Societal Level

To be able to provide effective interventions targeted at the individual and community levels there must be an understanding of how factors at the societal level impact IPV. Societal norms are interrelated and interdependent with what is experienced in the community, a neighborhood, and one's home.

Two perspectives have dominated the debate about the role of gender in IPV.[74] The first

perspective has been guided by feminist theory, asserting that IPV is largely a gendered crime. Proponents of this viewpoint assert that males are usually the perpetrators of IPV, due to patriarchal ideologies and structures. This inequality extends to social constructions of masculinity and femininity. The linking of manhood to dominance, toughness, or male honor has been shown to support a culture that fosters violence against women.[75,76] Rigid gender dichotomies can not only hurt both men and women, they also exclude individuals who do not explicitly identify as male/female.

The second approach proposed by some family violence researchers views IPV as emanating from a variety of factors that potentially lead to males as well as females becoming either victims or perpetrators, or both. While acknowledging that IPV may result from a desire for power and control, some have contended that women can have as much desire to dominate their partners as men.[77,78,79,80] Those from the feminist perspective argue that this behavior of women is often in self-defense, and that male violence against women is much more likely to result in more severe physical harm against women when it occurs, than when women commit violence towards males.[81,82,83] Evidence from national surveys and from dual arrest data and recidivism data in Connecticut support this latter perspective.[84]

Cyber bullying and sexting are two new behaviors that have become widespread among teens, which could manifest as IPV when they occur between intimate partners and result in experiences of victimization. Bennett et al. conducted a study of college-age students' experiences with "electronic victimization" among friends and dating partners.[85] Four specific types of electronic victimization were identified: direct hostility, intrusiveness, public humiliation, and exclusion. In an unpublished dissertation cited by Alvarez, females reported being victimized via electronic communication more frequently and were also more likely to report distress as a result of the victimization.[86] More research is needed on these experiences among children and adolescents as they relate to IPV.

Resources: Existing IPV Prevention Strategies and Programs for Youth in CT

According to the 21 program directors and managers who responded to our Strategic Directions survey at least 61 primary prevention programs for IPV are currently being implemented across the state, and likely many more are being implemented than we were able to document.

Programs include implementation of evidence-based curricula such as Safe Dates and Second Step as well as numerous community education activities especially in schools.

The Engaging Youth Work Team noted that there does not seem to be a standard curriculum for teen dating violence or for youth exposed to domestic violence utilized in Connecticut. All the groups represented on the Work Team are currently doing something that addresses ways to keep our teens safe. Speak Act Change, Respect WORKS!, Safe Dates, and Love is not Abuse are some of the better known programs currently being implemented. Attention is also being focused on issues related to school climate and bullying. Yet there is no clear consensus as to *how well and effectively* we are reaching our youth to prevent teen dating violence and to address the risks faced by youth exposed to domestic violence in their homes.

From our Strategic Directions Survey, of the 41 different organizations represented by survey respondents who listed where they worked, over half (58%) reported that their organization offered some form of primary prevention IPV program for youth. Almost one third (32%) of respondents who completed the survey indicated that their organizations have IPV prevention programs for youth in schools and (21%) reported that they have programs for youth after school. However, whether or not IPV primary prevention programs are offered in schools is highly variable across school districts depending on the availability of resources, knowledge, and/or commitment in this area.

On the Strategic Directions Survey, changing social norms related to domestic violence was chosen as a top priority by many of the respondents and also discussed in many explanations of respondent's rationale for their priorities. One fourth of the respondents 25% (28/112) indicated that their organization currently sponsors programs to encourage positive social norms that prevent intimate partner violence.

CCADV member agencies already have in place many community education activities focused on youth, but not all of the current activities are based on sound theory or are evidence based. In January 2011, CCADV initiated a specialized Prevention Capacity Building Training over a twelve-month period that was attended by community educators/prevention specialists from their member agencies. In addition to gaining a greater understanding of primary prevention,

each participant designed and has begun implementing a school-based plan of action to deter IPV in its earliest stages. Plans include strategies for engaging youth in middle and high schools and organizing at college campuses and within their communities. Below is a sampling of community educator goals and activities from their designated plans:

- To create a youth leadership task force on teen dating violence and healthy relationships
- To develop, facilitate and evaluate cyber-bullying prevention education using the ADL Cyber-Bullying curriculum
- To sustain violence prevention education in grade six while expanding to grade seven using the Second Step model
- To create a Peer Education Program in grades 4-8 with the purpose of increasing leadership and social action skills
- To create a team of men within the community who are prepared and committed to work with boys on violence prevention education and activities

CCADV will continue to provide training and technical assistance to support each agency as they expand their local capacity for providing evidence-based primary prevention programming.

As a result of recent legislation, the Connecticut State Department of Education has mandated that teachers in schools be trained in teen dating violence prevention. They have begun updating their website to include information on teen dating violence prevention for educators. More resources, however, are needed to evaluate the outcome of these training initiatives and to assess any new policies and/or programs being offered in schools.

<u>Plan: Goals and Activities for Engaging Youth in IPV primary prevention</u>

The Engaging Youth Work Team agreed that much more could be done throughout Connecticut to engage youth in IPV primary prevention activities and the Team welcomes leadership in best practices to inform these efforts. One of the top goals for the next three years is to expand the use of evidence-based curricula to promote healthy relationships in youth-serving agencies and institutions throughout the state. This will be achieved through providing trainings on Safe Dates, Second Step and other evidence-based or best practices curricula to professionals working at community-based organizations, schools and other institutions. In the course of our strategic planning efforts, the Manson Correctional facility for youth has requested the Safe Dates curricula to be considered for adoption in their facility. The Governor's Prevention Partnership

also plans to offer/host trainings in teen dating violence prevention for mentoring programs across the state. However, due to their high cost, some organizations are not able to afford to purchase these evidence-based curricula. There is also an issue of how much time is allocated for prevention efforts. If youth only receive a program once, for a very brief time, as part of a health class or community-based program, this may be insufficient to achieve longer-lasting behavior change. Also, it is important that the initiatives satisfy a variety of requirements for school, state agency partners, and youth programming, and that programs are appropriate for a range of developmental stages (middle school, high school, and college). Programs also need to be culturally competent and appropriate for urban, suburban and rural youth.

A second goal is to involve youth in IPV primary prevention activities. Curricula such as Safe Dates and other similar curricula with peer leadership or bystander components are designed to ensure that youth are active participants in promoting healthy relationships among their peers. Another set of activities that aims to involve youth in IPV prevention is to offer teen dating violence prevention workshops at conferences oriented towards youth or youth serving agencies and having these workshops be co-facilitated by youth.

A third goal is to increase positive messaging about healthy relationships using social media and a mobile application (app) called td411, which was developed by CCADV. This is a potentially effective strategy for reaching youth since they spend considerable time using social media such as Facebook, Instagram and Pinterest. According to research by the Pew Research Center Internet and American Life Project, fully 95% of teens in the U.S. (ages 12-17) use the internet and eight in ten online teens use some kind of social media.[87] CCADV and its partners plan to update the existing app and engage in a comprehensive social marketing campaign to help promote use of the app among teens.

Plan: Anticipated Outcomes and Outcome Indicators

The anticipated intermediate outcomes are increased healthy relationship norms among youth. Youth will also increase their skills and knowledge to become active bystanders in preventing IPV and to engage in healthy relationships-including positive communication, anger management, and conflict resolution. We also aim to improve social leadership competencies of

youth. Pre and post surveys will be administered by programs to assess outcomes in those agencies utilizing evidence-based or best practices curricula for preventing IPV among youth.

The long-term outcomes that are aimed for is at least a .5% decrease in the incidence of teen dating violence in Connecticut (from 8.2% to 7.7%) among high school youth as reported on the School Health Survey (CSHS).[20]

We plan to evaluate progress toward our long-term outcome in year three; however we recognize that it could take from 5 to 10 years to achieve these results. Also, several potential confounding factors are that increased awareness of IPV could result in an increase in reporting of IPV and the economic outlook in Connecticut may continue to decline, both of which could contribute to higher reported IPV rates among teens.

Strategic Direction One: Engaging Youth in IPV Primary Prevention

Target Population: Youth ages Pre K-21, Community Leaders and Service Providers

Partners: Community Based Organizations, Schools, Youth Correctional Facilities, Faith Community, Mentoring Programs, Legislative Champions, Trade Associations

INPUTS	GOALS	OUTPUTS			OUTCOMES	
		Year One	Year Two	Year Three	Intermediate	Long-Term
• CCADV staff • Governor's Prevention Partnership mentoring network • td411 APP • Partnership with Manson Juvenile Detention Center • True Colors • CCADV member agencies • Evidence Based and Promising Practices Curricula • Funding from government or private foundations	1. Increase healthy relationship content in youth oriented agencies and institutions.	• Two new agencies or institutions adopt an evidence based (EB) or best practices primary prevention curricula. • Five mentoring programs trained in teen dating violence (TDV) & promoting health relationships. • CCADV member agencies reach 10% more youth w/ EBP in primary prevention.	• One additional new agency or institution adopt an EB or best practices primary prevention curricula. • Ten mentoring programs trained in TDV & promoting health relationships. • CCADV member agencies reach 15% more youth w/ EBP in primary prevention.	• Five new agencies or institutions adopt an EB or best practices primary prevention curricula. • Fifteen mentoring programs trained in TDV & promoting health relationships. • CCADV member agencies reach 20% more youth w/ EBP in primary prevention.	1. Increased healthy relationship norms among youth (as measured on pre and post surveys). 2. Youth increased their skills and knowledge to become active bystanders & engage in healthy relationships, including positive communication, anger management, & conflict resolution (as measured on pre and post surveys). 3. Increase the social leadership competencies of youth (as measured by # of youth trainers/youth-led activities).	1. Half a percentage point decrease in TDV incidence (as measured on CT School Health Survey (CSHS).
	2. Increase youth involvement in IPV primary prevention.	• Fifteen youth are trained to co-facilitate healthy relationship or TDV workshops.	• TDV or healthy relationship workshops are facilitated at two new youth conferences.	• TDV or healthy relationship workshops are facilitated at one additional new youth conference.		
	3. Increase positive messaging through social media & td411 app.	• td411 app updated and re-launched.	• 50 youth download the new app.	• 100 youth download the app.		

Assumptions

- Safe Dates & other EB curriculum are available that are a good fit with many schools & institutions, and suited to CT's diverse populations.
- Apps and social media are effective methods for delivering IPV prevention messages with youth.

External Factors

- Cultural values & norms: Code of silence/fear of reporting IPV, values and norms that that promote IPV, ongoing conversations about IPV, social media/sexting/textual harassment.
- Legislation: Some new legislation in support of IPV prevention, strong champions, National School Climate Standards.

Strategic Direction Two: Reinforcing Boys and Men Role in IPV Primary Prevention

Need: Incidence and Prevalence of IPV for Boys and Men

Boys and men may be either victims or perpetrators of IPV, or both. According to the Connecticut School Health Survey for 2011, 9.3% of male high school students reported having been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months.[20]

Males are more likely to be arrested on IPV related charges and research shows that generally males who engage in IPV are more likely to cause serious physical harm to their victims than females who engage in IPV. In 2011, there were 20,990 family violence related arrests in Connecticut comprising 1/3 of all criminal court cases. Perpetrators were most commonly male (77%) and over the age of 18 (92%). Of the 18,132 victims, 26% were male.[27]

Research: Risk and Protective Factors for Boys and Men

Individual Level

Past experiences of sexual harassment, inter-parental violence, and prior experience of domestic violence relate to ongoing IPV victimization and perpetration for males and females, but the processes linking them may be different.[35,88] For male teens, being a perpetrator of IPV correlates with suicidal ideation, poor mental and physical health, and lower life satisfaction.[35,89] Mood disorders and anxiety linked to low self-worth, perceived lack of control, are associated with being a male perpetrator of IPV.[47]

Low socioeconomic status is generally a risk factor for being a perpetrator of IPV.[47] Having frequent alcohol and drug problems is also a well-known risk factor associated with male perpetrators.[90] The behaviors of external locus of control, bargaining, public fronts, excuses, controlling behaviors, and manipulation may be red flags for male perpetrators.[91]

Relationship Level

An acceptance of IPV is a significant predictor for college males becoming perpetrators of sexual violence.[88] Desire for power and control in relationships, dominance and control of the

relationship by one partner over the other, and marital dissatisfaction, anxiety about relationships, and perception of a less favorable power balance in the relationship are correlated with males being perpetrators of IPV.[92,93,94,95] Many IPV perpetrators do not recognize emotional abuse, social control and other forms of controlling behaviors to be forms of violence. Some do not even understand how harmful their violence is to their relationship. Associations have also been found between intimate partner violence and situations in which husbands have lower status or fewer resources than their wives. It is hypothesized that this association may be mediated through ideas of successful manhood and crises of male identity.[96]

Increased bonding with a partner is a protective factor for men having grown up in violent families avoiding becoming perpetrators of IPV.[97] Having the competence to solve problems and prevent conflict is a resilience factor for males in relationships.[43] Fathers can also play an important protective role by role-modeling and educating their sons and other males on how to have healthy, respectful and equitable relationships with women.[98]

Community and Societal Level

Economic distress is a risk factor for males perpetrating IPV.[99] For Vietnam veterans the severity of Posttraumatic Stress Disorder (PTSD) symptoms and war-zone stressor variables were identified as factors directly related to male perpetration of IPV.[100]

<u>Resources: Existing IPV Prevention Strategies and Programs for Boys and Men in Connecticut</u>

On the Strategic Directions Survey, only 5% of respondents (from 3 agencies) reported that their agency had IPV prevention programs specifically for boys or men. Hence, there seems to be a gap in male-specific IPV programs in Connecticut, which may explain why reinforcing boys and men role in IPV prevention was one of the top four priorities for 54% of our survey respondents. The Boys and Men Work Team likewise noted that there are very few male-focused IPV program initiatives in Connecticut. Based on a brief survey the team sent to providers and organizational partners in the counties of Fairfield, Litchfield and New Haven, the majority surveyed (42/48) felt that it was important to target men, youth, and boys for the purpose of reducing IPV.

Many school-based primary prevention programs are designed to be for both males and females. However these may still involve gender-specific activities. Some program directors who participated in the strategic planning process felt that their healthy relationship programs were more effective when both genders participated together, while others felt that it was best to initially create safe spaces for each gender to talk separately and then merge the two groups for the remainder of the program. Research could be brought to bear on this question of the comparative efficacy of gender-specific versus mixed gender IPV prevention programs for youth.

The Engaging Boys and Men Work Team identified several existing programs targeting men or boys including the Danbury Women's Center and Greenwich YWCA primary prevention programs. The Jockey Hollow Middle School Healthy Relationship program (S.H.A.R.E) has been implemented in Monroe, CT with health educators and police officers for the past three years. One of the agencies that reported having a male-only program on our Strategic Directions Survey is the Women's Center of Bridgeport, which offers the "One Man Up" program modeled after leadership curricula such as Jackson Katz's Mentors in Violence Prevention and Men Can Stop Rape's Strength Campaign. It is a multi-session program that uses social norming theory and peer support to address ending violence against females. The program uses a hands-on, problem-solving approach to explore media gender stereotypes, dating/domestic violence, sexual harassment and assault, men ally movement strategies, and, if age-appropriate, the role of homophobia and pornography in fueling gender-based violence. Other curriculum and resources are: Coaching Boys to Men, Boys Will be Boys, Safe Dates, and Gender Matters.

Many domestic violence agencies in Connecticut have campaign initiatives aimed at involving men and male youth as allies in the movement to end interpersonal violence and become change agents of healthy masculinity and gender equality. Often these take the form of pledge drives and annual events or fundraisers sponsored by men's affinity groups during the nationally recognized Domestic Violence Awareness Month of October (for specific examples see Strategic Direction Table Thirteen below).

Additionally, numerous family and mental health service agencies in Connecticut offer support groups for young males based on positive youth development, with some specifically providing

"Boys Circles" focused on issues of teen dating violence. The Council of Churches of Bridgeport is among the many faith-based organizations that have programs to engage boys in positive youth development and to promote healthy relationships. The John S. Martinez Fatherhood Initiative of Connecticut, led by the CT Department of Social Services, provides programs to improve fathers' ability to be fully and positively involved in the lives of their children and is a potential partner in the delivery of IPV prevention content to fathers. The Court Support Services Division subcontracts to a number of service providers to offer intervention programs for batterers that are aimed at preventing repeat offenses (secondary prevention). Some of these men might also benefit from becoming allies in movements to end IPV, helping them to become positive forces for change in their communities.

Plan: Goals and Activities to Increase Involvement of Boys and Men in IPV Primary Prevention

The plans for the next three years include the following four goals. One goal is to increase the involvement of boys and men in IPV prevention initiatives throughout Connecticut. This includes increasing the number of boys and men who take the White Ribbon Pledge or become engaged in any men's initiative against domestic violence in Connecticut.

Our second goal is to involve youth in IPV prevention strategies using Positive Youth Development (PYD) approaches. The PYD is a best practice approach aimed at helping youth acquire the knowledge and skills they need to become healthy and productive adults. PYD draws on young people's strengths and recognizes their unique contributions. It is a comprehensive framework that also emphasizes the supports and services necessary to help young people transition successfully through various stages of development into young adulthood.

Our third goal is to implement evidence-based curricula and other best practices for IPV primary prevention for boys and men in multiple settings across the state. This includes having Boys Circles at schools and other youth serving agencies.

Lastly, our fourth goal is to educate youth service providers, educators and school resource officers on how trauma impacts IPV behaviors in boys. Initially training on this topic will be rolled out with mentoring programs across the state in a partnership between CCADV and the Governor's Prevention Partnership.

Plan: Anticipated Outcomes and Outcome Indicators

The success of goal one will be measured each year by tracking the number of new campaigns pledges for boys and men and the number of boys/men who sign up to participate in prevention activities at major campaign events. Additional intermediate outcomes for young males include: increased young male's knowledge about gender stereotypes and pro-social norms against IPV and a decrease in the perception that masculinity involves violence. These intermediate changes will be assessed using pre and post surveys with boys participating in the different programs. The long-term outcome we aim to achieve is at least a 5% decrease in the number of male offenders, youth and young adults ages 18-29, committing family violence reported by the Connecticut Department of Emergency Services and Public Protection.

Strategic Direction Two: Engage Boys and Men in Intimate Partner Violence Primary Prevention

Target Audience: Boys and Men of All Ages, Community Leaders and Service Providers

Partners: Community-Based Organizations, Faith Community, Schools, PTAs, Sports Team & Neighborhood Recreational Centers, Boys' & Men's Associations, Fatherhood Initiative, Police Departments and School Resource Officers, Municipal Leaders

INPUTS	GOALS	OUTPUTS			OUTCOMES	
		Year One	Year Two	Year Three	Intermediate	Long-Term
• CCADV staff • Regional IPV Coalition in Fairfield County • In-kind resources from Community Based Organizations • CCADV member agencies • Evidence Based and Promising Practices Curricula • Funding from government or private foundations.	1. Increase involvement of boys & men in IPV prevention initiatives throughout Connecticut	• 150 boys & men take the White Ribbon Pledge or become engaged in any Men Against Domestic Violence Initiative.	• 250 boys & men take the White Ribbon Pledge or become engaged in any Men Against Domestic Violence Initiative.	• 350 boys & men take the White Ribbon Pledge or become engaged in any Men Against Domestic Violence Initiative.	1. Increased awareness of IPV among boys & men (as measured on # new pledges, signup lists for program info). 2. Increased young males' knowledge about gender stereotypes & pro-social norms against IPV (as measured on pre-post surveys). 3. Increased awareness of how trauma impacts IPV-related behaviors in boys among service providers (as measured on pre-post surveys). 4. Decrease in the perception that masculinity requires violence (as measured on pre-post surveys).	1. At 5% decrease in the # of males, ages 18-29, committing family violence offenses as indicated by the DESPP family violence arrest data.
	2. Involve youth in developing IPV prevention strategies using Positive Youth Development.	• 50 new youth (at least 50% male) are involved in IPV prevention in 2 communities.	• 100 new youth (at least 50% male) are involved in IPV prevention in 3 communities.	• 150 new youth (at least 50% male) are involved in IPV prevention in 4 communities.		
	3. Implement EBPs for IPV prevention for boys or men in multiple settings and regions across the state	• Two Boys Council Trainings held. • Two new EBP primary prevention initiatives for boys or men launched	• Three Boys Council Programs held. • Three new EBP primary prevention initiatives for boys or men launched	• Five Boys Council Programs held. • Five new EBP primary prevention initiatives for boys or men launched		
	4. Educate youth service providers, educators, and SROs on how trauma impacts IPV-related behaviors in boys.	• Three male-oriented mentoring programs receive trainings on how trauma impacts IPV-related behaviors in boys	• Five male-oriented mentoring programs receive trainings on how trauma impacts IPV-related behaviors in boys	• Ten male-oriented mentoring programs receive trainings on how trauma impacts IPV-related behaviors in boys		

Assumptions

- Building upon youth's strengths and assets to develop IPV prevention activities can promote pro-social behaviors that will reduce IPV.
- Raising Awareness through Pledge campaigns can promote pro-social norms that will lead to reductions in IPV.
- EBP such as Boys Council are culturally appropriate for boys and men from diverse communities.

External Factors

- Schools: increased use of SROs in some towns, mandates to prevent violence post Sandy Hook.
- Economy: growing poverty, budget deficits, shrinking revenue for nonprofits.
- Culture: cyber bullying, violence in the media, gender norms that may promote violence, cultural diversity.

Strategic Direction Three: Raising Awareness about IPV and IPV Primary Prevention

Need: Public Awareness of IPV and Knowledge of IPV Primary Prevention

We do not have current data regarding the general public's awareness of IPV in Connecticut. However, many of the individuals working in the domestic violence field that we surveyed felt that raising awareness is critically important. On our Strategic Directions Survey, 56% (63/112) of respondents selected either raising awareness or launching a prevention campaign as one of their top four priorities. As one respondent stated, "We need to raise awareness and really educate about the issue if people are going to feel like they have the power to become agents of change." Other rationales that were given for this being a top priority included: a) to increase recognition of the existence of the problem, b) to connect people to programs, c) to change social norms, d) to engage the public to take action on this issue, e) to overcome shame or stigma, and f) to counter the idea that IPV is a private or personal issue.

Many respondents also expressed the view that altering social norms is the only way to bring about broad, long-lasting social change. Consider one respondent's comment that "changing social norms related to domestic violence, is, I believe, the ultimate goal and most effective way to combat violence in our communities." The Engaging Youth Work Team observed that many youth programs in Connecticut have public awareness initiatives around bullying, being kind, school climate, etc. These local PSAs may help to raise awareness, but may be limited in terms of their behavioral impact over the long haul. There is need for more training about best practices and effective social marketing curriculum for youth.

Research: Messaging, Social Norms and Social Marketing Campaigns to Prevent IPV

Nationally, there is growing public awareness of the magnitude of intimate partner violence and of the harm it causes to our families, communities, and economy. In the U.S., numerous governmental agencies and not-for-profit organizations utilize mass media campaigns, educational kits, community events and social marketing to help raise awareness about domestic violence. This is generally one of the first steps in IPV prevention efforts. These efforts are needed, in part, because domestic violence is often treated as a private matter, and victims are often afraid to speak out for fear of retaliation from perpetrators or others in their community that

may appear to sanction the violence.

Social marketing campaigns involve the application of commercial marketing techniques to the planning, implementation and evaluation of programs intended to change individual behavior. IPV prevention campaigns typically aim to strengthen social norms, which deem coercion, threats and violence in relationships to be unacceptable, to counter antisocial norms promoting such violence (typically with a focus specifically on ending violence against women), and promote gender equality. Campaigns are also commonly used to inform people of domestic violence victim services. Theoretically-informed campaigns have the potential to prevent IPV injuries and fatalities, and also help shift social norms towards ensuring that violence in intimate relationships becomes universally unacceptable.[101] Also, such campaigns can be used to help people learn the warning signs of being in an abusive, unhealthy relationship. In designing these campaigns careful consideration should be given to the impact of the messaging on all audiences that might be exposed to the campaign, not just the intended audience.[102] For example, campaigns aimed at showing the harmful impact of IPV on children may impact perpetrators and victims differently.

Another targeted approach is social marketing campaigns geared toward bystanders.[102,103] Previous research has estimated that bystanders witness up to one third of IPV incidents and shown that they can play important roles in helping to deter violence and change social norms.[102,104]

An increasing number of primary prevention campaigns specifically target males as potential allies in preventing domestic violence or as potential beneficiaries of preventive services.[98,102] Campaigns referred to as “deterrence appeals” aim to inform potential perpetrators and victims of legal sanctions against IPV, including stalking and restraining orders. Such campaigns often follow the adoption of new laws and may focus on preventing perpetration of a family violence crime or increasing reporting of a crime. However, consistent with legislation in other areas (e.g., underage drinking, drunk driving laws), research has shown that deterrence appeals are most effective for perpetrators if they believe they are likely to be caught, convicted and given a substantial penalty.[102] Furthermore, it is recommended that deterrence appeals be accompanied by behavior change strategies that increase perpetrators self-efficacy to end their violent behavior

or assist victims in overcoming barriers to reporting the abuse.[102] It is unclear whether social norms campaigns emphasizing that violence is unacceptable are as effective in changing the behavior of perpetrators who may secretly engage in acts of violence. An alternative to negative appeals is the use of positive appeals, for example messaging such as "treating your children's mother with respect is a great way to give your children the best start in life."[134]

Social marketing campaigns that are theory-based and utilize audience research in their design are generally considered to be the most effective.[105,106] Among the common psychological behavior change theories used in IPV primary prevention campaigns are transtheoretical model of behavior change,[107] theory of planned behavior,[108] social norms theory,[109] prospect theory,[110] protection motivation theory,[111] elaboration likelihood model,[112] narrative persuasion theory,[113] and experiential learning. The integrated model for social marketers approach combines several of these theories, including the stage of change and protection motivation theory.[114]

Resources: Existing Campaigns in CT

On the Strategic Directions Survey, 26% (29/112) of respondents reported that their agency had conducted raising awareness activities in the past year. A sampling of primary prevention campaigns that are currently underway in Connecticut is provided in the table below.

Table Thirteen: Public Awareness Campaigns pertaining to IPV prevention in CT[***]

Campaign Description	Lead Agency	Methods	Target Audience	Date Launched
Clothesline Project The Clothesline Project brings awareness of the number of women in our communities that have been victimized. The display includes dozens of T-shirts that were artfully decorated with thoughts and emotions of victimized women and children. www.clotheslineproject.org	CCADV	T-shirt display	Public	1992

[***] This is only a sampling of IPV campaigns in CT.

Campaign Description	Lead Agency	Methods	Target Audience	Date Launched
First 100 Plus CCADV's "First 100" program honors male leaders from across the state who have worked to raise awareness of the availability and access to domestic violence services in CT.	CCADV	Pledge Drive	Men	2011
Men Make Difference Campaign The Men Make A Difference Campaign draws attention to the issue of domestic violence by engaging high profile men- throughout the greater Hartford area in a variety of public awareness activities.	Interval House	Pledge Drive	Men	2010
Operation Red Jungle "Operation Jungle Red" (OJR) was created to start conversations about the acts of violence- including sexual assault, social media violence, domestic violence and campus violence- committed by men. The goal is to raise awareness of how men are socialized and the impact of that socialization on society.	Women's Center of Greater Danbury Western CT State University	Experiential Learning Activities	Young College Men	2011
Silent Witness Project The Silent Witness Project is a memorial to women whose lives were ended abruptly and violently at the hands of a husband, ex-husband, partner or stalker. The Silent Witness exhibit has life-size silhouettes of women and is a powerful testament of commitment to break the silence about domestic violence.	CCADV	Display	General Public	1995
td411 td411 is a smart phone application to provide teens with information on where to get help if they are in unhealthy or violent relationships; to provide guidance on what defines a healthy relationship; and to inform teens how to help a friend experiencing dating violence.	CCADV	Mobile Application	Teens	2010

Campaign Description	Lead Agency	Methods	Target Audience	Date Launched
Walk a Mile in Her Shoes® The International Men's March to Stop Rape, Sexual Assault & Gender Violence. A Walk a Mile in Her Shoes® Event is a playful opportunity for men to raise awareness in their community about the serious causes, effects and remediations to sexualized violence. http://www.walkamileinhershoes.org/	Multiple agencies across CT	March and Experiential Learning Activities	Men	2010
Where Do You Stand? The campaign focuses on engaging CT men in being active in the prevention of sexual violence in their communities. It utilizes bystander intervention theory and techniques to equip men with the tools necessary to take a stand against all forms of sexual violence. It empowers men to use their voice, influence, and actions to become a part of the solution, rather than being a part of the problem. www.connsacs.org/wheredoyoustandct.htm www.mencanstoprape.org/Strength-Media-Portfolio/preview-of-new-bystander-intervention-campaign.html	CONNSACS	Posters, postcards, banners, floor graphics, wristbands, half-day to three day trainings on healthy masculinity and bystander intervention (BI)	Young College Men	2013
White Ribbon Campaign The White Ribbon Campaign is the largest effort in the world of men working to end violence against women. In 1991, a handful of men in Canada decided they had a responsibility to urge men to speak out about violence against women after The Montreal Massacre on December 6, 1989. On that day, 14 female students at the Ecole Polytechnique were killed. www.cwfefc.org/wrcpledge.html www.whiteribbon.ca/pledge/	Center for Women and Families Bridgeport	Pledge Drive Paired with Walk a Mile in Her Shoes event	Men	2009

Prevention Legislation Pertaining to IPV

Since primary prevention encompasses a broad-range of underlying risk and protective factors, many governmental policies either directly or indirectly relate to IPV primary prevention. A few examples of existing state legislation that relate to primary prevention of IPV include:

- An Act Requiring School-Based Professional Development, which requires training on preventing violence, teen dating violence, domestic violence, child abuse and youth suicide.[115]
- An Act Concerning Responsible Fatherhood and Strong Families[116], which includes recommendations for addressing intimate partner violence prevention in these programs.
- An Act Promoting a Safe and Healthy School Climate.[117]
- An Act Concerning Gun Violence Prevention and Children's Safety.[118]

There is still much more that could be done to strengthen our prevention programming across the state and to ensure that the root causes of IPV are ameliorated.

Plan: Goals and Activities to Raise Awareness of IPV

A central goal of the statewide plan is to raise awareness of IPV over the next three years by establishing a Speaker's Bureau including men from First 100 Plus, which are a group of male leaders and allies working to end domestic violence in Connecticut.

A second goal is to identify best practices for social marketing campaigns for IPV prevention targeting under-presented populations, in particular African American, Latino, Native American, LBGTQ and other groups that are disproportionately affected by IPV according to local and some national data. A university partner will be identified to assist with these efforts.

To advance policy in Connecticut around ending domestic violence, the third goal is to inform legislators of the importance of IPV prevention. In year one, CCADV intends to produce a report of Statutes and State policies that contribute to the prevention of IPV. In years two and three, plans include making policy recommendations and informing legislators of these recommendations.

Plan: Anticipated Outcomes and Outcome Indicators

The intermediate outcomes are to increase knowledge about IPV primary prevention with recommended practices for men and boys with exposure to violence as measured by number of speaking engagements and post-test surveys. We expect to increase awareness of IPV as evidenced by increased calls to domestic violence agencies.[†††] We aim to strengthen social norms protective of IPV, which we will measure using post surveys at conferences, speaking opportunities and other events. In the short-term, we expect that Connecticut policy makers will endorse new legislation or modifications to existing legislation for the prevention of IPV and promoting healthy relationships. Long-term, after 5-10 years, we strive to see a 5% reduction in IPV assaults and fatalities as measured by DESPP family violence arrest data. We also expect for the Connecticut legislature to have passed new laws or revisions of existing legislation that promote healthy relationships and prevent intimate partner violence.

[†††] Another potential tracking method could be a question added to the CCADV member hotline intake assessment that asks "How did you hear about our services?"

Strategic Direction Three: Increase Awareness of IPV and IPV Prevention

Target Audience: Public**, S**ervice Providers, Professionals, Community Based Organizations, Legislature, Youth and Teens

Partners: The "First 100 Plus", Nutmeg Big Brothers/Big Sisters, CT Boys and Girls Clubs, CT Girls and Boys Scouts, True Colors, Girls, Inc., Police Athletic Leagues, State Department of Education, teachers and other educators, Business, government, sports, community and other statewide leaders and lawmakers

INPUTS	GOALS	OUTPUTS			OUTCOMES	
		Year One	Year Two	Year Three	Intermediate	Long-Term
• CCADV Staff • First 100 Men Speaker's Task Force on Domestic Violence	1. Establish a Speaker's Bureau including men from First 100 Plus.	• Ten men will be recruited to join the DV Speaker's Bureau and provide IPV prevention education w/ 50 of their peers.	• Fifteen men will be recruited to join the DV Speaker's Bureau and provide IPV prevention education w/ 75 of their peers.	• 25 men will be recruited to join the DV Speaker's Bureau and provide IPV prevention education w/ 100 of their peers.	1. Increased knowledge about IPV primary prevention and best practices for men and boys w/ exposure to violence (as measured by the number of speaking engagements and post-test surveys). 2. Increased public awareness on IPV as evidenced by increased calls to domestic violence agencies. 3. Increase social norms protective of IPV (as measured on post surveys at conferences, speaking and other events). 4. CT policymakers endorse new bills (or revisions) that promote healthy relationships and prevent IPV.	1. 5% reduction in IPV assaults and fatalities reported by DESPP. 2. CT legislature passes new laws or revisions of existing legislation that promotes healthy relationships and prevents IPV.
	2. Identify best practices for social marketing to prevent IPV targeting underrepresented populations in existing campaign efforts.	• An academic institute will be identified to help develop and produce a social marketing campaign to prevent IPV. • CCADV will unveil redesigned website.	• Strategies developed for consistent messaging & standardized communication practices across agencies. • Strategies include best practices for reaching underrepresented populations.	• A unified strategy for IPV prevention campaigns will be articulated and broadly disseminated in Connecticut.		
	3. Lobby to inform policy makers of the importance of IPV prevention.	• Report of Statutes and State policies that contribute to the prevention of IPV.	• Policy recommendations for the prevention of intimate partner violence in Connecticut.	• CT Policymakers training w/ curriculum that covers the needed changes to laws and any new laws regarding IPV prevention.		

Assumptions

- Saturation of information (public awareness campaign) is key to better learning.
- Speaker's Task Force interested in supporting policy initiatives.

External Factors

- The seasonal operation of the legislature.
- Legislation: emphasis on Results Based Accountability
- Economy: growing poverty, budget deficits, shrinking revenue for nonprofits.

Strategic Direction Four: Strengthening and Increasing IPV Prevention Programs

Need: Capacity Building Priorities for IPV Primary Prevention in CT

The Strategic Directions survey asked about the capacities, resources, and funding at organizations involved in IPV prevention work. Respondents included individuals and organizational managers and directors involved with preventing intimate partner violence from across the state. Based on the 112 respondents, the top four capacity building priorities for the state were as follows:

1. Training of education, health and human services professionals in IPV primary prevention. Only 2% of respondents identified themselves as extremely knowledgeable about evidence-based practices for IPV primary prevention, while 87% ranged from somewhat knowledgeable to no knowledge at all. As for staffing, only 39.5% of respondents said that their agency has a "prevention specialist" on staff or staff members dedicated to IPV prevention.
2. The second priority was building knowledge on the root causes of IPV. As explained by one respondent, "You have to start at the root of any issue."
3. The third priority was increased funding for IPV prevention. Under 30% of respondents indicated that their organization has funding available for primary prevention programming.
4. The fourth priority was increasing organizational capacity to implement primary prevention programs.

Other gaps identified by the Capacity Building Work Team are a lack of effective prevention (as well as intervention) programming for offenders, as well as their children. There is also a recognized need for more programming in rural areas and programming for LGBTQ and immigrant populations.

Research: Best Practices for IPV Primary Prevention Programs

Preventing IPV requires efforts at multiple levels ranging from the individual, relationship, community and the societal. To be most effective, dating violence prevention programs should be tailored to particular at-risk groups and types of communities.[119,120] Even universal programs should be culturally sensitive in their application.[121]

Regarding the timing of delivering IPV prevention initiatives, typically universal teen dating violence prevention programs are provided to middle or high-school youth. Some researchers propose that offering primary prevention programs to middle school-aged youth is especially important, since this is the age when they more consciously start exploring their gender identity and romantic relationships.[122] Others propose that programs provided during times of transition (e.g., as youth move into middle school or high school, at times of relationship instability, or during the transition to parenthood) may achieve the strongest results.[123,124]

At the individual level, primary prevention can help people develop the awareness, knowledge, attitudes and behavioral skills that support healthy relationships. IPV prevention programs need to consider the occurrence of both physical and psychological violence. Programs that target a broad range of IPV behaviors (physical, sexual, stalking, cyber-aggression) are most likely to be effective.[125] Pepler argues for a developmental-systemic approach to IPV prevention that recognizes the links between IPV and experiences of familial stress, childhood bullying, and adolescent substance use.[126]

Specifically, as stated by the Centers for Disease Control in a strategic planning document, IPV primary prevention strategies should include the following relationship skills and belief/value systems: a) nonviolent conflict resolution; b) communication skills; c) coping with stress; d) recognition of partner's right to autonomy; e) shared decision making; and f) maintaining trust.[127] More recent approaches supported by the research findings on dual IPV relationships emphasize that unhealthy, destructive patterns of behavior in relationships are often bi-directional, involving both partners in the relationship.[122]

Parent or family-based interventions also have the possibility of interrupting the intergenerational transmission of IPV. Programs that aim to address multiple risk factors that include peer and family-based attitudes, norms and behaviors, can have long-term positive effects on individual and relationship functioning.[128]

Community level activities are also critical to the success of primary prevention efforts. A Futures Without Violence report on community-level prevention of IPV lists the following key steps: 1) raising awareness of the problem of family violence and establishing social norms that

make violence unacceptable, 2) connecting community residents to services, 3) changing social and community conditions that contribute to violence, 4) building networks of leaders within a community and 5) making services and institutions accountable to community needs.[129]

Resources: Trainings and Curricula in Connecticut

Numerous resources are available to support trainings in IPV primary prevention nationally due in large part to the dedication of many institutions including the U.S. Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Useful online training materials include: PreventConnect.org—a national online project dedicated to the primary prevention of sexual assault and domestic violence, the CDC Dating Matters website,[130] and several state IPV coalition websites and toolkits, especially those with CDC-funded DELTA plans (e.g. North Carolina's DELTA Plan toolkit[131]).

For Connecticut specific information, a list of local trainings in sexual assault prevention has been developed and included in Department of Public Health's Sexual Assault Prevention Plan for 2010-2017.[132] CCADV regularly hosts trainings related to domestic violence and semi-annually publicizes its trainings on its website and via a training catalog.[133] Most CCADV member agencies also offer brief introductory trainings in IPV prevention within their communities. Training of schoolteachers and other school professionals in teen dating violence prevention is also mandated by the State Department of Education.[134]

A few hospitals in Connecticut such as Saint Francis Hospital and Hartford Hospital have been active in training health care professionals to screen for IPV, which also can assist with raising awareness and measuring the impact of IPV prevention efforts. Stamford Hospital has collaborated with their local domestic violence agency (Domestic Violence Crisis Center) to develop a medical advocacy program.

A brief list of evidence-based programs for youth is provided below and will be expanded with the development of a toolkit on IPV primary prevention for use in Connecticut.

Sample Evidence-Based & Promising Curricula

Safe Dates prevents dating abuse through the use of a highly engaging and interactive program, which helps teens recognize the difference between caring, supportive relationships and

controlling, manipulative, or abusive dating relationships. Designated as a Model Program by the Substance Abuse and Mental Health Services Administration, it was selected in 2006 for the National Registry of Evidence-based Programs and Practices (NREPP), and received high ratings on all criteria.

The *Second Step* program takes students from preschool all the way through middle school. Each grade level features developmentally appropriate ways to teach core social-emotional skills such as empathy, emotion management, and problem solving. Its principles are consistent with the RTI/PBIS Continuum, which involves the practice of 1) providing high-quality instruction and interventions matched to student need, 2) monitoring progress frequently to make decisions about changes in instruction or goals, and 3) applying child response data to important educational decisions.[135]

Girls Circle and The Council for Boys and Young Men are gender-responsive models that incorporate motivational interviewing, cultural responsiveness, strengths-based approaches, and trauma-responsive practices. Girls Circle and The Council for Boys and Young Men provide practical applications to promote resiliency and increase protective factors for youth development. These are designated a "promising approach" in the Model Programs Guide of the Office of Juvenile Justice and Delinquency Prevention.

Coaching Boys into Men (CBTM) is a program created by national nonprofit Futures Without Violence. The CBTM program works with coaches to teach their male athletes about building healthy relationships and how to intervene when witnessing disrespectful and abusive behaviors among their peers. The year-long evaluation study, with 1,513 male athletes in 16 California schools, found that the program resulted in a significantly lower rate of IPV in the past three months relative to a control group of athletes.[136]

Expect Respect is built on an ecological, trauma-informed model and offers a comprehensive prevention program for youth in middle and high schools. It has 3 primary program components that 1) support boys and girls who have been exposed to violence, 2) mobilize youth as leaders and 3) engage schools, parents and community organizations in creating safe and healthy

environments. This is considered a promising program based on preliminary outcome data[137], and is currently being evaluated in a CDC-funded randomized control trial.

Dating Matters™: Strategies to Promote Healthy Teen Relationships is a universal prevention program developed by the CDC that is based on best practice models. It is being targeted at 11- to 14-year-old youth to build skills prior to their experience of relationship violence. The program is built on the premise that it is essential to directly address both individual and relationship risk factors.[122] It is presently being pilot-tested in a randomized cross-site evaluation with around 45 schools.

Plan: Goals and Activities to Strengthen IPV Prevention Programs

CCADV has committed to providing enhanced primary prevention trainings and to take the lead, with support from its strategic planning partners, in assisting other organizations and institutions in Connecticut to build their capacity to provide IPV primary prevention programming and to evaluate their programs.

Goal one for Strengthening IPV Primary Prevention is to provide trainings in IPV primary prevention for diverse professionals in social services, health care and education. A train the trainer approach will be taken. The training may be adapted for online as well as face-to-face delivery. The training will include a module on root causes of DV and on cultural responsiveness.

A second related goal is to make evidence-based curricula and resources for IPV primary prevention more accessible to professionals, agencies, schools and institutions. This will be accomplished through the development of a toolkit that will be made available online. The toolkit will include standardized curricula for professional development on teen dating violence that includes information on how staff can translate what they learn to their students.

Thirdly, our goal is to ensure that programming for IPV prevention is culturally responsive. In preparing the toolkit, efforts will be made to identify evidence-based practices (EBP) or promising practices for IPV primary prevention for multiethnic and specific at-risk populations. Cultural competency will be achieved through trainings and by building agencies' capacity to

evaluate the curricula that are being used for effectiveness. Recommendations for evaluations include conducting focus groups with program participants to determine whether or not the curricula and staff delivering the intervention are respectful and inclusive of their culture and the materials are congruent with their cultural beliefs and values.

Goal four is to establish regional IPV prevention coalitions. Efforts will be made to ensure that these coalitions are located in towns with the highest family violence offense assault rates and that these coalitions are inclusive of professionals from a broad range of community sectors and community members from socially marginalized and under-served populations.

Plan: Anticipated Outcomes and Outcome Indicators

The main outcomes are increased knowledge of IPV primary prevention, the root causes of IPV and evidence-based practices among professionals. This will be measured on post-test surveys following trainings. An increased uptake of evidence-based programs for IPV primary prevention will be tracked through referrals to trainers and requests for curricula from CCADV and the Connecticut Clearinghouse. Steering committee members and CCADV member agencies will also provide updates as to their programming activities during quarterly meetings. Results of pre and post surveys with youth in primary prevention programs should demonstrate evidence of their effectiveness with youth of diverse cultural backgrounds. Long-term evidence in support of the cultural competency of our primary prevention practices will be that reductions in teen dating violence incidence are equivalent in magnitude for males and females, all racial and ethnic groups and also GLBT youth in Connecticut. This will be measured from assessing results of the school health survey by race and ethnicity and potentially an independent community survey with GLBT youth.

Strategic Direction Four: Strengthening and Increasing the Number of IPV Primary Prevention Programs

Target Audience: Service Providers, Professionals, Community Based Organizations, Leaders in Communities most impacted by IPV

Partners: CCADV, CCADV Member Agencies, CT Department of Public Health**,** Governor's Prevention Partnership, State Department of Education, Department of Social Services, State Department of Correction, Civic Leaders (e.g. governor and mayors).

INPUTS	GOALS	OUTPUTS			OUTCOMES	
		Year One	Year Two	Year Three	Intermediate	Long-Term
• CCADV Training Institute • Corporate Sponsors • Trained Community Educators • State Department of Education Teen Dating Violence prevention mandates • State funding	1. Provide trainings in IPV primary prevention for professionals in social services, health care, education.	• Develop a basic training in primary prevention. • Recruit and train 4 new prevention trainers. • 10 school districts. trained in TDV	• Pilot training in 3 different settings. • 15 school dist. trained in TDV prevention.	• 50 professionals receive prevention training. • 20 school districts trained in TDV prevention.	1. Increase knowledge of IPV primary prevention, root causes and EBP among professionals (as measured on post surveys). 2. Increased uptake of EBP in diverse institutional settings (as evidence by successful referrals to trainers and requests for curricula from CCADV and CT Clearinghouse). 3. Curriculum used for IPV primary prevention w/ youth is culturally appropriate for targeted populations (as indicated by pre and post survey and focus groups). 4. Regional coalitions formed continue to be active.	1. Increased statewide capacity for delivering IPV primary prevention EBP (as evidenced by statewide assessment of perceived IPV primary prevention capacity and organizational self-assessments). 2. Decrease in TDV is equal in magnitude for males & females, race/ethnicity and GLBT groups (as indicated on the CSHS and a community survey of GLBT youth).
	2. Make EBP for IPV primary prevention curricula & resources more accessible to professionals, agencies and institutions.	• Compile an IPV primary prevention EBP toolkit. • Update TDV information on the SDE and CCADV website.	• Make toolkit available on the CCADV website and link to the site.	• Toolkit accessed by at least 80 individuals in Connecticut.		
	3. Ensure cultural competency of IPV prevention, including the needs of GLBT youth.	• Identify EBP appropriate for each multiethnic/specific population (if available) and disseminate via trainings and toolkit.	• Evaluate two IPV prevention programs by race/ethnicity & solicit feedback from participants regarding cultural fit.	• Evaluate two IPV prevention programs by race/ethnicity and solicit feedback from participants regarding cultural fit.		
	4. Establish regional IPV prevention coalitions located in towns w/ highest FV offense assault rates.	• Identify best-practice model(s) and guidelines for toolkit • Identify lead agencies or leaders for two regions.	• Form two regional coalitions. • Procure funding/resources for these coalitions.	• Two regional coalitions launch new IPV prevention initiatives.		

Assumptions

- Many professionals lack an understanding of root causes of IPV and primary prevention best practices
- Early identification of IPV via healthcare screening could help reduce the number of violent assaults
- Regional coalitions are best suited to launch new initiatives to address IPV root causes and primary prevention needs at the community-level.
- Cultural competency is essential for the success of IPV prevention efforts.

External Factors

- Public lack understanding of primary prevention
- Legislation: TDV & bullying prevention mandates, new gun laws in CT, national school climate standard.
- Funding: federal/state budget cuts, prevention funds needed
- Nonprofits: limited evaluation capacity, data in need of analysis

Strategic Direction Five: Results-Based Accountability

Need: Data and Evaluation Tracking and Reporting Capacity

Even though IPV data is available at the state or local level, there generally are limited resources for the data to be analyzed on a consistent basis to be used in planning and quality improvement efforts. Some domestic violence agencies collect and analyze their own outcome data for primary prevention programs they administer in schools or in the community, but this data is not typically made public. This makes it challenging to compare outcome results across different programs and to determine which ones are best suited for use in which settings.

Many women seek treatment for illnesses and injuries sustained in an abusive relationship. Yet, an estimate is that only 1 in 35 are correctly diagnosed by a healthcare professional.[138] Fewer than 15% of women report ever being asked by their healthcare provider about IPV despite the indication that women would disclose abuse if asked directly.[139,140] Lack of training in working with victims of IPV creates a barrier to successful diagnosis and intervention for women experiencing IPV.[141] Inconsistency in screening also contributes to underreporting of IPV related injuries in medical records and claims data, which makes it more difficult to accurately determine the incidence and prevalence of IPV.

Research: Best Practices for IPV Primary Prevention Tracking and Monitoring, Data Collection and Evaluation

Ongoing data collection and monitoring of IPV by public health departments, in partnership with social service agencies, health care, educational systems and police, can be used to identify communities with the highest risk for IPV and provide a basis for assessing the effectiveness of prevention strategies.

Research on IPV prevention using population level data is best accompanied by efforts to rigorously evaluate program level outcomes to identify the most effective approaches and document their value. Evaluation approaches should follow best practices appropriate for each particular program design and setting. The U.S. government has mandated the use of empirically-supported prevention and health promotion programs at all schools. Merging

scientific research with community knowledge and participation has become a best practice in intervention research, which is supported by the National Institute of Health (NIH), Centers for Disease Control and Prevention (CDC) and other federal and community foundation funders.

While randomized control trials are widely considered the most scientifically rigorous method of evaluating intervention outcomes, they can be costly and are sometimes unfeasible for smaller community organizations typically involved in IPV prevention work. Most program evaluations assess self-reported changes in attitudes, beliefs, norms, and/or behaviors. Programs generally should try to utilize validated measures for evaluating IPV risk and protective factors, which will help them to compare results with those of other programs. If resources are available, outcomes may be assessed using an experimental or quasi-experimental design, involving both an intervention group and a control/comparison group. Participatory evaluation approaches have the added advantage of building organizational and individual capacities to engage in evaluation work and can also increase the likelihood that findings will be used to inform quality improvements. As effective prevention strategies are identified, it is important to sustain and disseminate these strategies, while also making sure that they are a good fit within their new settings and are adapted to ongoing societal changes.

Resources: Evaluation, Existing Databases, Reporting Procedures, and Screening Methods

Increasingly, national and local funders and administers of prevention programming are requiring that programs report results utilizing scientifically rigorous evaluation methods. However, funding, resources, and lack of evaluation knowledge or capacity are still major constraints to this occurring with many programs. Opportunities are available for program directors and staff to increase their own evaluation knowledge and capacity through training programs and online resources provided by numerous federal funding agencies and evaluation organizations. For example, the Centers for Disease Control and Prevention provide a list of online program evaluation manuals[142] and their National Center for Injury Prevention and Control also provides a compendium of IPV assessment tools.[143]

Some of the primary sources of data that may be used for evaluating IPV impacts for our statewide plan on a population level are as follows:

- CT Department of Public Health School Health survey
- The Department of Emergency Services and Public Protection Domestic Violence reporting system
- Department of Children and Families reports
- CT Hospital Association CHIME
- CADH Health Equity Index
- CCADV databases
- CONNSACS College report card

Screening by Health Care Professionals

The U.S. Preventive Services Task Force has recently recommended screening by health care providers for IPV with all women of childbearing age so as to refer women who screen positive to intervention services.[144] While the CDC provides information on different screening assessment tools for healthcare practitioners, they do not endorse any particular method.[125] The American Medical Association recommends physicians screen for physical, sexual, and psychological abuse as part of the medical history.[145] Several of the most widely used screening tools are the Hurt, Insult, Threaten, Scream (HITS) instrument, the Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT), and the Woman Abused Screen Tool (WAST).[143] Many of these screening methods focus on direct behavioral questions. This is important because often women will not think of themselves as the victim of abuse, but by focusing on their partner's behavior subjectivity in their responses is reduced.[143]

Plan: Goals for Next Three Years to Enhance Evaluation Capacity and Accountability

Goal one is to increase the evaluation capacity of IPV primary prevention efforts in schools and community-based organizations. Evaluation capacity will be enhanced through identifying funds and resources for this purpose. Resources can include partnerships with students and university professors who have the skills and experience to do this work.

For goal two, the Injury Prevention Center at Connecticut Children's Medical Center, under the direction of Garry Lapidus, PA-C, MPH, plans to spearhead an epidemiological study to assess IPV-related injuries using existing ICD-9/ICD-10 codes in the Healthcare Cost and Utilization Project (HCUP) and CHIME databases with data analytics support from Truven Health Analytics, a national company that manages the HCUP databases for the Agency for Healthcare

Research and Quality (AHRQ). The HCUP databases bring together state-level data and the Federal government data to create a national information resource of patient-level health care data. The Center intends to apply for funds for a pilot study that will evaluate several methods of screening for IPV in emergency care and other settings. If successful, the plan will be to conduct a randomized control trial of these methods, which will inform best practices guidelines for screening by health care professionals. Although this is a secondary prevention strategy, it will also contribute to the state's ability to track and monitor IPV injury rates. The plan also may include analyzing the cost and benefits of interventions to increase screening for IPV among health care providers.

A third goal is to evaluate our primary prevention efforts and the direct and long-term outcomes of these efforts. Quarterly steering committee meetings will be used to track ongoing progress along with annual evaluation reports.

Plan: Anticipated Outcomes and Outcome Indicators

Intermediate outcomes include increased evidence of IPV prevention programs effectiveness and increased early identification of IPV by medical professionals in pilot sites. Also, another outcome will be sustained partnerships and accountability to deliver on the statewide plan as assessed in our annual progress reports. Long-term outcomes include 1) increased investment in teen dating violence prevention by private and public sources as measured by CCADV member agency reports, 2) increased early identification of IPV by medical professionals statewide as measured by new screening policies and procedures, 3) increased statewide capacity to assess IPV related injuries as indicated in state publications and reports, and last, but not least, 4) an increased capacity of IPV prevention evaluation to demonstrate results statewide as indicated by our final three-year evaluation report.

Strategic Direction Five: Enhance Results Based Accountability of IPV Primary Prevention Initiatives

Target Audience: Schools, Legislators, Community Based Organizations, Emergency Room doctors, primary physicians and other health care professionals

Partners: State Department of Education, Connecticut Children's Medical Center, St. Francis Hospital Trauma Center, Truven Health Analytics.

INPUTS	GOALS	OUTPUTS			OUTCOMES	
		Year One	Year Two	Year Three	Intermediate	Long-Term
• CT Department of Emergency Services and Public Protection (DESPP) Family Violence reporting system. • CT School Health Survey (CSHS/YRBS) • All Payer Claims Database (2014).‡‡‡ • -AHRQ, HCUP database • -CHA-CHIME database§§§	1. Increase evaluation capacity of IPV primary prevention efforts in schools & community based organizations	• Procure funds and resources to assess TDV prevention efforts in schools and community-based organizations	• Assess outcomes of TDV prevention efforts in schools and community based organizations	• Assess outcomes of TDV prevention efforts in schools and community based organizations	1. Increased evidence of the effectiveness of TDV prevention in schools. 2. Increased early identification of IPV by medical professionals in pilot sites 3. Sustained partnerships and accountability to deliver on statewide in our annual progress reports.	1. Increased investment in TDV prevention by private and public sources (as indicated by CCADV reports). 2. Increased early identification of IPV by medical professionals (as measured by new screening policies and procedures) 3. Increased capacity to assess IPV related injuries (state publications and reports) 4. Increased capacity to evaluate IPV prevention programs statewide (three-year evaluation report).
	2. Study the effects & cost/benefits of an intervention to increase screening for IPV in health care****	• Analyze baseline data from claims and hospital data in CT	• Pilot-test intervention of IPV screening methods	• Apply for funding for a randomized control trial (RCT) of IPV screening and cost/benefit analysis		
	3. Evaluate Statewide Plan progress and outcomes	• Develop and distribute evaluation tools. • Quarterly Steering Committee meetings to report on progress	• Quarterly Steering Committee meetings to track progress. • Report process & outcome evaluation results annually	• Quarterly Steering Committee meetings to track progress. • Report process & outcome evaluation results annually		

Assumptions

- Early detection of IPV will save costs and lives
- Evidence of IPV prevention programs effectiveness in schools will lead to increased private and public support and funding for prevention
- Cost savings and benefits of early screening will lead to increased uptake

External Factors

- Legislation: emphasis on Results Based Accountability, Affordable Care Act emphasis on preventive care including IPV screening.
- Funding: federal/state budget cuts, prevention funds needed
- Systems: Health Information Exchanges, All-Payer database, and CHIN database systems roll out.

‡‡‡ The All-Payer Claims database is a new CT database system being implemented as part of the health care reform in 2014.

§§§ This refers to the CT Hospital Association CHIME database.

**** Note: this is secondary prevention, but can also improve our capacity to assess outcomes of primary prevention efforts.

Connecticut Statewide IPV Prevention Plan

INPUTS	OUTPUTS	SELECT ACTIVITIES	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
Partnerships representing: • Domestic violence agencies • Education systems • Youth serving organizations • Police • Healthcare systems • Community educators • Government • Corporations • Universities and colleges • Business and community leaders	• EBP IPV primary prevention training and workshops • EBP IPV prevention Toolkit • IPV prevention programs in youth serving organizations and institutions • Coordinated IPV prevention campaign activities • Regional IPV coalitions • Quarterly Steering • Committee meetings • Ongoing evaluation • Routine screening in healthcare facilities • Youth participation in IPV prevention activities	• Implementing EBP in youth serving organizations and institutions • Coordinating a social marketing campaign • Workshops on teen dating violence at conferences • Training professionals in IPV primary prevention • Educating professionals on the root causes of IPV • Strengthening evaluation capacity • Pilot testing new positive youth development interventions • Pilot testing methods for increased screening in health care facilities	• Increased healthy relationship norms among youth • Increased awareness of IPV among boys & men • Increased youth's knowledge about gender stereotypes & pro-social norms against IPV • Increased skills to become active bystanders & engage in healthy relationships among youth • Increased knowledge of IPV primary prevention, root causes and EBP among professionals • Increased uptake of EBP in diverse institutional settings	• Decreased IPV incidence and prevalence among youth • Increased early identification of IPV by medical professionals • Reduced IPV assaults and fatalities • Increased statewide capacity for delivering IPV primary prevention EBP • Increased statewide capacity to assess IPV injuries • Increased statewide capacity to evaluate IPV prevention programs
EXTERNAL FACTORS				
• Public • Legislation • Funding • Non-Profits • Schools • Economy • Culture	• Lack of understanding of primary prevention • Teen dating violence and bullying mandates, new gun control laws, national school climate standards, emphasis on results-based accountability and the Affordable Care Act emphasis on preventive care • Federal and state budget cuts • Limited evaluation capacity, existing data in need of analysis • Increased use of school resource officers in some towns, mandates to prevent violence post Sandy Hook • Growing poverty, budget deficits, shrinking revenue for non-profits • Cyber bullying, violence in the media, gender norms that promote violence, cultural diversity			

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Appendix A

Risk and Protective Factors

Risk and Protective Factors Chart

Risk Factors- identifiable factors, conditions, or situations associated with an increased danger of intimate partner violence
Protective factors- identifiable conditions that may help one avoid IPV; traits or characteristics that reduce the risk of experiencing IPV

Level	Risk Factors	Sources	Protective Factors	Sources
Individual	1. Generational DV/ Early trauma: Witnessing or experiencing violence as a child 2. Low Income 3. Substance Abuse 4. Mental Health Problems: low self-esteem, poor impulse control, anxiety, depression, anger 5. Young Age 6. Unemployment 7. Social Isolation 8. Prior Relationship Aggression	1. White and Smith, 1995; Tjaden, 2000; Martinez-Torteya, 2009 2. Benson, et al, 2001; Black et al, 1999; Henry et al. 2012 3. Leonard & Blane, 1992; Leonard & Senchak, 1993; Flanzer, 1993 4. Chalk & King, 1998; Kantor & Jasinski, 1998; Black et al, 1999; Riggs et al, 2000; Wolfe et al. 2009 5. Fagan & Browne, 1994 6. Benson et al, 2001; Riggs et al, 2000 7. Heise, 1998 8. Riggs et al, 2000	1. Education (Higher G.P.A) 2. Healthy self-esteem; respect for self and others 3. Healthy communication skills 4. High Income 5. Social Support	1. Kaukinen, 2004; Cleveland et al. 2003 2. O'Keefe 1998 3. Cleveland et al. 2003; Marcus 2002 4. Benson, et al, 2001; Fox and Benson, 2006 5. Straus et al., 1980; Heise, 1998; Howard et al. 2009
Relationship	1. Financial Strain in Relationship 2. Marital Conflict 3. Gender Inequality in Relationship 4. Desire for power and control in relationship 5. Status Incompatibilities (income, education, relationship expectations) 6. Unmarried or Cohabitating	1. Benson et al. 2005; Benson et al, 2003 2. Hotaling & Sugarman, 1990; Black et al, 1999 3. Browne & Williams, 1993; Coleman & Straus, 1986; Morley, 1994 4. Felson & Messner, 2000 5. Tjaden, 2000; Benson et al, 2003; Anderson 1997	1. Healthy Relationships 2. Healthy Male Role Models 3. Egalitarian Partnership 4. Financial Security	1. Buote et al. 2010; Marcus 2002: Antle et al. 2011 2. Richardson, 2009 3. Coleman and Straus, 1986; 4. Fox et al 2002

This list of Risk and Protective Factors was created by the CT IPV Prevention Steering Committee, and citations were added by CCADV research interns.

		6. Tjaden, 2000; Benson et al, 2003;		
Community	1. Lack of sanctions or ineffective sanctions 2. Disadvantaged Neighborhood 3. Poverty	1. Counts, et al 1992 2. Benson et al. 2003; Fox & Benson, 2006 3. Byrne et al, 1997; Hotaling & Sugarman, 1990	1. Community Awareness 2. Programs for Kids 3. Cohesive communities and low tolerance for IPV	1. Yonas et al. 2011 2. Gardner et al. 2012 3. Browning, 2002
Societal	1. Widespread Technology 2. Perception that DV is not a crime 3. Societal Gender Inequality	*1.* Draucker 2010; Wolak 2003 *2.* Hatty, 2000 3. Levinson, 1989; Heise 1998; Wolfe 2009	1. Stricter Laws and Public Policy* 2. Social Norms 3. Gender Equality 4. Women's Economic Independence	1. Klein 2009; Hirshal et. al 2007 *2.* McDonnell et al. 2011; Salazar et al. 2003; Simon et al. 2009 3. Heise 1998; Levinson 1989; Martin et al. 2006 4. Levinson 1989

* contradictory findings

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Appendix A

Risk and Protective Factors

Connecticut Domestic Violence Prevention Strategic Directions Survey

Findings and Recommendations

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Connecticut Domestic Violence Prevention Strategic Directions Survey

Findings and Recommendations

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The Connecticut Coalition Against Domestic Violence is a statewide coalition which works collaboratively with its 18 community based domestic violence agencies in Connecticut. Each agency offers free services to victims24-hours-a-day to include hotline, safety through shelter, counseling and support groups and help to obtain a restraining order. If you or someone you know needs support, call the statewide free and confidential hotline at 888-774-2900. To learn more about CCADV, visit us online at www.ctcadv.org.

Table of Contents

Introduction

Intimate partner violence is a critical issue that calls for community-oriented approaches to stop violence before it can begin. If intimate partner violence is viewed as a societal and community issue, intervention strategies targeted at only individuals and families are insufficient to address the problem. Therefore, we must combine both prevention and intervention approaches to ensure meaningful change.

In February 2012 the Connecticut Coalition Against Domestic Violence (CCADV) formed a Prevention Steering Committee to guide the development, scope, and direction of a state-level intimate partner violence prevention plan. Its purpose is to reframe and build upon current statewide efforts intended to prevent intimate partner violence from occurring in the first place. The steering committee is a wide consortium of experienced prevention practitioners, stakeholders, and advocates. Members were chosen based on their expertise in domestic violence, experience with primary prevention, involvement with public health, and ability to make high-level policy changes. Committee members are committed to developing a data-driven and evidence based 3-5 year plan to prevent intimate partner violence. Upon completion of their work, the statewide plan will be unveiled in summer 2013.

Initial work of the steering committee focused on developing consensus about the definition of intimate partner violence, drafting a vision statement, and discussing the core components of a statewide, long-range prevention plan. The steering committee meets monthly, the meetings are consistently well-attended and members participate actively. Meeting time is not spent on administrative or bureaucratic tasks rather thoughtful discussions about intimate partner violence, prevention trends, and information geared towards the development of an implementable plan.

In June 2012, CCADV and the steering committee developed and disseminated a Strategic Directions Survey to solicit input to identify 4-5 strategic directions to be included in the plan. The survey link was sent electronically via Survey Monkey to key organizational directors, staff, state and local entities, and community- based organizations working to eliminate intimate partner violence across the state; follow-up interviews with key individuals and organizations working in this area were also held. The survey results are intended to inform the decision-making process of the Statewide Steering Committee as they determine 4-5 strategic directions for the Statewide Prevention Plan.

The following information details the findings and recommendations of the survey.

Executive Summary

The results of the Strategic Directions Survey yielded two lists of the top four priorities for intimate partner violence (IPV) prevention programming and prevention capacity-building. The results also captured information on primary prevention programs already in place and the capacity and resources already possessed by organizations in Connecticut.

Results of Prioritizing Programming

Respondents were asked to rank their top four priorities for future primary prevention programming. The reasoning behind the respondent's choices can be found in the section entitled "Prioritizing Potential Primary Prevention Programs." The top four selections were:

1. Targeting youth and young adults for education and involvement
2. Engaging men in prevention strategies
3. Strengthening or increasing the number of primary prevention programs
4. Changing social norms related to IPV

Respondents were then asked to rank their top choices for future primary prevention capacity and resource building. The reasoning behind the respondent's choices can be found in the section entitled "Prioritizing Potential Areas for Capacity and Resource Building." The top four selections were:

1. Training education, health, and human services professionals on IPV primary prevention
2. Building knowledge on the root causes of IPV
3. Advocating for increased funding for IPV prevention
4. Increasing organizational capacity to implement IPV primary prevention programs

Results from Existing Prevention Programming Questions

The survey results also highlighted information on existing primary prevention programming. This information helps to clarify the priorities selected for the potential areas of primary prevention programs. The respondents reported a total of 136 primary prevention programs in place throughout the state This surprisingly large number of programs appears to reflect some duplication in reporting from respondents. Upon further examination, it was clarified that some of the numbers were duplicated, modifying the actual number of prevention programs from 136 to 61.

Of the 44 respondents that indicated their agency was involved with IPV prevention programming for youth, the majority (88%) were involved with programs in schools and somewhat fewer had programs after school (56%) or that involved youth in community-based prevention activities (48.8%). However, respondents consistently emphasized the importance of engaging youth and ending the cycle of violence, indicating that while they are being served, stakeholders still see a strong need to focus on the youth population.
For the second priority of engaging men, there were relatively few respondents who indicated that

their organizations have primary prevention programs exclusively for men. Only two respondents reported their agencies were involved in IPV prevention activities to promote healthy relations or better parenting skills specifically for males. And only three respondents reported that their agencies were involved in IPV prevention activities specifically for males to address harmful social norms such as traditional gender ideals or norms permissive of violence. This reveals that there may be a gap in male-focused programs and could explain why Engaging Men is a high priority for 54% of the survey respondents.

The final programming priority, changing social norms related to domestic violence, was chosen as a top priority by many of the respondents and also discussed in many explanations of respondent's rationale for their priorities. Of the 50 respondents that indicated their agency was involved with IPV prevention activities, 52% indicated that they were involved with programs to encourage positive social norms that prevent intimate partner violence and 56% indicated that they were involved with programs to counter social norms that otherwise encourage violence. While many organizations are already involved in efforts to change social norms through intimate partner violence prevention, their rationale responses show that many feel altering social norms is the only way to bring about broad, long-lasting social change. Consider one respondent's comment that "changing social norms related to domestic violence is, I believe, the ultimate goal and most effective way to combat violence in our communities."

Other Notes

While the primary prevention strategy of increasing public awareness on IPV did not enter the top four priorities list, it did emerge as an important theme in many of the respondent's rationale for their answers. One third of all respondents providing rationale, discussed the importance of increasing public awareness as a crucial strategy for preventing intimate partner violence. Therefore, despite the absence of a public awareness-focused strategy in the list of top four priorities, this strategy may warrant further discussion.

Results from Existing Prevention Capacity and Resource Questions

The survey also asked respondents about the capacities, resources, and funding at their organizations. This information is useful for exploring the top four priorities for capacity and resource building.

Training of education, health and human services professionals was identified as the top capacity building priority. Only 13% of respondents identified themselves as extremely knowledgeable about IPV while 87% ranged from somewhat knowledgeable to no knowledge at all. As for staffing, only 39.5% of respondents said that their agency has a "prevention specialist" on staff or staff members dedicated to IPV prevention.

The second capacity building priority identified was building knowledge on the root causes of IPV. As explained by one respondent, "You have to start at the root of any issue. If domestic violence in general is still in the closet then it will be difficult to change the norm. Getting to children and teens prior to them establishing their mores is, I believe, a key element in addition to changing the culture."

Only 14 respondents indicated that their organization has funding for prevention-specific programs or activities and 16 reported having other state or local resources for IPV prevention. This indicates that there is a lack of designated funding streams and resources for IPV primary prevention. This lack of funding and resources for the majority of organizations explains why so many respondents emphasized the crucial importance of increasing funding as the first step to engaging in primary prevention.

The fourth capacity building priority, increasing organizational capacity to implement primary prevention programs, speaks to a variety of issues involved in primary prevention, including funding, staffing, tools, and training.

Recommendations

This report is intended to be used by the Prevention Plan Steering Committee to create 4-5 strategic directions for the State Prevention Plan. The data collected highlights potential gaps in resources and programming throughout the state, and also reflects the opinions of various stakeholders concerning potential strategic directions. This report can be used to facilitate discussion and decision-making, but further research may be necessary. In particular, the Steering Committee may want to further investigate the existing primary prevention programs in Connecticut, to get more reliable data on the number of programs, the number of people served, and the budget allocations to primary prevention.

Introduction to the Survey

The Strategic Directions Survey for the Statewide Prevention Plan was distributed to Connecticut Coalition Against Domestic Violence (CCADV) member agencies, community educators, and other community stakeholders focused on intimate partner violence (IPV). The purpose of this survey was two-fold; first, to gather information on primary prevention programs already in place throughout the state, and second, to determine what various stakeholders see as the needs and opportunities in IPV prevention. The survey results are intended to inform the decision-making process of the Statewide Steering Committee as they determine 4-5 strategic directions for the forthcoming Statewide Prevention Plan.

To achieve the first purpose, respondents were asked about their experiences with IPV primary prevention, the type of organization for which they work, and the programs in place at their organizations. Specifically, respondents were asked how long they had been working in IPV primary prevention, which organization they work for, and what their position is within their organization. They were also asked about the location of and populations served by their organization, to assess coverage of the entire state.

Respondents were then given three lists of primary prevention programs and were asked to check off the programs their organization sponsors or participates in. Respondents were also asked whether their programs served only males, only females, or males and females together, to better understand what groups get the most primary prevention programming. The survey then asked respondents about the capacity, resources, and other agencies with which their organization collaborates in order to understand the gaps across the state. These questions helped to create a picture on the current status of IPV primary prevention programs in Connecticut.

To complete the second objective, two lists were compiled: one list of potential primary prevention programs and a second of potential ways to increase organizational capacity and resources to pursue primary prevention. The options for both of these lists came from a review of the strategic directions and plan goals from DELTA IPV Primary Prevention Plans from 14 states. Other options were generated through brainstorming and the experiences of CCADV staff. Respondents were asked to select what they believe are the top four priorities for primary prevention programming and organizational capacity and resource building. Respondents were asked to elaborate briefly on why they chose their four selections for both lists.

At the end of the survey, respondents were asked if they would be willing to participate in a follow-up interview if necessary and whether they were interested in serving on one of the smaller work groups of the Statewide Primary Prevention Plan.

Demographics of Respondents

There were 156 respondents to the survey. 99 respondents fully completed the survey, 57 respondents partially completed the survey.

Respondents' Involvement in IPV Primary Prevention

- 49.4% (77/156) of respondents said that they were currently or had been recently involved in IPV primary prevention efforts. 50.6% (79/156) of respondents said they were not involved in primary prevention.

The following data reflects 67 of the 77 respondents who answered yes to the above question. (Note: Ten respondents did not answer the question.)

- Of the 67 respondents who said that they were involved in IPV primary prevention, 63% have been involved in IPV primary prevention for over 5 years, 16% have been involved for 2-3 years, 13% have been involved for 1 year, and 8% have been involved for less than a year.
- 43% of the 67 respondents who said that they were involved in IPV primary prevention were employees of CCADV Member Agencies, another 15% of the 67 respondents were employees of governmental or law enforcement agencies, and 42% of the respondents were involved in educational, community-based or social service organizations.
- 31% of the 67 respondents were Program Directors or Managers within their organizations, 13% of respondents were Executive Directors of their organizations, and 28% were direct service staff.

There was at least one respondent serving each county in Connecticut and the state as a whole. 23% of the respondents were involved in agencies serving the entire state of Connecticut. 20% of respondents serve Windham County, 14% of respondents serve Fairfield County and 14% of respondents serve either Hartford County or the Hartford Metro Area.

Agencies Represented by County

County	**Agencies Responding**
Hartford County	Prudence Crandall Center, Interval House, Bristol Youth Services, Wheeler Clinic, CCSU Women's Center
Fairfield County	Greenwich Police Department, The Women's Center, YWCA Greenwich Domestic Abuse Service, The Center for Women and Families of Eastern Fairfield County, Planned Parenthood Bridgeport
Middlesex County	New Horizons/Community Health Center Inc, Non-Violence Alliance
New Haven County	Clifford Beers Clinic, Meriden-Wallingford Chrysalis, Center for Domestic Violence Services at BhCare, Madison Youth and Family Services, Southern Connecticut State University, Planned Parenthood of New England
Litchfield County	Susan B. Anthony Project, Women's Support Services
Tolland County	The Network Against Domestic Abuse, EASTCONN
Windham County	Domestic Violence Program of United Services, EASTCONN, Generation Family Health Center
New London County	The Women's Center of Southeastern Connecticut

Statewide	CT Department of Public Health, The Office of the Child Advocate, CCADV, CT Department of Children and Families, Connecticut Community for Addiction Recovery, Problem Gambling Services, CT Department of Mental Health and Addiction Services, Judicial Marshal Academy, Advocacy Unlimited, Connecticut Center for Nonviolence, CT Department of Social Services, CT Department of Correction

Respondents' Knowledge on IPV Primary Prevention

Question 16: There were 124 respondents who completed the question: "Please rate your knowledge in the following areas."

Respondents' Knowledge on IPV Primary Prevention

	Not at all	Slightly	Somewhat	Very	Extremely
Risk and protective factors for IPV in your community or area	6.5%	12.9%	33.1%	31%	14.5%
Evidence-based practices for IPV primary prevention programs	18.5%	21.8%	33.9%	23.4%	2.4%
Existing IPV primary prevention services throughout CT	15.3%	21.8%	39.5%	20.2%	3.2%

Results from Questions on Existing Primary Prevention Programming

- 24 respondents supplied information on existing primary prevention programming in their agency or community group. The 24 respondents were from 21 different organizations throughout the state, 11 of these organizations were CCADV member agencies and the other 10 were governmental, law enforcement organizations, or community groups.
- Respondents reported a total of 136 primary prevention programs in Connecticut serving 72,185 people with an overall total of $745,670 dedicated to IPV primary prevention programs and services.*
- Among the 11 CCADV member agencies responding, their organizations' annual budgets for IPV primary prevention ranged from $0 to $ 240,000. Collectively, they reported a total of approximately 100 different primary prevention programs.

* Note: The data collected on the number of IPV primary prevention programs, the number of people served by the programs, and the amount of the organization's budget allocated to primary prevention may not be fully accurate. These numbers are most likely affected by reporting error and further interviewing and investigating should be conducted in order to obtain a better picture of existing programs and budget allocations for primary prevention. Upon further examination, it

was found that there was a duplication of identified programs, modifying the number to a total of 61 prevention programs statewide.

Question 11: The survey asked, "*In the past year, which specific types of IPV prevention programs has your agency or community group been involved in*?" Check all that apply." There were 41 respondents who responded to this question. Those that skipped this question likely did so because they did not work at agency involved in IPV prevention programming for youth. The relative percentages for each type of program and the gender breakdown for each program type gives us some indication of the IPV primary prevention programs and gaps that may exist for our state. However, since a number of the 41 respondents worked at the same agencies and we did not survey a representative sample of agencies across Connecticut, these findings must be interpreted with caution. Only 37% (N=59) of the 157 respondents who initiated taking the survey, listed the agency where they worked. Of the 41 agencies[1] represented by survey respondents, 58% were involved in IPV prevention programming for youth in the past year according to one or more respondents.

Respondents who reported that their agency has IPV primary prevention programs by program type and targeted gender

Type of program	% of respondents out of those who selected any program type **(N=41)**	For each type of program, breakdown by gender		
		For Males Only	For Females Only	For both Males & Females
Youth education or trainings in school	878% (N=36)	5.6% (N=2)	13.9% (N=5)	97.2% (N=35)
Youth education or trainings after school	58.5% (N=24)	4.2% (N=1)	16.7% (N=4)	91.7% (N=22)
Youth involvement in community-based prevention activities	48.8% (N=20)	0% (N=0)	20.8% (N=4)	79.2% (N=16)
Programs for youth identified as at-risk for becoming victims of IPV	58.5% (N=24)	0% (N=0)	25% (N=6)	80% (N=19)
Programs for youth identified as at-risk for perpetrating IPV	29.3% (N=12)	8.3% (N=1)	0% (N=0)	91.7% (N=11)
Programs in a juvenile detention center	0.1% (N=3)	0% (N=0)	33.3% (N=1)	66.7% (N=2)
Culturally specific programs	1.7% (N=7)	0% (N=0)	14.3% (N=1)	85.7% (N=6)

These results indicate that currently, most primary prevention programs for youth engage males

[1] For the purposes of this analysis the Dept. of Children and Families was divided into it's regional divisions represented by our respondents.

and females together in the same programs. Most of the organizations surveyed conduct programs either in or after school, while few did programs in juvenile detention facilities. There are very few programs exclusively focused on boys and young men; only three agencies offer male-focused programming in schools. There are more programs centered on reaching girls for primary prevention, particularly focused on involving girls into community prevention activities and on girls at-risk to become victims of IPV. All of the seven respondents who indicated that their organizations conducted culturally-specific primary prevention programming wrote that the programs were focused on Latinos or Hispanics; one respondent also wrote that their organization conducted culturally specific programming with the developmentally disabled.

Question 12: Participants were asked, "In the past year, which other types of primary prevention activities has your organization or community group been involved with?" There were 50 respondents who responded to this question indicating that their agencies had been involved in other types of primary prevention activities. Those that skipped the question likely did so because their agencies were not involved in these activities.

Only 37% (N=59) of the 157 respondents who initiated taking the survey, listed the agency where they worked. Of the 41 agencies[2] represented by survey respondents, 63% were involved in one or more IPV prevention activities listed in the chart below in the past year according to one or more respondents.

Respondents who reported that their agency was involved in other IPV prevention activities by type of activity and targeted gender

Type of activity	% of respondents out of those who selected any program activity **(N=50)**	For each type of activity, breakdown by targeted gender		
		For Males Only	For Females Only	For both Males & Females
Programs promoting healthy relationships	92.0% (N=46)	4.3% (N=2)	8.7% (N=4)	93.5% (N=43)
Promoting better parenting skills	62.0% (N=31)	6.5% (N=2)	22.6% (N=7)	77.4% (N=24)
Programs for individuals at-risk of becoming victims or perpetrators of IPV	54.0% (N=27)	3.7% (N=1)	29.6% (N=8)	85.2% (N=23)
Programs in prisons	16.0% (N=8)	25.0% (N=2)	37.5% (N=3)	62.5% (N=5)

[2] For the purposes of this analysis the Dept. of Children and Families was divided into its regional divisions represented by our respondents.

Type of activity	% of respondents out of those who selected any program activity (N=50)	For each type of activity, breakdown by targeted gender		
Programs to alter harmful social norms, such as traditional gender ideals or norms permissive of violence	56.0% (N=28)	10.7% (N=3)	21.4% (N=6)	92.9% (N=26)
Programs to support social norms that discourage IPV, such as gender equality	52.0% (N=26)	7.7% (N=2)	23.1% (N=6)	92.3% (N=24)

Results indicate that the programs most frequently employed by agencies are programs promoting healthy relationships, healthy parenting and programs for individuals at risk of victimization or perpetration of IPV for both men and women. Many respondents also indicated their organizations are undertaking efforts to alter the social norms that affect IPV as a way of preventing the violence. These respondents indicated that their programs focus on both males and females, rather than one specific gender. Few respondents indicated that their organization had programs for IPV primary prevention based in prisons.

Question 13: Thirty-nine (39) individuals responded to the question: "Which other environmental strategies has your organization been involved in for IPV primary prevention?" Again those that skipped the question likely did so because their agencies were not involved in these strategies.

Respondents who reported that their agency was involved in other environmental strategies

Environmental Strategy	% of total respondents for all environmental strategies (N=39)
Encouraging community involvement in prevention	82.5% (N=33)
Raising public awareness through activities such as vigils or health fairs	72.5% (N=29)
Advocating for policy change	70.0% (N=28)
Involving faith and community leaders	60.0% (N=24)
Working with the media to spread IPV prevention messages	50.0% (N=20)

Existing Primary Prevention Capacity and Resources

Question 15: Forty-four (44) individuals responded to the question: "What resources, capacity, or infrastructure for primary prevention programs does your organization already possess?"

Respondents who identified resources, capacity and infrastructure

Capacity, resource, or infrastructure	% of total respondents for all capacity areas (N=44)
Ability to collect data on IPV incidences	54.5% (N=24)
Use of evidence-based strategies in primary prevention programming	52.3% (N=23)
A prevention specialist on staff or staff members who focus on IPV prevention	50.0% (N=22)
Ability to promote public policy supportive of primary prevention efforts	45.5% (N=20)
Other state and local resources that support IPV prevention activities	36.4% (N=16)
Capacity for ongoing monitoring and evaluation of program effectiveness	38.6% (N=17)
Funding for prevention-specific programs or activities	31.8% (N=14)

The results of this question indicate that the majority of organizations represented by respondents on this survey do not have any funding allocated for IPV primary prevention. Also, the majority of organizations do not have any other state or local resources to support IPV prevention activities. In addition, the majority of organizations do not have the capacity to monitor or evaluate the effectiveness of their programs. Most organizations do not have the ability to promote IPV primary prevention public policy or the ability to collect data on IPV incidences. Evidently, there are gaps in these organizations ability to fund, support, and evaluate IPV prevention programming.

Collaborations with other Organizations

When asked, "Which state agencies, organizations or community groups has your organization or group collaborated with in its IPV prevention efforts?"- 28 respondents supplied 106 different collaborators, ranging from school systems to police to the Department of Children and Families. The most frequently cited organizations were school systems, with 14 of the 28 respondents saying that they collaborate with either individual schools in their areas or entire school systems. In total, 22 school systems or individual schools were listed as collaborators with the respondents' organizations. The next most frequently listed collaborators were other service organizations, ranging from Homeless Connect and New Opportunities to the United Way and Connecticut Sexual Assault Crisis Services. 14 of the 28 respondents said that their organization partners with other unspecified service organizations.

Seven respondents listed youth or child organizations with which their organizations work. Some examples were youth services bureaus, Girl Scouts, childcare programs, and educational organizations. Seven of the respondents listed governmental organizations or government-sponsored programs, such as city/town park and recreation departments, law enforcement, and the Department of Children and Families. Respondents also listed religious organizations, YMCA/YWCA, colleges, CCADV, local domestic violence service providers, libraries, and community organizations as collaborators with their agencies.

Prioritizing Potential Primary Prevention Programs

Question 17: Respondents were asked to rank their top four choices out of a list of potential areas in which to focus future primary prevention programming for the state plan. Below is the final ranking of the list based on the respondents' choices. (Note: Priorities were ranked based on the number of respondents who ranked the item in the top four.)

Rankings in which to focus IPV prevention programming

Potential Program	Top 4 ranks/total	Rank Average	Final Ranking
Targeting youth and young adults for education and involvement	62/108	2.21	1
Engaging men in prevention strategies	58/108	2.53	2
Strengthening or increasing the number of primary prevention programs	52/109	2.17	3
Changing social norms related to IPV	47/109	2.57	4
Increasing the use of evidence-based strategies in prevention programs	39/108	2.54	5
Promoting healthy relationships	38/108	2.42	6
A multimedia, public awareness campaign aimed at preventing IPV	36/109	2.58	7
Increasing cultural competency of primary prevention programs	31/108	2.97	8
Increasing public awareness of IPV and IPV prevention	25/108	2.40	9
Encouraging community involvement in IPV prevention	18/108	2.83	10
Promoting better parenting practices	17/108	2.53	11
Encouraging grassroots involvement such as survivor-led programs	13/109	3.23	12

Question 18: Justifications: Respondents were also asked to supply their reasoning after selecting their top 4 choices.

Choice One: Engaging Youth

Twenty-six (26) respondents discussed their choice of "engaging youth and young adults for education and involvement," many of them saying that youth are a crucially important population for prevention and that we must end the cycle of violence during childhood. One respondent wrote, "Engaging and involving youth is also essential to prevent violence in the future—to prevent the development of future perpetrators of violence. Also, involving youth in reaching other youth can be very effective." Another respondent said, simply, "Prevention begins with our young people." Another wrote, "Education of our young people regarding 'healthy' relationships… and [a] no tolerance of violence message [are] key."

Choice Two: Engaging Men

Twenty-four (24) of the respondents who justified this choice wrote about the need to engage men. Respondents wrote that men are important to prevention as victims, perpetrators, negative role models, positive role models, and as a potential voice that has been underutilized thus far. One respondent said, "Men have not had a strong voice in this movement for so long, and I believe it is sorely missed. While the majority of men are NOT abusive, we are under-utilizing the power that the voices of those men have in being able to change the 'idea' and 'image' of what it means to be a 'real man'."

Choice Three: Strengthening Programs

Thirteen (13) respondents elaborated on their choice of "strengthening or increasing the number of primary prevention programs." One respondent wrote that "saturation is very important" in terms of primary prevention programs. Another respondent said, "We must develop new as well as strengthen and increase existing programs to reach a wider audience." One respondent noted the lack of primary prevention programs in the state saying, "We will need more services to meet the increasing needs." Another respondent commented, "Strengthening these programs by having a main message and cultural competency will help the campaign against IPV take on the values of the community."

Choice Four: Social Norms

Seventeen (17) respondents spoke about the need to begin efforts for "Changing social norms related to intimate partner violence." Their answers discussed how broader social change is needed to end IPV once and for all and how this broad change will be most effective by addressing the social norms around violence. One respondent elaborated on her choice saying, "The most significant social change programs reflect a significant effort to change social norms. Social norms change by involving not only key partners in a particular field, but members of our own community, as well as wide-spread movement of solidarity across neighborhoods, states, and nations." Another said, "Changing social norms related to domestic violence is, I believe, the ultimate goal and most effective way to combat violence in our communities."

Choices Seven and Nine: Public Awareness

Although neither of the public awareness-related choices from the above list made it into the top four priorities, 31 respondents mentioned the importance of increasing public awareness on IPV and educating the public on IPV, as well as reaching broad audiences. One respondent wrote, "We need to raise awareness and really educate about the issue if people are going to feel like they have the power to become agents of change." Some respondents emphasized the importance of reaching wide audiences to convey IPV prevention messages, saying "I think that the broader the audience the more effective the result" and "[public awareness] reaches the most people." Another respondent explained, "Public awareness is likely to drive many of the other factors related to primary prevention work… [Unless] the general public understands the issues and dynamics involved [in IPV] and their capability to assist in preventing and making long term change, it will be more difficult to engage communities." Since so many of the respondents wrote about the importance of public awareness for prevention, the option may deserve further consideration. It may be the case that since there were two public-awareness oriented options on the list, that the vote was "split," so neither option made it to the top four, even though 50 respondents put one of the public awareness options into their top four.

Prioritizing Potential Areas for Capacity and Resource Building

Question 19: Respondents were asked to rank their top four choices out of a list of potential areas in which to focus future primary prevention resource capacity and infrastructure building for the state plan. Below is the final ranking of the list based on the respondents' choices.

Rankings in which to focus IPV prevention resources and capacity

Potential Capacity Building	Top 4 ranks/total	Rank Average	Final Ranking
Training education, health, and human services professionals on IPV primary prevention	52/98	2.62	1
Building knowledge on the root causes of IPV	50/98	1.86	2
Advocating for increased funding for IPV prevention	49/98	2.27	3
Increasing organizational capacity to implement IPV primary prevention programs	47/98	2.57	4
Strengthening state and local resources to support IPV prevention efforts	43/98	2.77	5
Potential Capacity Building	Top 4 ranks/total	Rank Average	Final Ranking
Increasing the use of evidence-based strategies in prevention programs	40/98	2.63	6

Promoting public policy that supports IPV prevention	37/98	2.65	7
Coordinating with governmental and non-governmental organizations on prevention efforts	27/98	2.44	8
Increasing number of staff members focused on IPV primary prevention within organizations	20/98	2.50	9
Building capacity for data collection and analysis	20/98	2.9	10
Increasing organizational capacity to evaluate IPV primary prevention programs	7/98	3.00	11

Question 20: Justifications: Respondents were also asked to supply their reasoning concerning the selection of their top four choices.

Choice One: Training education, health, and human services professionals on IPV primary prevention

Thirteen (13) respondents discussed their choice of training other service professionals on IPV to improve primary prevention. Respondents wrote that utilizing other service professionals can be a way to maximize resources and exposure of IPV primary prevention messages. One respondent wrote, "Training other professionals will help us reach greater numbers, thereby increasing the odds of truly creating ongoing change." Another said, "Given limited resources, existing resources (e.g. health teachers) must be maximized." One respondent shared, "As with any new initiative, you first must educate professionals in the field to then build organizational capacity to address the issue."

Choice Two: Knowledge on IPV root causes

Thirteen (13) respondents explained why they chose "Building knowledge on the root causes of IPV" for their top 4 selection. One respondent said, "I think with anything understanding the root and causes is important to stopping it. We can't really, fully stop something until we stop it at the source." Another wrote, "It is imperative that we also continue to build our knowledge about the root causes of IPV, so that our work stays relevant to trends in our area and that we remain knowledgeable on current research."

Choice Three: Increasing Funding

Twenty-four (24) respondents discussed the importance of increased funding, many of them saying that it is an essential first step to any prevention program and some elaborating about the need to put funding towards hiring more staff for service organizations. One respondent wrote, "[We] have never had adequate and secure funding for prevention, and programs are over-stretched." Another

said, "Prevention and other types of education programs receive little or no funding, making it difficult to deliver healthy relationship programs to a broad audience." A respondent also wrote, "We can't educate and prevent IPV without funding, and unfortunately, everything else is reliant on getting funding for more educators in order to increase [our] knowledge on the root causes of IPV." Only one respondent offered a different perspective on funding, saying, "I think these are more important than the others, because having all the funding in the world doesn't necessarily mean people will work with us and hear us. I've been able to do some great programs without any budget. Of course it would be nice, but it's not the important part."

Choice Four: Capacity to Implement Programs

Nine respondents who justified their prioritization of the importance of increasing organizational capacities to implement primary prevention programs. One respondent said, "We need for agencies to be able to implement programs, and we need other organizations to help." Another respondent wrote about the broader goal for increasing organizational capacity, saying, "If organizations have increased capacity to implement [programs], I am hoping that the increased capacity can also be utilized to collect data and implement programs."

APPENDIX A

STRATEGIC DIRECTIONS SURVEY

Survey Introduction

The Connecticut Coalition Against Domestic Violence and a steering committee of state community members have begun the process of creating a Statewide Intimate Partner Violence Prevention Plan to strengthen intimate partner violence primary prevention in Connecticut. Primary prevention means stopping intimate partner violence (IPV) before it occurs, rather than responding once it happens or working to prevent its recurrence. Primary prevention focuses on strategies to stop both first-time perpetration and first-time victimization. As a part of the planning process, we are looking for input from various community stakeholders and our member agencies to identify 4-5 strategic directions for primary prevention of intimate partner violence in Connecticut. There will be additional opportunities for participation on our planning committees, which will be formed in the fall.

All of your individual responses will be kept confidential by CCADV and only aggregate responses, without names or organizations, will be made public. If you have any questions while completing the survey, please contact Linda Blozie, CCADV Training and Prevention Coordinator at (860) 282-7899 or lblozie@ctcadv.org.

Demographic Information

1. What is your name?

2. Primary prevention means stopping IPV before it occurs, rather than responding once it happens or working to prevent its recurrence. Primary prevention focuses on strategies to stop both first-time perpetration and first-time victimization. Are you currently involved in or have been recently involved in activities aimed at intimate partner violence primary prevention?

3. How long have you been involved in IPV primary prevention work?

4. What organization or community group do you belong to?

5. What type of organization or community group are you a part of?

    - CCADV Member Agency
    - Social Service Agency
    - Law Enforcement

- Criminal Justice
- Governmental Agency
- Educational Organization
- Faith Based Organizations
- Survivor or Family Based Organization

6. What geographic region does your agency serve?

   - Greater Hartford Metro Region only
   - Fairfield County
   - Hartford County
   - Litchfield County
   - Middlesex County
   - New Haven County
   - New London County
   - Tolland County
   - Windham County
   - Statewide
   - Other (please specify)

7. Which best describes your current position in IPV prevention work?

   - Executive Director
   - Program Director/Manager
   - Administrative Staff
   - Direct Service Staff
   - Leader of a Community Group
   - Volunteer
   - Other (such as a school principal or other position involved in IPV as a collaborator with other organizations)

IPV Programming Information

Please note, these questions relate to IPV primary prevention activities ONLY, we mean primary prevention to be any activity or program that prevents intimate partner violence BEFORE it has occurred. The following questions for Executive Directors or Community Leaders may not apply to all organizations, but please supply all the information you can for statewide planning purposes. This information will be reported in aggregate form by region and/or county.

We will do our best to protect confidentiality of your organization, however if your organization is the only one providing IPV primary prevention services in a particular region that completed this survey, it is possible that your organization may be associated with this information. We will also ask for information about your program budget, but any financial information you choose to provide will not be reported in such a way that any individual agency could be identified. You can also opt not to provide financial information about your prevention programming, although it will be helpful for us to be able to document existing resources being directed toward IPV prevention.

8. Of the programs at your organization or community group, how many would you consider to be intimate partner violence primary prevention programs?

9. Approximately how many people were served by your programs specific to IPV primary prevention in the past year?

10. What is your 2012 annual budget for IPV primary prevention related programs/services?

11. In the past year, which specific types of IPV prevention programs has your agency or community group been involved in? Check all that apply and specify if for males only, females only, or both males and females.

    - Youth education or trainings in school
    - Youth education or trainings after school
    - Programs for youth identified as at-risk for becoming victims of IPV
    - Programs for youth identified as at-risk for perpetrating IPV
    - Programs in a juvenile detention center
    - Culturally specific programs- if so, please specify for which group

12. In the past year, which other types of primary prevention activities has your organization or community group been involved with? Check all that apply and specify if for males only, females only, or both males and females.

    - Programs promoting healthy relationships
    - Promoting better parenting skills
    - Programs for individuals at-risk of becoming victims or perpetrators of IPV
    - Programs in prisons
    - Programs to alter harmful social norms, such as traditional gender ideals or norms permissive of violence
    - Programs to support social norms that discourage IPV, such as gender equality

13. Which other environmental strategies has your organization or community group been involved in for IPV primary prevention?

- Involving faith and community leaders
- Working with media to spread IPV prevention messages
- Raising public awareness through activities such as vigils or health fairs
- Encouraging community involvement in prevention
- Advocating for policy change
- Other- if so, please specify

14. If applicable, which state agencies, organizations or community groups has your organization or group collaborated with in its IPV prevention efforts?

15. What resources, capacity, or infrastructure for primary prevention programs does your organization already possess? Check all that apply.

- Ability to collect data on IPV incidences
- A prevention specialist on staff or staff members who focus on IPV prevention
- Use of evidence-based strategies in primary prevention programming
- Capacity for ongoing monitoring and evaluation of program effectiveness
- Funding for prevention-specific programs or activities
- Other state and local resources that support IPV prevention activities
- Ability to promote public policy supportive of IPV prevention efforts
- Other-if so, please specify

Personal Knowledge on IPV Primary Prevention

16. Please rate your knowledge in the following areas: not at all knowledgeable, slightly knowledgeable, somewhat knowledgeable, very knowledgeable, extremely knowledgeable.

- Risk and protective factors for intimate partner violence in your community or area
- Evidence-based practices for IPV primary prevention programs
- Existing IPV primary prevention services throughout Connecticut

Prioritizing Potential Prevention Programming

17. Below is a list of potential areas in which to focus primary prevention programs and activities for the state plan. Based on your experience and knowledge, please rank ONLY what you think are the TOP 4 areas for future prevention programming, where 1 is the

highest priority. Please mark N/A for the options that you do not select. NOTE: ONLY RANK 4 OPTIONS FOR THIS QUESTION.

- Strengthening or increasing the number of primary prevention programs
- Increasing the use of evidence-based strategies in prevention programs
- Increasing cultural competency of primary prevention programs
- Targeting youth and young adults for education and involvement
- Engaging men in prevention strategies
- A multimedia, public awareness campaign aimed at preventing IPV
- Increasing public awareness of IPV and IPV prevention
- Encouraging community involvement in IPV prevention
- Encouraging grassroots involvement such as survivor-led programs
- Promoting healthy relationships
- Promoting better parenting practices
- Changing social norms related to IPV

18. Please provide your rationale for choosing your top 4 areas for improving IPV primary prevention programming.

19. Below is a list of potential areas in which to focus primary prevention resource, capacity, and infrastructure building for the state plan. Based on your experience and knowledge, please rank ONLY what you think are the TOP 4 areas for future prevention capacity building, where 1 is the highest priority. Please mark N/A for the options that you do not select. NOTE: ONLY RANK 4 OPTIONS FOR THIS QUESTION.

- Building knowledge on the root causes of IPV
- Increasing organizational capacity to evaluate IPV primary prevention programs
- Increasing the use of evidence-based strategies in prevention programs
- Advocating for increased funding for IPV prevention
- Strengthening state and local resources to support IPV prevention efforts
- Increasing organizational capacity to implement IPV primary prevention programs
- Building capacity for data collection and analysis
- Increasing number of staff members focused on IPV primary prevention within organizations
- Promoting public policy that supports IPV prevention
- Coordinating with governmental and non-governmental organizations on prevention efforts
- Training education, health, and human services professionals on IPV primary

prevention

20. Please provide your rationale for choosing your top 4 areas for improving primary prevention capacity and resource building.

21. In addition to this survey, we wish to conduct follow up interviews with our member agencies to provide the necessary background and elaboration on the questions above. May we call you to follow up on this survey?

22. What is the best number at which to reach you?

23. What is the best email address at which to reach you?

24. Using the results of this survey, the Statewide IPV Prevention Steering Committee will be creating strategic directions for the prevention plan. Committees will be formed to focus on researching and implementing specific strategic directions, would you be interested in serving on one of these committees? If so, please provide your phone number in the box above so that we can contact you with further information.

25. Any questions or comments?