NEW MEXICO – SEXUAL VIOLENCE FREE

A Statewide Strategic Plan for the Primary Prevention of Sexual Violence 2015-2020

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New Mexico – Sexual Violence Free
A Statewide Strategic Plan for the Primary Prevention of Sexual Violence
2015-2020

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ACKNOWLEDGMENTS

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OUR VISION: SAFE COMMUNITIES FREE OF SEXUAL VIOLENCE

OUR MISSION: TO PREVENT SEXUAL VIOLENCE THROUGH EDUCATION, COMMUNICATION, COLLABORATION, AND COMMUNITY ACTION BY FOCUSING ON HEALTHY RELATIONSHIPS, GENDER EQUITY, CULTURAL STRENGTHS, AND RESPECT FOR OTHERS.

EXECUTIVE SUMMARY

New Mexico – Sexual Violence Free: A Statewide Strategic Plan for the Primary Prevention of Sexual Violence, 2015-2020, serves as a path toward ending sexual violence in our state. It provides a framework and establishes a vision, mission, goals, and objectives for moving primary prevention forward. The plan is meant to be used by agencies, organizations, universities, community coalitions, policy-makers, prevention professionals, and other individuals interested in reducing the burden of sexual violence (SV) in New Mexico.

Sexual Violence: Causes and Effects

SV is any intentional act of a sexual nature that is imposed by a person on another person without that person's consent, regardless of their relationship, through physical force, coercion, intimidation, humiliation, causing or taking advantage of another's drug or alcohol intoxication, or taking advantage of another person's inability to consent. Examples are rape, touching, sexual harassment, threats of violence or of consequences such as job loss, stalking, forced prostitution, and human trafficking.

Anyone can be a victim or perpetrator of SV. But the root cause of SV is oppression; that is, SV is a means by which people with more power subjugate those with less power. Social norms pertaining to power, privilege, secrecy, privacy, gender roles, gender expression, and other social determinants of health help perpetuate SV. Therefore, members of the following groups are especially at risk of SV: women, children, people of color, immigrants and refugees, older adults, people with disabilities, and lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) people. People who are members of more than one of these groups have an especially high risk of SV victimization.

SV has numerous adverse effects on its survivors, those who provide services to survivors, and society in general. These include physical injury, psychological problems, stigmatization, sexually transmitted diseases, unwanted pregnancy, an increased risk of substance abuse, and financial costs for medical and mental health services, law enforcement, and incarceration.

Sexual Violence in New Mexico

About 25% of women and 5% of men in New Mexico will experience an attempted or completed rape sometime during their life. Fifty-three percent of NM SV assault survivors are under 18 years of age. New Mexico also has relatively large populations in which SV occurs at a disproportionately high rate: immigrants, Native Americans (NAs), rural residents, and LGBTQ people. Moreover, although SV is underreported in all populations, it is especially likely to remain unreported in these groups because of fear of or unfamiliarity with law enforcement or the legal system, fear of retaliation, poverty that makes it difficult to avoid unsafe environments and access resources, and social norms of secrecy and privacy. This strategic plan includes a fact sheet pertaining to SV for each "priority population" in New Mexico.

Primary Prevention of Sexual Violence

The most effective way to prevent SV is to stop it before it happens (primary prevention). This can be difficult because of community and cultural norms. SV must therefore be addressed at multiple levels of society by using strategies that both increase factors that protect against SV victimization and decrease factors associated with a higher likelihood of perpetration. The best approach is the public health model. The steps in this model include defining the extent of the problem; identifying who is most affected; developing and testing prevention strategies; and promoting wide-spread adoption of effective prevention strategies.

Because SV is supported by community and societal norms that implicitly or explicitly condone it, the most effective primary prevention programs are those with a socioecological focus. Such programs comprehensively address violence at multiple levels, focus on community engagement, build on proven practices that help to prevent violence, and focus on community health and improving underlying social conditions. Specific programs that have been found to be effective or promising include *Safe Dates, Shifting Boundaries, Coaching Boys Into Men,* and *Bringing in the Bystander*.

Development of the 2015-2020 Strategic Plan

The plan was developed by the University of New Mexico (UNM) Prevention Research Center (PRC) in collaboration with the New Mexico Department of Health (NMDOH), New Mexico Coalition of Sexual Assault Programs, Inc. (NMCSAP), an advisory group of SV prevention professionals and advocates, content experts, community members, and prevention practitioners. A three-tiered advisement and feedback structure was used to gather information for the plan. Tier 1 consisted of leaders in SV prevention from throughout New Mexico, tier 2 of people who could provide expert advice and feedback for priority populations and specific plan components, and tier 3 of rape crisis center (RCC) staff and participants in 11 focus groups. Focus group participants were service providers, people in communities with RCCs, and people in priority populations.

Themes from Focus Groups

Five themes consistently emerged from the focus groups: SV as a public health problem, inclusion of response with primary prevention, the need for community-specific SV programming, development of a common language to address sexual violence and its prevention, and promising and successful prevention strategies in New Mexico. The priority populations provided additional insights. For example, the rural participants noted structural challenges to SV prevention, such as long travel distances, access to resources, and funding deficits. The LBGTQ group recommended that educators and health care providers undergo training to increase their awareness and sensitivity to LGBTQ people and issues, including factors that affect active consent to sexual activity. The overarching concern of the immigrant focus group was the safety of people reporting SV. Participants in the NA focus group described the need for culturally relevant education that addresses SV and historical trauma among NAs directly.

The Strategic Plan

The advisement and feedback structure informed the following vision, mission, goals, and objectives for the new 5-year plan ending June 2020.

Vision

The vision of the Sexual Violence Prevention program is safe communities free of sexual violence.

Mission

The mission of the Sexual Violence Prevention program is to prevent sexual violence through education, communication, collaboration, and community action by focusing on healthy relationships, gender equity, cultural strengths, and respect for others.

Goals and Objectives

Goal 1. To change norms pertaining to acceptability of SV in New Mexico.

Objectives for Goal 1 include expanding collaborations, conducting readiness assessments, conducting prevention programming, and developing targeted messages. Completion of these objectives would result in improved community engagement, greater use of an anti-oppression framework in prevention efforts, increased integration of best practices for primary prevention, development of a state-level SV communications plan, and integration of media strategies to reduce SV.

Goal 2. To create safer environments by changing policies and infrastructure.

Objectives for Goal 2 include promoting development of environmental and organizational policies that decrease risk factors for SV perpetration and increase protective factors against victimization. Activities would result in the identification and implementation of policy and environmental strategies to reduce SV and greater integration of policy-level work into prevention efforts.

Goal 3. To increase use of the public health approach in statewide SV prevention efforts.

Objectives for Goal 3 are to continue to build a statewide infrastructure to support primary prevention and enhance statewide SV data collection. Results would include enhanced coordination of prevention programs; increased evaluation of prevention programs; more trained prevention practitioners; increased funding for surveillance and prevention efforts; more research on SV prevention and perpetration in New Mexico; increased dissemination of findings; increased SV surveillance; improved data sharing among SV prevention agencies; and enhanced identification of gaps in SV data.

BACKGROUND

Sexual violence is experienced throughout the world and affects individuals from the very young to the very old, is experienced across races and ethnicities, includes males and females as both victims and perpetrators, and occurs among people from all social and economic classes (Krug et al., 2002). The impacts of sexual violence include physical injuries, emotional and psychological problems (Chrisler & Ferguson, 2006), and other harmful consequences such as sexually transmitted diseases, unwanted pregnancies, increased risk for substance abuse and increased risk for subsequent physical and sexual assaults (Martin & Macy, 2009). Sexual violence is a significant public health problem in New Mexico as well, where 25% of women and 5% of men will experience a completed or attempted rape sometime in their lifetime (Caponera, 2014).

> ## It's difficult to prevent sexual violence because most of it is hidden in secrecy.

Research shows that the most effective way of preventing sexual violence is by stopping it before it occurs, an approach known as primary prevention (Cohen et al., 1995). There are many reasons why implementation of this strategy is difficult and complex. Sexual violence typically exists in secrecy. This means it is very difficult to understand exactly how many people experience sexual violence and the circumstances under which it occurs. It carries great social stigma, with the person victimized by the crime often being made to feel responsible for the actions of the perpetrator. Community and cultural norms also influence how sexual violence is viewed and they affect the degree of community readiness to address it as both a health and social issue.

> ## " The more awareness, the more talking, the less shaming goes on. "
> -Focus Group Participant

A community's overall acceptance of violence as a normal occurrence is particularly salient, as is the extent to which sexual violence is tolerated. Violence in its many forms is an outcome of oppression – the notion that certain people or populations (e.g. males, whites, those of heterosexual orientation) are entitled to certain rights, such as safety, power and self-determination, that others (e.g. females, people of color, people who identify as gender non-conforming) are not (Krug et al., 2002). These complexities underscore the need to address sexual violence at multiple levels of society using a multitude of strategies that both increase factors that protect against sexual violence victimization and decrease factors that are associated with higher risk of perpetration (Centers for Disease Control and Prevention, 2004). They also underscore the necessity of approaching sexual violence prevention within the context of privilege and power structures that support, "…men's adherence to sexist, patriarchal, and/or sexually hostile attitudes [as an] important predictor of their use of violence against women…" (Flood, 2011).

In 2009, the New Mexico Department of Health (NMDOH) Office of Injury Prevention, the New Mexico Coalition of Sexual Assault Programs, Inc. (NMCSAP), and the University of New Mexico (UNM) Prevention Research Center (PRC) began to systematically assess the capacity of locally based sexual violence prevention practitioners to implement strategies for the primary prevention of sexual violence. Working with numerous communities and organizations throughout New Mexico, NMDOH, NMCSAP and the UNM PRC conducted a series of community-level focus groups and stakeholder interviews to gauge overall understanding of primary prevention principles, resources, and to identify barriers at both local and state levels related to the implementation of primary prevention strategies. The outcome of the assessment process was *Building Capacity for the Primary Prevention of Sexual Violence in New Mexico: a Three-Year Strategic Plan, 2009-2012 (Building Capacity)*. In addition to providing background on the state of sexual violence in New Mexico and best practices for primary prevention, the strategic plan provided a series of training opportunities for sexual violence prevention service providers designed to establish a baseline understanding of primary prevention of sexual violence. The training sessions were coupled with organizational-level technical assistance intended to

reinforce training content and support organizations in implementing primary prevention strategies. The strategic plan implementation was also evaluated to assess its success in achieving intended outcomes.

The newly developed NMDOH five-year strategic plan, *New Mexico – Sexual Violence Free: A Statewide Strategic Plan for the Primary Prevention of Sexual Violence, 2015-2020 (NM-SV Free Plan)*, builds on the efforts begun with *Building Capacity* and is intended to be the next step in a collaborative, state-driven process to end sexual violence in New Mexico. This strategic plan was developed by the UNM PRC in collaboration with the leadership team for sexual violence prevention planning efforts (NMDOH, NMCSAP and the UNM PRC), a strategic plan advisory group, content experts, and a diverse group of community members and practitioners from around the state.

WHAT IS SEXUAL VIOLENCE?

The definition of sexual violence used in the development of this report and in the work of primary prevention in New Mexico is as follows:

> Any intentional act of a sexual nature that is imposed on another person, regardless of their relationship, through physical force, coercion, intimidation, humiliation, causing or taking advantage of another's drug or alcohol intoxication, or taking advantage of another person's inability to consent. These acts can include a range of actions including but not limited to rape, unwanted touching, sexual harassment, threats of violence as related to sexual violence, threats of other consequences such as job loss, child sexual abuse, stalking, forced prostitution or human trafficking.

This definition was crafted by advisory group members during the development of *Building Capacity*. The purpose of collaboratively developing a definition of sexual violence was to ensure that those working to prevent sexual violence in New Mexico had a consistent understanding of what was meant by the term.

There are other definitions of sexual violence that include more detail, such as that in the NM Statutes (New Mexico Compilation Commission, n.d.) or less detail, such as that in The Violence Against Women Reauthorization Act (U.S. Congress, 2013) and the Office on Violence Against Women (U.S. Department of Justice, 2015). However, the consistent and most important concept in all definitions is that of consent. Attempted or completed acts of a sexual nature without the explicit consent of all parties are considered to be criminal acts at both federal and state levels.

Community members who participated in focus groups as part of developing the *NM-SV Free Plan* (see details in the Methods section) indicated that defining sexual violence was essential to prevention. Many participants argued that there is still widespread confusion about what constitutes sexual violence. Participants agreed that a broad definition that includes verbal abuse, non-contact sexual abuse, and discussions of power and control is important. Overwhelmingly, participants agreed that consent was the most crucial element that must be discussed and understood to further the work of primary prevention of sexual violence in our communities.

> " *So many [men] were surprised when we talked to them about sexual assault. At first they're like, 'Oh, I am not a rapist. I'm not a child molester,' but then as we went through what sexual violence was, they were surprised and you'd see these light bulbs go off…"*
>
> -Focus Group Participant

WHAT IS ACTIVE CONSENT?

The concept of active consent has been embraced by many sexual assault prevention programs and policies, particularly those on college campuses. The first state bill to codify active consent was California Senate Bill 967, passed in September 2014 (Bill Text - SB-967, 2014). The bill states:

> "Affirmative consent" means affirmative, conscious, and voluntary agreement to engage in sexual activity. It is the responsibility of each person involved in the sexual activity to ensure that he or she has the affirmative consent of the other to engage in the sexual activity. Lack of protest or resistance does not mean consent, nor does silence mean consent. Affirmative consent must be ongoing throughout a sexual activity and can be revoked at any time. The existence of a dating relationship between the persons involved, or the fact of past sexual relations between them, should never by itself be assumed to be an indicator of consent.

Promoting active consent within community-, school- and campus-based prevention education helps integrate consent as a valued community and social norm. Active consent policies may prove to be a promising practice that can help change the paradigm from victim-blaming, silence, and denial to holding perpetrators accountable for unwanted sexual behaviors. It is a welcome enhancement to definitions of sexual violence in that it removes ambiguity around what constitutes responsible, ethical and legal adult sexual behavior.

WHAT CAUSES SEXUAL VIOLENCE?

Sexual violence is a tool used by those with power to subjugate those with less power (California Coalition Against Sexual Assault, 1999). It manifests in many ways – from child sexual abuse shrouded in secrecy to an intimidation tactic used to punish those who challenge social norms to systematic rape used as a weapon of war (Krug et al., 2002). The root cause of sexual violence, and all other forms of

violence, is oppression. Oppression, whether intentional or unintentional, has been described as "…the experience of repeated, widespread, systemic injustice…" where "… specific privileged groups are the beneficiaries of the oppression of other groups, and thus have an interest in the continuation of the status quo…" (Deutsch, 2006).

Many individuals and groups in the United States and throughout the world experience oppression on a daily basis. Marginalization, exploitation and discrimination of these individuals and groups are based on a multitude of factors, among which are race, sex, gender identity, gender expression, class, religion, citizenship, age and ability   (California Coalition Against Sexual Assault, 1999; Dermer et al., 2010; Phipps, 2009). People experiencing sexual violence may be members of multiple marginalized groups. For example, a young woman sexually assaulted at college may also be a member of a racial minority, an African American male experiencing intimate partner violence may also be gay and an elderly female victim of abuse at the hands of a caregiver may be an undocumented immigrant.

> **"** *Sexual violence and institutional violence are hand-in-hand, because racism and classism and sexism, the [lack] of being able to mirror people's cultural experiences and backgrounds [in policies, organizations and legal processes].* **"**
> -Focus Group Participant

Those experiencing multiple types of oppression are especially vulnerable to sexual violence, particularly women of color (Black et al., 2011; Tjaden & Thoennes, 2000). According to the Women of Color Network (2006), this intersectionality of oppressions may mean that victims deal not only with the personal experience of rape but also larger cultural, historical and social contexts. These contexts can influence whether the crime is reported to law enforcement, whether it is disclosed to anyone,

whether the victim seeks services, and whether the act is even considered a crime by law enforcement, society and sometimes even family and friends.

It is imperative that sexual violence prevention advocates and organizations recognize that oppression is the root cause of all types of violence, including sexual violence, and that it is often reinforced by our social, political, justice, education, religious and economic institutions (California Coalition Against Sexual Assault, 1999). In order to have any long-term impact on sexual violence, prevention efforts must address the social structures that perpetuate inequality and inequity (Sokoloff & Dupont, 2005).

THE COSTS OF SEXUAL VIOLENCE

In 2010, researchers estimated that each rape in the United States cost taxpayers $151,423 (based on 2008 U.S. dollars) in tangible victim costs (e.g., medical care, mental health services, economic productivity loss), intangible victim costs (e.g., psychological pain and suffering and generalized fear of victimization) (Post et al., 2002), and criminal justice costs and offender productivity costs (Delisi et al., 2010). In 2013, New Mexico law enforcement agencies reported 1,445 incidents of rape (Caponera, 2014). Multiplying the number of rapes reported by law enforcement by the estimated cost per rape indicates that the costs of reported rape alone in New Mexico was close to $219,000,000. The number of unreported rapes in New Mexico in 2013 is estimated to be four times that of reported rapes (Caponera, 2014). Therefore, a better estimate of the total costs associated with rape in New Mexico in 2013 is close to $1 billion.

> The total yearly costs associated with rape in New Mexico are estimated to be nearly $1 billion.

Although attaching a dollar amount to the number of rapes committed in one year is sobering, it provides

a limited perspective of the effects of sexual violence, considering its many physical, psychological, and relational impacts. For example, sexual violence experienced by young children has been linked to chronic disease and health risk behaviors throughout adulthood (Centers for Disease Control and Prevention, n.d.-a). This research examining adverse childhood experiences (ACEs), including emotional, physical and sexual abuse; emotional and physical neglect; and household dysfunction such as substance abuse found that short- and long-term outcomes of ACEs are related to subsequent alcoholism, depression, fetal death, heart disease, liver disease, smoking, suicide attempts, and risk for intimate partner violence (Felitti et al., 1998). Moreover, as the number of ACEs increased, the risk of chronic health problems in adulthood escalated.

Other studies showed that adolescent victimization, including sexual victimization, can disrupt academic performance and educational attainment (Macmillan & Hagan, 2004). This in turn affects participation in the labor force, occupational status, and earnings in early adulthood that can result in significant reductions in earning potential and income over the life span. Additional education-related costs may include special education services for behavioral problems and learning disabilities associated with being a child witness of domestic violence, and training programs for people to re-enter the workforce after leaving abusive partners (Day et al., 2005).

In a review of sexual violence victimization as a public health problem, Basile and Smith (2011) included research linking sexual violence to physical health problems (e.g., genital injuries, sexually transmitted diseases, unwanted pregnancies, chronic pain), psychological issues (e.g., assumptions about the goodness of people, sense of safety in the world, anxiety, sleep disorders, post-traumatic stress disorder (PTSD), depression, suicidality), social and relationship impacts (e.g., readjustment to the workplace and loss of productivity, negative effects on intimate partner, family and friend relationships), and an increased likelihood of participating in risky health behaviors (e.g., unprotected sex, substance abuse, smoking, elevated number of sex partners). There are additional effects on persons with mental and/or physical disabilities and elderly people,

among whom abuse is often perpetrated by caregivers at home or in schools or other institutional settings (Alriksson-Schmidt et al., 2010; Jones & Powell, 2006; Martin et al., 2006; Mitra et al., 2011), and reporting may result in changes to living arrangements and limited access to important familial and social relationships.

Another consideration is the impact sexual violence has on people working with sexual assault survivors, including organizational volunteers and paid staff, as well as criminal justice personnel assigned to sexual assault cases. Providers and responders who have less organizational support within their agency, more exposure to trauma through higher caseloads, and are younger or are less experienced can undergo burnout (emotional exhaustion and reduced job satisfaction), secondary traumatic stress disorder (from listening to repeated stories of victimization), or vicarious trauma (intrusive thoughts and imagery). All of these conditions can lead to lower self-esteem, greater levels of interpersonal conflict, substance abuse, and mental health issues (Baird & Jenkins, 2003; Way et al., 2004).

Sexual Assault Nurse Examiners (SANE) may have additional stressors related to their participation in systems that can seem contradictory. In other words, what may be best for the client in terms of perpetrator accountability may not be best from a mental health perspective (Townsend & Campbell, 2008). SANE nurses may also be vulnerable to "mission failure"; that is, maintaining high forensic standards does not necessarily determine whether a case is prosecuted or has positive outcomes for the clients. This contributes to the high staff turnover among sexual violence providers, which in turn increases organizational costs related to filling staff positions, overtime pay to people covering for those unable to work, training new staff, and loss of productivity.

Qualitative data gathered through focus groups conducted as part of the *NM-SV Free Plan* planning process indicate that providers in New Mexico clearly understand and are witness to these costs within their local communities. Participants mentioned what for some are life-long behavioral and mental health consequences of sexual violence victimization, such as hopelessness, fear, isolation, low self-esteem, self-blame, self-harm and substance

abuse. They also mentioned other related outcomes such as teen pregnancy and academic underachievement. Societal costs were also recognized. One focus group participant mentioned the pervasive feeling of mistrust that can develop in what could be a small, close-knit community. Others mentioned economic impacts, people leaving communities because of their victimization, and the intergenerational aspect of sexual violence.

> " *…we have people who come in at the age of 65 who are still dealing with impacts from being ten years old and being sexually abused. Or not having memories until they're 30 and then this is impacting their life. So..there's no time frame, there's this lifelong impact possibly, especially if you know they didn't feel safe to tell anybody or didn't think they'd be believed, which is often the case. … It's not just it happens and then you deal with it for two years or whatever, it can be this really lifelong process.* "
>
> -Focus Group Participant

According to a United Nations report (Day et al., 2005), the consistent finding among studies of costs associated with violence against women is that monetary and societal costs are enormous, with estimates of billions of dollars annually. These calculations vastly underestimate the overall true costs of these crimes, given that they are consistently and significantly underreported. Society pays the price, and will continue to do so until the costs of prevention are recognized to be minimal in comparison and there is the political will necessary to address the underlying, systemic social structures that perpetuate sexual violence victimization and perpetration.

HOW TO PREVENT SEXUAL VIOLENCE

Unfortunately there is no simple solution for addressing sexual violence. Sexual aggressiveness and domination are often viewed as customary rights of those in power in societies throughout the world (Douglas et al., 2008). Male privilege is often reinforced by societal norms that uphold the notion of male superiority and value patriarchal structures, with rigid demarcations for acceptable male and female roles and behavior (Krug et al., 2002). Working to change social norms around male privilege and the acceptability of sexual violence must be a strong component of prevention efforts.

Models of Prevention

Because sexual violence is widespread, it is best approached through a systematic process known as the Public Health Model (Centers for Disease Control and Prevention, n.d.-d). The first step in this model is to **define the extent of the problem by carefully reviewing and analyzing national, state and local data related to sexual violence victimization and perpetration**. It is essential to know who is being most affected by sexual violence and where it is taking place so that prevention efforts can be targeted to populations and communities where they will be most effective.

It is also important to understand why some people are at higher risk than others, both for perpetration and victimization. This is the second step in the Public Health Model: **identifying risk factors (e.g., norms that support male superiority) and protective factors (e.g., emotional health and connectedness)**. It will then be possible to advance to the third step: **developing and testing prevention strategies**. Currently there is more evidence regarding susceptibility to sexual violence victimization than to perpetration, but there is emerging research on influencing cultural norms so communities and societies are safer from violence overall, and increasing interest in how policy implementation can strengthen prevention efforts.

The final step in the Public Health Model is **documenting and sharing results and promoting adoption of successful interventions**. This can be done through scientific channels such as a peer-reviewed journal article or conference presentation, community settings (e.g., training sessions, workshops, op-ed articles), or organization websites

and materials. Implementation of the Public Health Model is not a static process. After the fourth step, the cycle should be repeated to ensure that understanding of the state of sexual violence and how to address it effectively remains current.

Given that the act of sexual violence takes place between individuals but is supported by larger community and societal norms that may implicitly or explicitly condone it, primary prevention efforts simultaneously directed at multiple levels of the socioecology will be most effective (Lee et al., 2007). For instance, school curriculum designed to reduce intimate partner violence among students will have more impact if measures to change "community norms" within the entire school, such as anti-harassment policies and sexual violence prevention training for school staff, are implemented at the same time. A community health council prioritizing violence prevention in its strategic plan, establishing a working group to strengthen collaboration and relationships between violence-prevention organizations, and collectively developing a media campaign to raise awareness about sexual violence and its impact on the community would be another example of implementing multiple strategies at numerous levels of the socioecology.

Common elements for successful socioecologically based programs include the following: **comprehensiveness** –multiple strategies to impact multiple outcomes; **community engagement** – partnerships with communities to identify desired outcomes and design strategies to achieve those outcomes; **contextualized programming** – consistent with the communities' broader social, economic and political make-up; **theory-based** – based on proven behavior-change theories; **community health and strengths focus** – support community strengths and resources while addressing risk factors; and **focus on underlying social conditions** – address root causes of social problems rather than changing individual-level behaviors (Casey & Lindhorst, 2009).

The Public Health Approach to Violence Prevention is attached as Appendix A. Appendix B, the Socioecological Model, shows how factors at different levels of the socioecology relate to sexual violence (Centers for Disease Control and

Prevention, 2004). Additional examples of primary prevention strategies that can be implemented across multiple spheres of influence are shown in Appendix C, the Spectrum of Prevention (Davis et al., 2006).

Evidence-Based and Promising Programs for Sexual Violence Perpetration Prevention

The programs described in this section are strategies designed for specific populations at the individual and relationship levels of the socioecology. Pairing them with community and/or society-level interventions would result in the greatest impact.

In 2014, DeGue et al conducted a systematic review of primary prevention strategies for sexual violence perpetration. They specifically examined programs designed to reduce perpetration. The researchers noted that the greatest hindrance to understanding what works in prevention is a lack of rigorous research design and comprehensive evaluation needed to deem efforts "evidenced-based," and that this problem was due largely to limited research dollars allocated to studying sexual violence.

After reviewing 140 programs, DeGue et al (2014) identified two programs shown to be effective for preventing sexual violence perpetration: *Safe Dates* (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=141), a middle-school-based curriculum designed to prevent initiation of emotional, physical and sexual abuse in teen dating relationships; and the school-wide component of *Shifting Boundaries* (https://www.crimesolutions.gov/ProgramDetails.aspx?ID=226), which involves revising school rules regarding dating violence and sexual harassment, temporary school-based restraining orders, posters to increase awareness and reporting, and student 'hot spot' maps of unsafe school areas to determine the placement of faculty or school security for greater surveillance.

The researchers also identified two other programs considered promising: *Coaching Boys Into Men* (http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/), a program that utilizes athletic coaches to model respect and promote healthy relationships among student athletes; and *Bringing in the Bystander* (http://cola.unh.edu/prevention-innovations/bringing-bystander%C2%AE), a training

program for college students designed to build skills for confronting rape myths and sexist language and safely intervening in potentially violent situations.

> " *Why is it important for your buddies not to commit sexual violence? It is because it is a weakness. So [prevention programming] needs to focus on the why. If he's good with communicating [positively and respectfully] with women he's going to be a lot more successful. He's gonna be in a lot less trouble. He's gonna know to handle situations more confidently.* "
> -Focus Group Participant

In addition, nine principles of effective prevention programs (i.e., curricula) have been identified (Nation et al., 2003): **comprehensive, appropriately timed, varied teaching methods, sufficient dosage, administered by well-trained staff, provided opportunities for positive relationships, socio-culturally relevant, theory-driven, and included outcome evaluation**. DeGue et al (2014) noted that, with the exception of outcome evaluation, the programs they identified as being effective adhered to all nine principles.

SOCIETAL FACTORS THAT CONTRIBUTE TO SEXUAL ASSAULT: SOCIAL DETERMINANTS OF HEALTH

Figure 1. Centers for Disease Control and Prevention, Healthy People 2020.

Social determinants of health include societal factors related to our communities, systems, and environments and policies that contribute to health. Social determinants are often seen as "upstream" or underlying factors. An estimated 70% of individual health is a result of social and economic factors (40%), the physical environment (10%) and access to care and treatment (20%; University of Wisconsin Population Health Institute County Health Rankings Model, 2010 – www.countyhealthrankings.org/our-approach). Poverty, lower levels of education, and reduced access to care are familiar social determinants that affect many health problems.

Estimates of the contributions of social, economic, and environmental factors and access to care have not been made specifically for sexual violence, but there is evidence that these determinants play a strong role. Poverty increases the risk of both non-partner sexual violence (Krug et al., 2002) and intimate partner violence (Jewkes, 2002). Poverty may make it more difficult to avoid unsafe environments and increase stress in the home. It may also make leaving a home in which sexual violence is occurring more difficult. According to the U.S.

Census Bureau (2014), 20.4% of New Mexicans were living below the poverty level in 2009-2013. For African Americans and Native Americans, the percentage was 26.4% and 34.1% respectively (2014).

Access to care and treatment is critical to comprehensive prevention, including prevention of the physical and mental health consequences of sexual violence. In 2013, 16% of all New Mexicans had no health insurance and 22% of women aged 19 to 64 had no health insurance (Henry J. Kaiser Family Foundation, n.d.). The majority of the counties in New Mexico are also considered medically underserved and health profession shortage areas (U.S. Department of Health and Human Services, 2014).

Additional social determinants that play a role in sexual violence include social norms around gender roles, gender inequality, and gender expression; high levels of violence in general in a community; unsafe public places; and a lack of community or criminal sanctions against sexual violence (Bott, 2010). Gender norms that reinforce unequal roles between men and women, discourage gender expression outside of traditional male and female roles, and emphasize aggression as masculine and submission as feminine contribute to sexual violence (Bott, 2010). Male-bonding activities and the idea of "proving" masculinity contribute to the problem of sexual violence, and social norms can prevent witnesses of these activities from intervening when sexual violence occurs.

Social norms are reinforced when communities and societies fail to take action against sexual violence. Norms of secrecy and privacy regarding what happens within a family contribute to spousal sexual assault, child abuse, and intergenerational sexual assault (Davis et al., 2006). Community responses that involve denial, disbelief, and victim-blaming not only cause harm to the survivors but also perpetuate a permissive environment that allows future perpetration. These societal norms may be reflected in many of our systems, including law enforcement, criminal justice, education, public policy, religion, and the media.

The complex issue of sexual violence cannot be addressed without attention to the social determinants of health. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the physical, economic, and social environments that permit sexual violence to occur will we be able to substantially reduce sexual violence.

SEXUAL VIOLENCE IN NEW MEXICO IN 2013

Data Sources

Data on sexual violence in New Mexico is available from the New Mexico Interpersonal Violence Data Central Repository, which began capturing statewide sexual assault data in 2001. The data are from three main sources (law enforcement, courts, and service providers made up of rape crisis centers, SANE units and community mental health center therapists) and reflect information captured by those agencies and organizations. Reports analyzing these data are published annually and include data from the first, and only, statewide violence victimization survey conducted in New Mexico to date (Caponera, 2014). The Survey of Violence Victimization in New Mexico (SVV) surveyed a random sample of 4,000 adults, 2,000 men and 2,000 women, in 2005-2006. The SVV provides the best available estimates of the incidence and prevalence of rape and attempted rape in New Mexico, as these crimes frequently go unreported to law enforcement and survivors may wait years to seek treatment or may never seek treatment. SVV data revealed that 1 in 4 adult women and 1 in 20 adult men had survived rape or attempted rape in their lifetimes (Caponera, 2007). The SVV survey has not been repeated to date.

Overview

Law enforcement reported 4,058 sex crimes in 2013, with rape accounting for 1,445 of them. If the rates of both reported and unreported rape (6 per 1,000) are considered, a better estimate for New Mexico in 2013 would be 6,366.

Sexual Assault Offenders

According to data reported to New Mexico service providers regarding offenders:
- 98% were male
- 80% were adults (over 18 years old)
- 82% were of the same race/ethnicity as their victims
- In 89% of the cases, the offender was known to the victim
- In 32% of the cases, the offender was a family member

Sexual Assault Survivors

According to data reported to New Mexico service providers regarding survivors:
- 91% were female
- 53% were under 18 at the time of their most recent sexual assault
- 37% had a disability at the time of the assault; of those, 71% were mentally or emotionally disabled
- Twice as many survivors who used alcohol or drugs were victimized by a stranger compared with survivors who did not use alcohol or drugs

I think [sexual violence] prevents people from achieving what they can achieve throughout their lifetime . . . . In New Mexico . . . I think it's preventing us as a whole from being our best and achieving prosperity.

-Focus Group Participant

Sexual Assault Reporting

- According to the SVV, only 17% of sexual assaults in New Mexico are reported to law enforcement
- Only one-third of sex crimes that come to the attention of service providers are reported to law enforcement
- According to the SVV, females report their assault to law enforcement 3 times as often as do males

Arrests and Dispositions

- In 12% of rape cases, there was a suspect arrest
- 44% of sexual assault cases in statewide district courts were dismissed

Details regarding specific populations in New Mexico at higher risk of sexual violence victimization are in the Priority Populations section of this report. *Sex Crimes in New Mexico XII* contains additional data and analysis (Caponera, 2014).

Data Gaps

Although national data on sexual violence are collected through a variety of mechanisms (e.g., Uniform Crime Reports, National Intimate Partner and Sexual Violence Survey (NISVS), National Crime Victimization Survey), they all have limitations. For example, the Uniform Crime Report captures only forcible rape reported to law enforcement. Other types of sexual assault and those not reported to law enforcement are missed. The NISVS captures a much broader range of information and provides some state estimates, although it does not report these according to demographic characteristics. Further, the NISVS does not capture data from individuals living in residential facilities (e.g., older adults, persons with disabilities, incarcerated persons) or those without a telephone. Many of these populations are considered at higher risk for sexual assault. The most recent state data available from NISVS are from 2010.

In order to better understand and prevent sexual violence in New Mexico, regular surveillance, augmented by specific research, is needed. Regular surveillance through violence victimization surveys and climate surveys will provide more accurate estimates of victimization, perpetration, populations at increased risk, and changes in social and cultural norms around gender roles, gender identity, and privacy/secrecy. Surveillance is necessary for better prevention program planning and evaluation and analysis of trends to effectively inform programming. Surveillance should therefore be conducted on an annual or bi-annual basis. Surveillance data does have limitations. Augmenting it with special research studies would increase understanding of sexual violence in priority populations that may result from regular survey methods (e.g., incarcerated people, Native Americans, homeless, immigrants). It would also permit the testing of population level (e.g., marketing campaigns, policies), universal (e.g., healthy relationships) and priority population (e.g., children, persons with disabilities) interventions.

The collection and analysis of accurate and timely surveillance and research data is critical to moving the field of sexual violence prevention forward nationally and in New Mexico. There are currently limited sources of available data, especially population-based and among priority populations, for the state. Closing these data gaps should be a priority in moving toward a New Mexico that is sexual violence free.

PRIORITY POPULATIONS

Several populations have been identified as being at higher risk of victimization in New Mexico. These include African Americans; students on campuses; children; people living with disabilities; immigrants and refugees; people who identify as lesbian, gay, bisexual, transgender, or questioning/queer; Native Americans; older adults, people living in rural communities, and women. The disproportionate risks observed in these populations and the considerations needed when conducting prevention efforts with these communities are described in this section.

Prevention efforts with priority populations will be most successful when individuals that are representative of priority populations are involved in planning efforts and program implementation. They have the greatest understanding of the strengths, barriers, perceptions and culture of the priority population of which they are members. Enlisting members of priority populations to lead prevention efforts is consistent with principles of community empowerment. These principles suggest that problems and potential solutions are best defined by the "community" (priority population), and that people who feel they have influence over developing solutions to problems affecting their community are more invested in creating change and are disposed to prioritizing the rights, interests and well-being of their community (Clinical and Translational Science Awards Consortium, 2011).

PERSONS IN CORRECTIONAL FACILITIES

While the *New Mexico – Sexual Violence Free* strategic plan does not include persons in correctional facilities as a priority population, work in this group is under way, as required by the Prison Rape Elimination Act (PREA). PREA provides a critical framework for addressing sexual violence in correctional facilities. It includes mandatory standards to ensure that incarcerated survivors receive services and that correctional facilities implement practices to prevent sexual assault.

Correctional facilities include jails, prisons, juvenile facilities, military and Indian Country facilities, and Immigration and Customs Enforcement facilities. Individuals housed in these facilities are at risk of sexual assault by guards and other inmates. Data on sexual assault in these facilities are limited. The Bureau of Justice Statistics estimates the sexual violence victimization rate among state prison populations to be between 4% and 10%. Approximately half of the cases involve other inmates and half involved staff. A 2012 survey indicated that about 9.5% of adjudicated youth in juvenile facilities reported experiencing sexual violence perpetrated by another youth or facility staff (Beck et al., 2013). Although data on the prevalence of sexual victimizations in New Mexico prisons are lacking, applying the 4% to 10% range from the Bureau of Justice Statistics to the current NM Department of Corrections population of 7,174 inmates suggests that between 287 and 717 of state prison inmates have experienced or will experience some form of sexual violence while incarcerated. No data on rates of victimization in NM county and juvenile facilities are available.

NMCSAP is working with the 11 sexual assault service providers (SASPs) in New Mexico, as well as with the New Mexico Department of Corrections (NM DOC) and other organizations, such as Just Detention International (JDI), to assist with implementing PREA and developing services for incarcerated survivors. Currently, the level of implementation varies widely among correctional facilities. Some facilities have developed services in collaboration with local SASPs and SANE programs; others are in the early stages of implementation. Key actions taken in the statewide PREA implementation effort include on-going information sharing and technical assistance between NMCSAP and SASPs on delivering services to incarcerated survivors; NMCSAP's development and adoption of PREA service core standards for SASPs; NMCSAP's drafting of a statewide memorandum of understanding between NM DOC and SASPs for provision of PREA services; NMCSAP's securing Violence Against Women Act funds to offer a 2-day training on PREA implementation for victim service agencies and NM DOC staff in fiscal year 2016; NMCSAP's on-going collaboration with JDI to bring more resources to New Mexico; and, on-going meetings between NMCSAP, SASPs, and NM DOC staff to build collaboration.

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG PRIORITY POPULATIONS

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG AFRICAN AMERICANS

African Americans comprise 2.5% of New Mexico's population (U.S. Census Bureau, 2014) and are disproportionately at risk for experiencing sexual violence (Caponera, 2014). Sexual violence of African Americans has occurred in a unique historical context and was deeply engrained in the institution of slavery (Sommerville, 2004). In the 1800s, rape laws were race-specific: whereas an African American man could be put to death for raping a white woman, there were no legal sanctions for white men raping African American women (Sommerville, 2004). These policies and practices were fueled by and contributed to a belief that African American women were hypersexual and invited sexual assault (West & Johnson, 2013).

- According to the National Violence Against Women survey, 18.8% of African American women reported being raped sometime in their lifetime (Tjaden & Thoennes, 2006).
- The elevated risk of African Americans for sexual assault must also be understood in reference to current day contexts that put marginalized people at greater risk. There is great diversity within the African American community, and certain groups are more vulnerable: those who are poor, living with HIV, who identify or express themselves as bisexual, lesbian, transgender or queer, or who are incarcerated.
- According to a report from the National Sexual Violence Resource Center, "Incarcerated at between 2 and 3 time the rate of White women, Black women are overrepresented in the criminal legal system. Depending on the study, more than half of incarcerated women were raped or experienced criminal sexual penetration before coming to prison" (West & Johnson, 2013).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, they also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

4% of survivors reporting to service providers were African American although African Americans only comprise **2.5%** of the population in NM.

(Caponera, 2014)

The lifetime incidence of rape among African American youth in NM is **1.7** times higher than among non-African American youth.

(Green et al., 2015)

6% of victims and **9%** of offenders in assaults reported to law enforcement in Bernalillo County were African American.

(Caponera, 2014)

Evidenced-Based and Promising Practices:
So far no sexual violence prevention curricula for African Americans have been shown to be effective in preventing sexual violence victimization or perpetration. Research shows that the best way to stop sexual violence is through primary prevention strategies. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003). Cultural sensitivity includes trauma informed prevention specialists and providers who are educated about African American history, are ethnically diverse and from African American communities. Prevention should take a strengths-based approach.

The following programs may be effective with African American populations, although culturally specific programming should be developed and evaluated specifically with African Americans:

- **Safe Dates**:
  http://www.hazelden.org/web/go/safedates
- **Men Can Stop Rape**:
  http://www.mencanstoprape.org/
- **Coaching Boys Into Men**:
  http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Sexual assaults are vastly underreported. Reasons for underreporting include concerns about system response, concerns about confidentiality in small communities, a long history of law enforcement abuse of authority and disproportionate sentencing based on race, and historical trauma.
- There is a clear need for more research and better data regarding African American populations.
- There is a need for culturally specific, evidence-based sexual violence prevention strategies and program evaluation developed by or in collaboration with African American communities.

Community Resources:
New Mexico Rape Crisis Centers: Located in Albuquerque, Farmington, Las Cruces, Portales, Santa Fe, Silver City and Taos. Rape crisis centers provide crisis intervention, sexual assault exams, counseling, advocacy, outreach and prevention services. Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

Mental Health Center Sexual Abuse Program Coordinators: Located in each NM Behavioral Health Service Division-funded mental health center in the state. Contact information for each location can be found on the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"Because really those things [sexual violence and racism] don't operate in isolation of each other. Those are all interconnected forms of violence and you can't call yourselves doing anti-sexual violence work without also doing anti-oppression work . . . I think homelessness is a form of violence, I think that women and children living on the streets is a form of violence, I think that the vulnerability for women in that situation is a form of violence, I think racism is a form of violence. I think the disproportionate number of people of color that are in our prison and jail system is a horrendous form of violence."
- Focus Group Participant

PRIMARY PREVENTION OF CAMPUS SEXUAL VIOLENCE

New Mexico has seven post-secondary colleges and universities, with a total student enrollment of over 60,000 students, as well as branch campuses, community colleges, and tribal colleges. National attention to sexual assault on campus has resulted in legislation to address this issue. In 2013, President Obama signed into law legislation that strengthened and reauthorized the Violence Against Women Act and amendments to the Clery Act. The new regulations will afford more rights to survivors of sexual assault, dating violence and stalking. Programs must be implemented for staff and students, and prevention programming and procedures must be in place for when incidents occur (Clery Center For Security On Campus, n.d.).

- According to the Campus Sexual Assault (CSA) study conducted in 2007 (Krebs, et al., 2007), 1 out of 16 men will experience an attempted or completed sexual assault after entering college.
- Half of all student victims do not label their sexual assault incident as "rape" (Fisher, et al., 2003). This is particularly true when no weapon was used, no sign of physical injury is evident, and alcohol was involved—factors commonly associated with campus non-stranger rape (Bondurant, 2001).
- A National Institute of Justice Report found that 84% of colleges and universities offer confidential reporting, but only 46% offer anonymous reporting (Gonzales, et al., 2005).
- Less than 5% of completed and attempted rapes of college students are brought to the attention of campus authorities and/or law enforcement (Fisher et al., 2003).
- A 2006 campus survey found that 24% of bisexual women and 18% of lesbians were sexually assaulted while at university compared to 13% of heterosexual women (Martin, et al., 2011).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and, norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

From 1997 to 2013, females 18 to 24 years old consistently experienced **higher rates of rape and sexual assault** than females in other age groups.

(USDOJ, 2015)

1 in 5 women will experience rape over the course of a 5-year college career.

(Gonzales et al., 2005)

More than **3 in 4** student victims of rape and sexual assault knew the offender.

(USDOJ, 2015)

Evidenced-Based and Promising Practices:
According to the Centers for Disease Control and Prevention (DeGue et al., 2014), prevention strategies for campus populations must be comprehensive, addressing multiple levels of the socioecology. They should also be theory-based, based on the best available evidence, provide opportunities for skill-building and be evaluated for effectiveness in changing behaviors related to sexual violence perpetration and victimization. Only two primary prevention strategies have been shown to be effective for sexual violence prevention:

- **Safe Dates**: http://www.hazelden.org/web/go/safedates
- **Shifting Boundaries**: http://www.nij.gov/topics/crime/intimate-partner-violence/teen-dating-violence/documents/shifting-boundaries-all-schools.pdf

Both of these programs were developed for middle/high school students but may be effective models if adapted for college-age students. Other strategies that are promising include:
- **Bystander intervention programs**, such as *Mentors in Violence Prevention* (http://www.mvpnational.org/) and *Bringing in the Bystander* (http://cola.unh.edu/prevention-innovations/bringing-bystander%C2%AE)
- **Strategies to engage men**, such as *Coaching Boys Into Men* (http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/)
- Initiatives focused on **developing healthy sexuality and relationship skills**
- **Comprehensive public awareness campaigns**, e.g., integrating Take Back the Night rallies coupled with educational training for staff and sexual assault prevention education in freshman orientation sessions

Policy level strategies that may be promising for reducing campus sexual violence (Tharp et al., 2013) include increasing alcohol pricing, limiting alcohol outlet density and banning alcohol on campuses and in college dorms. However, it should also be noted that eliminating access to alcohol will not eliminate campus sexual violence (Lisak & Miller, 2002).

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Campus climate surveys should be conducted to provide baseline and ongoing data about campus sexual violence.
- Schools need clear definitions of sexual violence that include understanding of consent.
- Sexual assaults are vastly underreported. Reasons for underreporting include concerns about confidentiality versus anonymity.
- Policies should be clearly stated. More research should be done on the advisability of coordinated or separate procedures for reporting; investigating the report; informal administrative actions, such as issuing a no-contact order; formal adjudication on campus; and criminal prosecution (Gonzales, et al., 2005).
- Research that examines changes in violent behavior rather than only attitudes towards sexual violence is crucial.

Community Resources:
New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

Other resources for campus-based sexual violence prevention may include organizations such as women's resource centers, LGBTQ resource centers, Title IX coordinators and student counseling services.

"Young women [are] really just expecting to be raped as part of their college experience. 'It's just gonna happen, and when it does I'm not gonna call it that.' And so the individual effects ripple, right? You have individuals who are so traumatized that they lose their GPA, their grades start slipping, they might lose their scholarships, they might elect to leave college completely." - Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG CHILDREN

Children (those under the age of 18) are an especially vulnerable population when it comes to sexual violence. In a nationally representative sample, the prevalence of child sexual abuse was 10.1%; approximately three-quarters of the abused children were girls and one-quarter were boys (Pérez-Fuentes et al., 2013). Among female rape survivors, an estimated 40.4% were first raped before they were 18 and 12.1% before they were 11 (Breiding et al., 2014). Children are especially likely to be victimized by a family member or non-stranger, which increases the likelihood of another assault. About 35% of women who were raped as minors were also raped as adults compared with 14% of women without an early rape history (Black et al., 2011). In addition, adverse childhood experiences, including child sexual abuse and sexual violence, have been associated with a variety of health risk behaviors and outcomes in adulthood, including alcoholism, depression, smoking, suicide attempts, and heart disease (Basile & Smith, 2011; Felitti et al., 1998).

- Up to 48% of adolescent girls and up to 32% of adolescent boys have reported that their first sexual intercourse experience was forced (Harvey et al., 2007).
- It is extremely difficult for children to enforce boundaries when the person violating them is someone they likely know, love and trust, or is a respected person of authority (Caponera, 2014).
- Nearly one-third of sexual assault victims assisted by service providers in 2013 were under the age of 13 (Caponera, 2014).
- Researchers estimate that between 60% and 80% of victims of child sexual abuse do not disclose their abuse until adulthood, indicating that many may experience prolonged victimization or never receive treatment or services (Alaggia, 2010; Hébert, et al., 2009; Paine & Hansen, 2002).

Social Determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows for future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

More than half **(53%)** of sexual assault survivors seeking services in New Mexico were under 18 years of age at the time of the assault.

(Caponera, 2014)

Based on data collected by service providers in 2013, **94%** of the time, the perpetrator in victimizations of children (< 18 years) was known to the child.

(Caponera, personal communication, 2015)

Among perpetrators known to child survivors, **54%** of the time the known perpetrator was a family member.

(Caponera, personal communication, 2015)

Evidence-Based and Promising Practices:
Research on prevention of sexual violence affecting children has provided some recommendations. We know that programs that focus on victims protecting themselves don't work (Finkelhor, 2009) and that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

- **Coaching Boys Into Men**: provides high school athletic coaches with training and resources to promote respectful behavior among their players and help prevent relationship abuse, harassment, and sexual assault. http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/
- **Essentials for Childhood Framework**: evidence-based strategies to promote relationships and environments that help children grow up to be healthy and productive citizens. http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html
- **Safe Church**: gives churches the tools to equip and inspire individuals within the congregational culture to be proactive in preventing child sexual abuse in the church and community. https://www.safechurch.com/ChildrenYouth/Pages/default.aspx?cat=Children+%26amp%3b+Youth+Safety

- **Safe Dates**: prevents dating abuse by educating teens about the difference between caring, supportive relationships and controlling, manipulative, or abusive dating relationships. http://www.hazelden.org/web/public/safedates.page
- **Shifting Boundaries**: addresses sexual harassment and dating violence in middle schools through environmental strategies. http://www.nij.gov/topics/crime/intimate-partner-violence/teen-dating-violence/documents/shifting-boundaries-all-schools.pdf
- **Start Strong**: promotes healthy relationships among 11- to 14-year-olds and identifies promising ways to prevent teen dating violence. http://startstrong.futureswithoutviolence.org/about/

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- More rigorous studies on long-term outcomes associated with prevention programs
- More studies on effects of prevention programs on perpetration rates
- More studies on child sexual violence prevention in under-resourced communities (e.g. poor, rural, Native American, immigrants and refugees, LGBTQ people)
- More research on intergenerational child sexual violence prevention
- More data collection on child sexual abuse in foster and other out-of-home placements and research on effective prevention strategies within these settings

Community Resources:
New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers and for prevention efforts around the state can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"You can't make children responsible for preventing sexual violence, you can't make victims responsible for their assault."
- Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG PEOPLE LIVING WITH DISABILITIES

People living with disabilities (i.e., physical or mental impairments that substantially limit one or more major life activities) are at a much higher risk for sexual victimization than the general population (Casteel, et al., 2008; Martin et al., 2006; Rand & Harrell, 2009). The high rates of victimization may have several causes: perpetrators may feel that those they are victimizing are powerless to resist because of the severity and circumstances of their disabilities; survivors may be easier to manipulate because of cognitive disabilities; and communication difficulties may make it more challenging to disclose perpetration. In addition, because perpetrators are often family members or caregivers, those living with disabilities may fear having no one to take care of them if they disclose an assault or of being forced to move from their own home (Balderian, 1991).

According to the NM Youth Risk and Resiliency Survey (Green et al., 2015), 21.4% of high school students in New Mexico had either a long-term physical disability or a long-term emotional problem. Of the school-aged children living with a disability in New Mexico, 41.1% live below the poverty level (U.S. Census Bureau, 2014).

In 2013, over one-third (37%) of sexual assaults reported to law enforcement in New Mexico were committed against people with some type of disability. Most of these victims (71%) were mentally or emotionally disabled. Almost half the survivors (46%) were 18 years of age or older; the others (52%) were children or adolescents (Caponera, 2014).

- Children with disabilities are especially vulnerable because of their extreme dependence on their caregivers. Also, isolation due to their impairments can result in a lack of knowledge about sex or an unawareness that they are being sexually abused (Hershkowitz, Lamb, & Horowitz, 2007).
- Because people with disabilities are often trained by caregiver to be compliant, they are uniquely vulnerable to sexual abuse. The power and control dynamics of institutionalization are almost identical to those that foster sexual abuse (Crossmaker, 1991).
- Women with some type of disability are more than four times as likely to be sexually assaulted as women without a disability (Martin et al., 2006).
- Men with some type of disability are more than four times as likely to have experienced lifetime and past-year sexual violence victimization as men without disabilities, and past-year rates of victimization exceed those for women without disabilities (Mitra et al., 2011).

Research has shown that survivors with disabilities know their perpetrators **92%** of the time, and they are most often family members, caregivers or others with disabilities.
(Balderian, 1991)

Lifetime incidence of rape among physically disabled youth is **2.2** times higher than among their non-disabled counterparts in New Mexico.
(Green et al., 2015)

Lifetime incidence of rape among mentally or emotionally disabled youth is **3 times higher** than among their non-disabled counterparts in New Mexico.
(Green et al., 2015)

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

Evidenced-Based and Promising Practices: Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

So far, no specific sexual violence prevention curriculum for people living with disabilities has been shown to be effective in preventing sexual violence victimization or perpetration. Prevention program planning, development and implementation for those living with disabilities is often heterosexist. Barger, et al. (2009) recommend addressing this bias in prevention programming developed for this population. Policy recommendations include mandating criminal background checks for caregivers and decreasing opportunities for isolating clients in care facilities (Higgins, 2010). Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Sexual assaults within the disability community are under-reported for many reasons, including communication issues, fear of reprisal, and concern over loss of the living situation and access to caregivers and family members.
- There is a need for improved surveillance related to sexual violence within the disability community.
- There is a need for more research developed in collaboration with members of the disability community that is aimed to reduce both victimization and perpetration of sexual violence, including evaluation of existing programming.

Community Resources:
NM Aging & Long-Term Services Department, Adult Protective Services Division: Contact: 866-654-3219 or 505-476-4912, http://www.nmaging.state.nm.us/Adult_ProtectiveServices.aspx

Disability Rights New Mexico: Contact: 1-800-432-4682, http://www.drnm.org/index.php

NM Children, Youth and Families Department: Contact: 1-855-333-7233, http://cyfd.org/child-abuse-neglect

New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"[People with disabilities] are isolated and marginalized within our own deeply marginalized community, [which is] also layered by multiple identities because we too are trans, we too are of color, and we too are immigrants….When we think about violence and queerness and disability, it's impossible not to recognize the profound isolation we face and the complete lack of credibility we have."
- Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG IMMIGRANTS & REFUGEES

Approximately 9.8% of New Mexico's population are immigrants (U.S. Census Bureau, 2014.). People make the decision to immigrate to the United States for multiple reasons, but they often do so because they feel they are unable to care for their families or themselves. People may migrate because of poverty, human rights abuses, and violence. The transition from one country and culture to another can have an enormous impact on family security and structure, leaving immigrants, particularly women and children, vulnerable to violence, including sexual abuse (Easter & Refki, 2004).

New Mexico is home to immigrants and refugees from across the globe, but the highest proportion of immigrants are from Spanish-speaking countries, especially Mexico. New Mexico also resettles between 200 and 300 refugees each year. Refugees are those who have a well-founded fear of persecution and are therefore unable to return to their country of origin. Many have experienced sexual and other forms of violence prior to their arrival in the United States, particularly those who have experienced war, civil conflict, and life in refugee camps. Once in the United States, immigrants and refugees are often confused about or are not familiar with the U.S. legal system or their legal rights.

- During the migration journey, women and girls especially fear the possibility of being raped (Watson, 2006).
- State and federal policies pertaining to deportation of undocumented immigrants creates a climate in which abusers can use threats of deportation to keep victims silent about abuse (Runner et al., 2009).
- Immigrant domestic workers are especially vulnerable to sexual exploitation because they depend on their employers for their livelihood, live in constant fear of being deported, suffer social isolation, and are vulnerable to their employer's demands (Vellos, 1997).
- Female farmworkers are 10 times more vulnerable than other women to sexual assault and ha¬rassment at work (Lopez-Treviño, 1995).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010) and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization

Lifetime incidence of rape among immigrant youth is **1.4 times higher** than among their non-immigrant counterparts in New Mexico.

(Green et al., 2015)

Married Latinas were less likely to immediately define experiences of **forced sex by their spouses** as "rape" and terminate their relationships; some viewed sex as a marital obligation.

(Bergen, 1996)

Immigrants, both documented and undocumented, may **fear reporting sexual violence to authorities** which contributes to under reporting.

(U.S. Department of State, 2007)

(Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

Evidenced-Based and Promising Practices:
So far, no sexual violence prevention curriculum that addresses the unique needs of immigrants and refugees has been shown to be effective in preventing sexual violence victimization. Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

Although these programs were not developed for immigrant populations, the following programs may be effective with immigrants, although culturally specific programming should be evaluated for its effectiveness:
- **Safe Dates:**
  http://www.hazelden.org/web/go/safedates
- **Men Can Stop Rape:**
  http://www.mencanstoprape.org/
- **Coaching Boys Into Men:**
  http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/

Cultural sensitivity depends on trauma-informed prevention specialists and providers who are educated about the history of immigration in the United States, immigrant and refugee policy, and laws applicable to immigrants with different civil statuses (Cuevas & Sabina, 2010). Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Sexual violence of immigrants is under-reported. Reasons for under-reporting include fear that one's civil status or that of family members may be reported to authorities.
- Sexual violence occurs in many different contexts (during the migration journey, in employment, and in families) that prevention programming must take into account.
- Lack of language-specific and culturally competent services for immigrant and refugee populations.
- Lack of accurate data regarding sexual assault in immigrant detention centers.

Community Resources:
New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

Catholic Charities, Center for Immigration and Citizenship Legal Assistance (CICLA): Provides low-cost immigration legal assistance to immigrants, U.S. citizens, and U.S. legal permanent residents, including victims of sexual assault. Contact: (505) 724-4662, http://www.ccasfnm.org/immigration-legal-services.html

NM Immigrant Law Center: Provides legal assistance to low-income immigrant families facing separation due to deportation, asylum seekers, and unaccompanied minors. Contact: (505) 247-1023, http://nmilc.org/

New Mexico Asian Family Center: Free domestic and sexual violence outreach, advocacy, counseling and legal services for Asian with Limited English Proficiency (LEP) living in NM. Contact: 505-717-2877, http://nmafc.org/

"The majority of us are immigrants and a lot of times our immigration status is illegal. Sometimes we do know that [forced sex within marriage] is wrong, sometimes we know that it is unacceptable, but I'm scared to talk because of that. If I report it and they take him to jail, who is going to support me if I don't have documents and I have children?"
- Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG LGBTQ POPULATIONS

People who identify as lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ) experience high levels of discrimination based on gender identity, gender expression and sexual orientation. Sexual assault in this population is often ignored or dismissed, even though rates of LGBTQ sexual assault are comparable or higher than those in the heterosexual population (Paulk, 2014). Institutional bias, along with the predominance of homophobia, biphobia, transphobia and intolerance, sustain a climate in which it is difficult for LGBTQ people to report sexual violence or receive culturally competent services related to sexual assault (Ciarlante & Fountain, 2010).

- 46% of bisexual women and 50% of transgender women have been raped in their lifetime. These assaults often begin when the victim is as young as 11 or 12 (Durso & Gates, 2012; Walters, et al., 2013).
- It has been estimated that in some U.S. cities, up to 40% of homeless youth are LGBT (Durso & Gates, 2012). Homelessness dramatically increases the risk of being sexually assaulted (Goodman, et al., 2006).
- In 2013, 72% of anti-LGBTQ-motivated homicides were of transgender women, and 67% were of transgender women of color (Ahmed & Jindasurat, 2014).
- Law enforcement in the United States has a long history of both criminalizing and failing to protect LGBTQ people. Many use their positions of power and privilege to coerce LGBTQ individuals into having sex and to avoid prosecution for physically and sexually abusive behavior and blatant discrimination toward members of this community (Amnesty International, 2006).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

Evidenced-Based and Promising Practices: Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies

Lesbian, gay and bisexual (LGB) youth report being raped at rates that are **3.3 times higher** than their non-LGB counterparts in New Mexico.

(Green et al., 2015)

44% of lesbian women and **61%** of bisexual women have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

(Walters et al., 2013)

47% of bisexual men and **40%** of gay men experience sexual coercion, unwanted sexual contact and other types of non-rape sexual violence.

(Walters et al., 2013)

aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003). Other general prevention strategies when working with LGBTQ communities include the following:

- Implementation of school-based measures that work in tandem to promote a positive environment for LGBTQ youth, including: development of supportive student clubs such as Gay-Straight Alliances (GSAs); training staff and faculty to be supportive of LGBTQ students; providing curricula inclusive of LGBTQ people and experiences; and implementing non-discriminatory school policies (Kosciw, et al., 2014).
- Adaptation of:
  o Sexual violence prevention strategies or prevention strategies that address other public health issues, such as HIV-prevention or other types of violence
  o Universal prevention strategies such as Safe Dates, specifically for LGBTQ populations
- Implementation of:
  o Sexual violence prevention programs that include an LGBTQ-specific component (e.g., SAFE-T [Sexual Abuse Free Environment for Teens] or Fourth R)
  o Prevention programs that address heterosexism, homophobia, biphobia or transphobia (e.g., Welcoming Schools programs or Stand and Serve Clubs)
- Use of healthy LGBTQ relationship-focused curricula (e.g., LGBTQ Youth Partner Prevention Program or GroundSpark's Respect For All; NSVRC and PA Coalition Against Rape, 2012).

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Underreporting because of fear of being "outed," concerns about physical retaliation, the perceived humiliation of reporting an attack, and historical trauma perpetrated by those in power.
- Lack of cultural competence in outreach materials, organizational practices and providers for LGBTQ survivors of sexual and domestic violence.
- Need for more surveillance related to sexual violence within the LGBTQ community, including the ability to document gender identity on sexual assault surveys.
- Need for more research to better identify potential risk and protective factors for this population, especially in relation to victimization of adolescents, bisexual women, and transgender women.

Community Resources:
CasaQ: Homeless center for LGBTQ-identifying youth ages 14-17, located in Albuquerque, NM. Contact: 505-872-2099, http://www.casaq.org/

Transgender Resource Center of New Mexico: Contact: 505-200-9086, http://www.tgrcnm.org/

New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

Equality New Mexico: Contact: 505-224-2766, http://eqnm.org/

NM Gay Straight Alliance Network (GSAs): Contact: 505-983-6158, http://www.santafemc.org/programs/new-mexico-gay-straight-alliance-network

GLSEN (Gay, Lesbian & Straight Education Network): Contact: 212-727-0135, http://www.glsen.org/

"When you look at racism and transphobia and then just straight up misogyny, that's what's happening with transwomen of color. We're seeing all of those things come together in an explosive moment, often on the street. It just shines a light on everything that we're always talking about in terms of oppression." - Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG NATIVE AMERICANS

Native American women in the United States are 2.5 times more likely to be sexually assaulted than non-Native women (Perry, 2004), and 34.1% – or more than 1 in 3 – will be raped during their lifetime (Tjaden & Thoennes, 2000). The comparable figure for all U.S. women is less than 1 in 5 (Tjaden & Thoennes, 2000). The 2011 National Intimate Partner and Sexual Violence Survey (Breiding et al., 2014) found that approximately 55% of Native American women experienced sexual violence other than rape (made to penetrate, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experience) during their lifetime. An estimated 24.5% of Native men experienced sexual violence other than rape during their lifetime (Breiding et al., 2014).

- In 2013, Native Americans comprised 10.4% of New Mexico's population (U.S. Census Bureau,2014) and 13% of rape survivors (Caponera, 2014).
- Native American survivors of sexual abuse are often reluctant to report their experiences for a variety of reasons, including fear of violation of confidentiality, retaliation, and concern that reports will not be taken seriously and that perpetrators will not be held accountable (Amnesty International, 2007).
- Travel distance to services (Rural Assistance Center, 2015) and cultural competency of providers (Gebhardt & Woody, 2012) negatively impact help-seeking behaviors. Providers in New Mexico have reported these factors as barriers among Native American survivors in New Mexico.
- Native American survivors may also have an underlying lack of trust of the dominant system of care (e.g. law enforcement) based on historical trauma – a long history of oppression and colonization (Deer et al., 2008).
- A history of child physical and sexual violence during the boarding school era also contributes to the overall lack of trust for systems of care available to Native Americans (Deer et al., 2008).

Social Determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

As reported by service providers, **18%** of Native Americans in New Mexico experienced stranger-perpetrated rape compared to **11%** for White Non-Hispanic survivors
(Caponera, 2014)

The lifetime incidence of rape among Native American youth in NM is **1.3 times higher** than among non-Native American youth

(Green et al., 2015)

As reported by service providers, **88%** of Native American survivors of sexual assault reported that their offender was also Native American

(Caponera, 2014)

Evidenced-Based and Promising Practices:
Currently, there are no programs designed to prevent sexual violence specifically in Native American communities that have been rigorously evaluated. Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

Recommendations for prevention practices and promising strategies from prevention research developed with Native American communities include:
- Integrating culturally sensitive practices into prevention programming.
- Developing Tribal-specific, community-level interventions, (e.g., dialogue groups with Native American men regarding the potential role of oppression in community and interpersonal violence; the use of traditional healing to address historical trauma; and the development of mutual assistance circles among Native American women).

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Given the complex legal, criminal, and jurisdictional issues for prosecuting sexual assault in Tribal communities and on Native American lands, many Native American communities are still primarily focused on issues related to legal response and safety. Recommendations to address these gaps include the following:
  - o Extending safety and support for Native women beyond shelter options; providing long-term, affordable housing to create opportunities for women leaving abusive relationships to live in a community that extends safety, support, and a place to work toward reclaiming their connections with themselves and each other (Mending the Sacred Hoop, n.d.).
  - o Recognizing that domestic violence often occurs in combination with or leads to sexual assault; intervention in primary health care settings offers critical opportunities for early identification.
- Sexual assaults are vastly underreported. Reasons for underreporting may include jurisdictional and sovereignty issues (system response, authority to arrest/punish the perpetrator, and perpetrators who are non-Native), intergenerational trauma, and concerns about confidentiality in Tribal communities.
- There is a clear need for more research and better data among Native American communities.
- There is a need for culturally specific sexual violence prevention strategies and program evaluation developed by or in collaboration with Native American communities.

Community Resources:
Coalition to Stop Violence Against Native Women: Provides assistance and support to Native women who have been battered or sexually assaulted. Includes 15 domestic and/or sexual violence prevention and response organizations throughout the state whose contact information is available on the CSVANW website. Contact: (505) 243-9199, http://www.csvanw.org/index.htm

New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"It's just this cycle because there's a lot of shame around it. Communities are so small. People don't want their dirty laundry to be out there or for people to know that there's problems that exist within the relationship or within the family. So it kind of just continues to get swept under the rug." - Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG OLDER ADULTS

According to the U.S. Census Bureau, older adults (65 years old and older) comprise 13.7% of the U.S. population and 14.1% of New Mexico's population. Of the older adults in New Mexico, 41.1% are living with some type of disability and 11.8% are living in poverty (U.S. Census Bureau, 2013), both of which increase vulnerability to abusive situations.

Understanding the scope of sexual violence within the elderly population both nationally and in New Mexico is difficult because older survivors typically do not seek services for their assault and underreporting is common for a variety of reasons. These include fear of not being believed or shame associated with the assault; communication issues related to failing health, dementia, trauma or disability; lack of training among clinicians to suspect or recognize signs of abuse in the elderly population; and attributing physical or emotional manifestations of trauma to frailties and complications associated with aging (Burgess, 2006).

- There is a persistent ageist bias that the elderly are not sexual beings and are therefore at low risk for sexual assault, resulting in their being overlooked as potential victims and underserved by systems of care (Burgess & Clements, 2006).
- Most perpetrators of sexual violence against the elderly in household settings are spouses/partners, sons, or other relatives. Most perpetrators in care facilities are employees, followed by facility residents (Ramsey-Klawsnik, 2010-a).
- Risk factors for elder sexual abuse victimization include experiencing a prior traumatic event and low levels of social support (Acierno, et al., 2009).
- Risk factors for perpetrating elderly sexual abuse include high levels of unemployment, increased substance abuse, increased likelihood of mental health problems and social isolation (Acierno et al., 2009).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

> The majority of older victims of sexual violence are female, while perpetrators have ranged from juveniles to elders.
>
> (Ramsey-Klawsnik, 2010-b)

> A seminal study conducted in 1998 found for every **one** case of elder abuse, neglect, exploitation, or self-neglect reported, about **five** more go unreported.
>
> (National Center on Elder Abuse, 1998)

> The older a sexual abuse victim is, the less likely the offender will be convicted of the crime.
>
> (Perkins, 1997)

Evidence-based and Promising Practices:
Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes.

Although the Centers for Disease Control and Prevention acknowledges that more research is needed to understand how to prevent perpetration of sexual violence against the elderly, better coordination of services among agencies and organizations that serve the elderly and higher levels of community cohesiveness may act as protective factors (Centers for Disease Control and Prevention, 2014-b).

Policy recommendations for preventing sexual violence in nursing homes and other institutional settings include mandatory reporting policies; requiring workers to work in teams; and using volunteers to watch for signs of abuse (Payne, 2010). Other prevention measures include mandatory background checks and careful screening of caregivers; mandatory employee training that includes education on sexual abuse of the elderly; and disclosing previous abuse histories to care facilities to ensure they can adequately supervise elderly sex offenders referred for placement (Ramsey-Klawsnik, 2009).

Other prevention strategies are bystander training for elderly adults, caregivers, family members and community members; and improving norms around healthy relationships (Ramsey-Klawsnik, 2010-b).

Culturally competent services must consider generational issues related to attitudes and social climates from an age when sexual assault was not openly discussed, rape was almost exclusively considered the fault of the victim, and sexual assault services were largely nonexistent (Ramsey-Klawsnik, 2010-a).

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- No uniform reporting system for elder abuse in the United States
- Research on sexual abuse among older adults, including effects on victims, perpetrator behaviors, and the effectiveness of prevention policies and programs
- Need for improved surveillance related to sexual violence within the elderly population

Community Resources:
NM Aging & Long-Term Services Department, Adult Protective Services Division: investigates allegations of abuse, neglect or exploitation of adults over the age of 18. Contact: 866-654-3219 or 505-476-4912, http://www.nmaging.state.nm.us/Adult_ProtectiveServices.aspx

New Mexico Rape Crisis Centers: Located in Albuquerque, Farmington, Las Cruces, Portales, Santa Fe, Silver City and Taos. Rape crisis centers provide crisis intervention, sexual assault exams, counseling, advocacy, outreach and prevention services. Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

Mental Health Center Sexual Abuse Program Coordinators: Located in each NM Behavioral Health Service Division-funded mental health center in the state. Contact information for each location can be found on the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"[W]e're talking about violence, because the rates of sexual violence, maltreatment, exploitation . . . especially elders and particularly all of us who are [verbally challenged] are through the f***** roof."
- Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG RURAL POPULATIONS

New Mexico is the fifth largest state but is 36th with respect to population. It has been given frontier status based on its population density (17 persons per square mile versus 87.4 in the United States as a whole), and distance and travel time to get to service markets (National Center for Frontier Communities, n.d.).

Underreporting of sexual violence in rural areas is a significant problem, making it difficult to document the prevalence of sexual violence in rural communities. There are many reasons for this underreporting, including a lack of anonymity related to small population density and familiarity of community members with each other (Lewis, 2003). Survivors may not be comfortable reporting to police as law enforcement and assailants may be part of the same social network. Typically, services are not nearby and public transportation is lacking. Phone service may be limited or nonexistent. Rural localities also often have a culture of independence and self-reliance, with an underlying distrust of authority, persons perceived to be "outsiders" and government-supported systems of care. Loyalty to family is often part of the culture. There may also be practical considerations related to disclosing abuse, such as the victim being reliant on the abuser for food, housing, transportation or child care (Lewis, 2003).

- According to the Centers for Disease Control and Prevention, community and societal risk factors that have been associated with sexual violence perpetration include poverty, lack of employment opportunities, lack of institutional support from police and judicial systems, general tolerance of sexual violence within the community, weak community sanctions against sexual violence perpetrators, societal norms that support male superiority and sexual entitlement, and societal norms that maintain women's inferiority and sexual submissiveness (Centers for Disease Control and Prevention, n.d.-c). Research has shown these risk factors to be prevalent in many rural communities.
- In 2013, New Mexico was 49th in the nation with respect to poverty: 21.9% of the population was living in poverty compared with 15.8% in the United States as a whole (U.S. Census Bureau, 2014). In more than a third of New Mexico counties (12) in 2013, greater than 25% of the population lived in poverty (U.S. Department of Agriculture, 2013).
- Retention of qualified sexual assault service providers is difficult in rural settings, which may contribute to further marginalization of already underserved populations, such as people living with disabilities and LGBTQ people (Averill et al., 2007).

From 2005-10, females living in rural areas experienced sexual violence at a rate **36%** higher than females in urban areas.

(Planty et al., 2013)

46% of rural NM women in a study of domestic violence had also experienced sexual violence; **59%** had experienced sexual violence as a child.

(Krishnan, Hilbert, & McNeil, 2002)

In rural areas, the rate of sexual violence is **1.9 times** higher for female college-age nonstudents than students.

(Sinozich & Langton, 2014)

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors, but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

Evidenced-Based and Promising Practices: So far, no sexual violence prevention curriculum developed specifically for rural settings have been shown to be effective in preventing sexual violence victimization or perpetration. Research shows that the best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

In rural communities, practitioners need to engage both formal networks (e.g., rape crisis centers, law enforcement, medical providers) and informal networks (e.g., friends, family, churches) to address community violence (Averill et al., 2007; Bosch & Schumm, 2004).

Use of technology, such as Skype, to include geographically isolated partners in prevention planning may be a promising practice but necessitates funding to ensure that technology systems are adequate (Cook-Craig et al., 2010).

The following programs may be effective with rural youth, although culturally specific programming should be developed and evaluated specifically in rural communities:
- **Safe Dates:** http://www.hazelden.org/web/go/safedates
- **Men Can Stop Rape:** http://www.mencanstoprape.org/
- **Coaching Boys Into Men:** http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/
- **SafeChurch:** http://scclanc.org/clergy-congregation-care/safechurch/

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- Sexual assaults are vastly underreported in rural areas.
- There is a clear need for more research regarding sexual violence in rural communities.
- Rural communities often receive lower levels of funding because of population density and caseload levels. The funding is often inadequate to support the outreach efforts and relationship-building activities vital to development of prevention efforts and programming in rural communities (Lewis, 2003).

Community Resources:
New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers and prevention information can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"It is critical to get out to [the rural communities] because they're isolated and that just continues the secrecy and the abuse."
- Focus Group Participant

PRIMARY PREVENTION OF SEXUAL VIOLENCE AMONG WOMEN

One in four women in New Mexico experiences a completed or attempted rape during their lifetime (Caponera, 2014), compared with one in five women in the United States generally (Black et al., 2011). According to the 2005 Survey of Violence Victimization in NM, most survivors of rape (78%) are female whereas the majority of perpetrators (85%) are male (Caponera, 2014).

Violence affects women and girls globally, regardless of culture or class. Gender inequality and oppression are key to understanding the high rates of sexual violence against women and girls. The effects of sexual violence endure across the life course, and are associated with an increase in high risk behaviors including tobacco and alcohol use and an increased risk of depression, eating disorders, and suicidality (Basile & Smith, 2011). Chronic conditions such as obesity (Mason et al., 2013) and heart disease (Rich-Edwards et al., 2012) are also more likely to affect those who have a history of sexual violence.

Increasingly, researchers have called for prevention of sexual violence as the best way to address this global public health problem (Basile & Smith, 2011). Effective prevention efforts attempt to change norms around gender expression for both females and males, increase economic and educational opportunity for women, and enlist men in recognizing their ability to change sociocultural norms that contribute to the idea that sexual violence is normal and expected and to prevent sexual violence from occurring through bystander intervention (Ellsberg et al., 2014).

- Service provider data for 2013 show that more females (58%) than males (43%) sought therapeutic services in the year of their assault, 20% of the time, women who delay getting therapeutic services for a year will wait more than 20 years before seeking counseling (Caponera, 2014).
- Law enforcement data from 2013 indicate that 47% of reported rapes committed against females resulted in a suspect arrest (Caponera, 2014).
- In two-thirds (64%) of cases brought to the attention of service provider, survivors were victims of incest (Caponera, 2014).

Social determinants: Social determinants of health include societal factors that contribute to health. For example, poverty may make it more difficult to avoid unsafe environments; social norms around gender roles, inequality, and expression are directly related to sexual violence (Bott, 2010); and norms of secrecy and privacy contribute to spousal sexual assault and child abuse (Davis et al., 2006). Community responses of disbelief and victim-blaming not only cause harm to survivors,

NM Law enforcement reports (2013) that of all survivors where gender was reported, **84%** were female.

(Caponera, 2014)

Of those who sought sexual assault services in NM in 2013, for **90%** the abuser was known to the victim and **32%** were family members.

(Caponera, 2014)

Only **17%** of rapes in New Mexico were reported to police.

(Caponera, 2014)

but also perpetuate a permissive environment that allows future perpetration. Programs that focus on victims protecting themselves, especially child victims, do not reduce victimization (Finkelhor, 2009). Only by changing the societal factors that permit sexual violence will we be able to substantially reduce sexual violence.

Evidenced-Based and Promising Practices:

Research on prevention of sexual violence of women is in the evidence-building stage. Most interventions that have been rigorously evaluated target adolescents (e.g., Safe Dates; Casey, n.d.). The best way to stop sexual violence is through primary prevention strategies – preventing sexual violence before it occurs. Successful prevention efforts combine multiple strategies aimed at reducing risk factors for sexual violence perpetration and victimization related to cultural norms, beliefs and behaviors at the individual, relationship, community and society levels (Davis et al., 2006). Strategies may include programs, policies and environmental changes. Effective prevention programs are comprehensive; employ a variety of teaching methods; provide multiple sessions; are based in behavior-change theory; foster the development of positive relationships; are appropriately timed; and are developed in conjunction with the targeted community so practices are culturally and socially relevant (Nation et al., 2003).

- **Men as Partners (MAP):** This program specifically promotes gender equity as an important component of reproductive health through detailed experiential exercises for men or mixed groups exploring gender and power, healthy relationships, sexuality, violence, and fatherhood.
  http://www.engenderhealth.org/pubs/gender/index.php
- **Bystander Intervention:** Programs such as Step Up! Sexual Assault Bystander Intervention, Know Your Power, Green Dot Campaign, Mentors in Violence Prevention, and Red Flag Campaign teach bystanders ways to recognize potentially abusive or violent situations and safely intervene.

http://www.nsvrc.org/projects/150/bystander-intervention-resources
- **Coaching Boys Into Men**: This program utilizes the unique role coaches play in youth's life by providing high school athletic coaches with training and resources to promote respectful behavior among their players and help prevent relationship abuse, harassment, and sexual assault.
  http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/
- **Safe Date**s: This program prevents dating abuse by educating teens about the difference between caring, supportive relationships and controlling, manipulative, or abusive dating relationships.
  http://www.hazelden.org/web/public/safedates.page

Research continues on effective sexual violence prevention programming and policies. Go to http://www.cdc.gov/violenceprevention/sexualviolence/index.html for the most up-to-date information.

Gaps:
- More rigorous studies on long-term outcomes associated with prevention programs
- More studies on effects of prevention programs on perpetration rates
- More studies on sexual violence prevention among marginalized women (e.g., poor, rural, Native American, immigrant and refugees, LBTQ, incarcerated women, women subjected to sex trafficking)
- More prevention involving community-mobilizing strategies for prevention of sexual violence (Casey, n.d.)

Community Resources:
New Mexico Rape Crisis Centers and Mental Health Center Sexual Abuse Program Coordinators: Contact for individual centers can be found at the New Mexico Coalition of Sexual Assault Programs website: http://nmcsap.org/

"If we stay silent we are teaching our daughters to be silent."
- Focus Group Participant

THE SYSTEM FOR RESPONDING TO SEXUAL VIOLENCE IN NEW MEXICO

Prevention of sexual violence occurs at three levels. The first is primary prevention, which is designed to decrease its incidence: to stop the behavior from ever occurring. The second is secondary prevention, which is designed to decrease the prevalence of sexual violence in the population and reduce the likelihood of future violence. The third level is tertiary prevention, which is designed to mitigate the effects of sexual violence after it has occurred. Currently, most of the efforts in the sexual violence response system in New Mexico are focused on secondary and tertiary prevention.

The New Mexico Coalition of Sexual Assault Programs, Inc. (NMCSAP), with funding from the state and federal governments, leads the efforts to address sexual violence in New Mexico. The primary functions of NMCSAP are to provide training and technical assistance to sexual assault service providers, law enforcement, medical practitioners and mental health professionals. The New Mexico Department of Health (NMDOH) oversees a portion of federal and state funding designated for sexual violence prevention in the state. Most of the funding that NMDOH provides to NMCSAP is for tertiary prevention services, including reimbursement to medical centers and Sexual Assault Nurse Examiners (SANE) programs for medical expenses for physical examinations after sexual assaults. A portion of the money also supports operational costs of Rape Crisis Centers (RCCs) and SANE programs.

NMDOH also provides direct funding to some RCCs and community organizations for primary prevention services in New Mexico, most of which are school-based programs using sexual-violence prevention curricula. The state agencies and local providers also focus on efforts to broaden primary prevention beyond individual-level behavior change to multilevel strategies incorporating policy development, community collaborations, and media campaigns.

There are nine RCCs in New Mexico. Six of the centers—those in Taos, Santa Fe, Albuquerque, Farmington, Portales and Las Cruces—provide a full range of services, which include rape crisis services, therapy and advocacy. The other three—in Los Lunas, Raton/Clayton and Silver City—are in various stages of development regarding their services. Additionally, the New Mexico Asian Family Center and TEWA Women United provide some services and outreach specific to sexual violence. Every community mental health center in the state funded by the Human Services Department-Behavioral Health Services Division is required to have at least one therapist designated as the Sexual Assault Program Coordinator who provides crisis advocacy to recent victims of sexual assault in their communities. The NMCSAP's Coordinator for Sexual Assault Services assesses the resources and needs of individual RCCs and provides support and technical assistance to develop their services and potential.

SANE staff are medical examiners with advanced training in conducting acute medical/forensic examination of sexual assault survivors. There are currently nine communities with SANE programs. Several other communities are linked to an existing SANE program so that services are provided to victims in more isolated areas. Many communities are currently developing their own SANE programs. Each SANE program must be active in its area Multi-Disciplinary Team (MDT), which reviews local sexual violence crimes for the purpose of making systemic improvements to response, investigation and prosecution through increased coordination, provision of training and the development of protocols. The training of SANE providers and development of SANE programs are overseen by a statewide SANE Coordinator housed in the NMCSAP.

Another vital program in the sexual violence prevention system in New Mexico is the Para Los Niños Program at the University of New Mexico Hospital. Staffed by a multi-disciplinary team, Para Los Niños provides medical examinations of sexually abused and assaulted adolescents and children, crisis counseling, follow-up care for survivors, expert medical reviews of sexual abuse cases involving children or adolescents in other parts of the state, and training of social workers, law enforcement, district attorney's offices, and other professionals who require education about child sexual assault.

New Mexico also has eight Children's Advocacy Centers (CACs) throughout the state. Each CAC provides services designed to best serve the community in which it is located, but all provide forensic interviews of children who have witnessed violence or may have been subjected to abuse. All CACs also provide family advocacy services to the families of children involved, providing training in their respective school systems and communities on mandatory reporting. The purpose of the CACs is to provide a forensically sound interview that is age- and developmentally and culturally appropriate and conducted in a safe, child-friendly, neutral setting. CAC interviews are performed by trained, dedicated forensic interviewers. In most cases, the CAC services represent the first step in the prosecution of perpetrators of crimes against children. Currently, the Governor's office is leading an effort to assist CACs in becoming co-housed with law enforcement and Children Youth and Families Department (CYFD) staff. This would allow the forensic interview team to share case information with law enforcement and CYFD, thereby increasing opportunities to protect children. The interviews aid in prosecution while reducing the trauma associated with recounting the abusive or violent incident several times and to different audiences. Each CAC is part of an MDT that assists in investigating child abuse allegations.

Although all the services provide training, awareness-raising activities, and advocacy within their own communities, the NMCSAP provides the most extensive training throughout the state. NMCSAP does this both by using its own staff and contracted trainers, which allows greater flexibility to provide trainers representative of the training audience. Attendees of trainings run the gamut from school personnel and students to law enforcement to community members to mental health and medical professionals. The trainings also vary widely, and many are provided at the specific request of local communities or law enforcement. Since 2008, one of the most successful trainings has been an intensive 2-week certification training for mental health professionals on providing therapeutic treatment to juvenile sex offenders.

The judicial response to sexual violence in New Mexico is inconsistent. The NMCSAP has provided resources to the judges, such as a bench book, a self-directed video curriculum on the judge's role in cases involving sexual violence, and a manual on research regarding sexual assault and the legal system. However, it is up to each judge's discretion whether the resources are used, and many judges are concerned that if they receive training, their decisions will become biased. Infrastructure for dealing with cases involving sexual violence throughout the state, including prosecutors, judges, court rooms, and CACs, is lacking. Attempts have been made to bring cases involving children to trial within a year, but adult sexual assault cases are often not heard for up to two years.

The New Mexico Intimate Partner Violence Death Review Team (NMIPVDRT) is a multi-disciplinary team that reviews deaths related to sexual assault and intimate partner violence (IPV). It is modeled on child fatality review teams, which have been effective in increasing the health and safety of children and reducing preventable injuries and death. The purpose of the NMIPVDRT is to increase understanding of risk and protective factors associated with IPV and sexual assault, especially in relation to the systems designed to serve or protect victims, and to make recommendations, based on their findings, for preventing future occurrences of IPV and injuries and deaths associated with sexual assault.

Since 2003, when former Governor Bill Richardson fulfilled his campaign promise to provide a million dollars to enhance and grow agencies that assist survivors of sexual violence, New Mexico has had consistent support from the Governor's office and an increasing number of legislators. Governor Susana Martinez has continued her impassioned support of programs that assist survivors and has made herself available to address sexual violence at statewide advocacy conferences. She provides rapid response to NMCSAP and other agencies specific to challenges in statutes and funding involving the State of New Mexico.

SUMMARY OF PROGRESS SINCE COMPLETION OF THE 2009-2012 STRATEGIC PLAN

The *Building Capacity* strategic plan was completed in October 2012. It focused on building capacity of sexual violence prevention service providers to understand primary prevention concepts and best practices and implement primary prevention programming. The strategies for accomplishing this objective included providing a series of trainings aimed at establishing a foundation in primary prevention principles (e.g., root causes of sexual violence; using Prevention Institute's Spectrum of Prevention as a framework for primary prevention; best and evidence-based practices; and advocacy for primary prevention) and providing technical assistance related to training content.

Technical assistance provided by the University of New Mexico's Prevention Research Center (UNM PRC) included follow-up emails and phone calls to SASPs who attended the trainings to facilitate implementation of training concepts, a monthly group email that provided best practices information and highlighted service provider events and successes, and development of technical assistance tools to support programmatic work (e.g., a matrix of best and promising practices, anti-oppression and primary prevention talking points handouts).

Since the plan was completed, NMDOH, NMCSAP and the UNM PRC have continued to meet on a regular basis to maintain state-level planning for primary prevention. The UNM PRC has continued to provide technical assistance to organizations funded by NMDOH, in the form of primary prevention programming, including site-visits; program assessment; assistance with best-practices implementation; evaluation assistance; a quarterly newsletter and dissemination of training materials, research articles, and reports related to primary prevention. The UNM PRC also convenes primary prevention team meetings including NMCSAP, NMDOH, NMDOH-funded organizations and other community partners (e.g., Indian Health Service, UNM Women's Resource Center) to allow networking, learning opportunities, and team-building. Training sessions have addressed program evaluation, community readiness, working with faith-based communities, and involving men in sexual violence prevention work.

METHODS

Data Collection

A three-tiered advisement and feedback structure was used to gather information for the new strategic plan. Tier 1 consisted of the strategic plan advisory group, which was composed of leaders in sexual violence prevention from throughout the state. The group included members of the NMCSAP, NMDOH, Indian Health Service (IHS), Health and Human Services Department, UNM PRC, prevention team members from rape crisis centers around the state, the UNM Women's Center, and members of advocacy groups working with LGBTQ and disabled populations. Tier 2 was composed of people who could provide expert advice and feedback for priority populations and the plan as a whole. Tier 3 included staff of New Mexico's rape crisis centers (RCCs) and all focus group participants.

In late 2014 through early 2015, the UNM PRC conducted focus groups across the state in communities having RCCs and with priority populations for sexual violence prevention. We conducted 11 focus groups, including a pilot group with our tier 1 Advisory Group. Focus groups were conducted in Albuquerque, Farmington, Las Cruces, Portales, Silver City and Taos. Priority population focus groups were conducted with men in Albuquerque (primarily students at UNM); Spanish-speaking immigrants in Las Cruces; LGBTQ community members and providers in Santa Fe; and Native American community members, providers and students in Santa Fe. The number of participants in each group ranged from 8 to 24, with a mean of 12.7 (Table 1). Participants were recruited by RCCs and or members of the special population groups. We requested participation from those who were

already conducting sexual violence prevention work, potential partners whose work may or may not have been related directly to sexual violence prevention, and community members who were interested in the topic.

The focus groups lasted about 2 hours each. The same 10 guiding questions were asked in each group (see Appendix D). The first category of questions asked about unique attributes of their communities, including challenges and strengths related to sexual violence prevention, partnerships they had developed or would like to develop for sexual violence prevention, and what they believe are next steps in sexual violence prevention. The second category of questions asked for input on creating the strategic plan, including questions about short- and long-term goals, and envisioning what success would look like. Participants provided consent for their participation and were asked if they would like a copy of the strategic plan once it was finished.

Table 1. Location, population focus and number of participants in sexual violence prevention focus groups held in New Mexico, 2014-2015.

SITE	FOCUS	PARTICIPANTS
Albuquerque	Pilot with Advisory Group	11
Albuquerque	Community	16
Albuquerque	Male	11
Santa Fe	Native American	9
Farmington	Community + Rural + Native American	13
Las Cruces	Community	11
Las Cruces	Immigrant	23
Portales	Community + Rural	12
Santa Fe	LGBTQ	9
Silver City	Community + Rural	16
Taos	Community + Rural	8
Total Participants		139

Data Analysis

Focus groups were recorded and at least one team member took notes during each discussion session. UNM PRC staff analyzed the transcripts of the focus group discussions using NVivo 10, a software package for analyzing qualitative data. Two people read each transcript and coded them according to themes. Themes included specific topics we sought in the data and unexpected themes that were identified. All data related to prominent themes were gathered and examined for commonalities, differences, and patterns across all focus groups. This analysis provided the basis for the results presented in this strategic plan.

RESULTS

Looking closely at what our communities had to say provides a framework for approaching sexual violence prevention work in New Mexico for the next 5 years. Five themes were discussed repeatedly across all of the focus groups, representing a broad consensus among the diverse communities, practitioners and potential partners in sexual violence prevention about where prevention efforts should be focused. The themes included sexual violence as a public health problem; include response with primary prevention; community-specific prevention programming; developing a common language for prevention; and, promising and successful prevention strategies for New Mexico.

Sexual Violence as a Public Health Problem

Focus group participants recognized that prevention specialists, policy makers, public awareness campaigns and programs must work from a public health perspective. One participant commented, "Sexual violence is affecting the health of developing children to the point where it is [a public health issue like] smoking." Another participant said that we need to move our focus from the individual to the community, an idea tied to the public health perspective. Others reflected that it is important to frame sexual violence as a public health issue in order to address its cyclical nature; said one participant, ". . . the people that are perpetrating violence . . . there's something going on for them too and I want us to be a community that figures out how to take care of the whole community and figures out how to reach out to everybody."

There was also discussion about how to change the focus toward public health. The most mentioned suggestion was breaking down silos and teaching leaders, providers and educators about sexual violence: ". . . what if every HIV educator or domestic violence advocate or coach had more capacity to be talking about sexual violence?" There was discussion about bringing in new messengers beyond people working directly on the topic, ". . . we've been saying it for a very long time and that's had some success. We really need other people talking about this besides sexual assault advocates."

Including Both Response and Primary Prevention

Primary prevention is stopping sexual violence before it occurs. Focus group participants spoke about the difficulty of separating primary prevention strategies and those that incorporate response. Because sexual violence is cyclical, intergenerational, normalized and secretive, doing prevention is complex and can result in disclosure.

> . . . We've noticed that the children that we were serving, a majority of the time, the parents were victims of violence themselves as children. So there was this cycle. And we all know about the cycle of violence. We're starting what we call our family wellness program, and we're working with the parents specifically to help them deal with their history.

Participants spoke of the need for safe spaces for survivors, a holistic response, treatment for perpetrators and justice for survivors.

Community-specific Prevention Programming

Participants in all the focus groups recognized the importance of developing localized community-specific prevention strategies. Participants recognized that these qualities cannot be simplified as rural or associated with particular ethnic groups, cultures or languages or population density. As one participant reminded us, "We are not the same!," meaning that geographic communities all have unique histories and social dynamics. However, within geographic communities and across the state, participants recognized the importance of focusing on priority populations at greater risk for sexual violence because of marginalization and power imbalances. These include children, rural residents, Native Americans, African Americans, immigrants, people identifying as LGBTQ, people living with disabilities, students on college campuses, and older adults. Participants also emphasized the increased risk among populations where two or more of these identities intersected. Being aware of intersections and the histories of specific communities helps create prevention strategies that are both inclusive and targeted to unique aspects of communities. Proposed strategies for doing this included making sure providers are trained in sexual violence prevention and come from these communities. Other strategies involved having materials, providers, and campaigns in languages other than English. Participants recognized that community-specific strategies must go beyond translation into other languages; they

must also involve local vocabulary, slang, attitudes, values and beliefs. In one focus group, a participant talked about the success of the military in using this strategy: "For the military there's a set of Army values you know honor, integrity and stuff like that . . . . A peer would be like 'Hey, that's not very honorable what you're doing to that female over there.' Or 'You're making fun of that guy, you don't have much integrity by doing that.'" In the Native American focus group, participants described promising prevention strategies that incorporate local histories and build on cultural strengths and practices:

> I attended a workshop that was put on by an Alaska Native elder who everybody respected and a lot of people knew her, and she'd experienced rape as a child. And she's in her 80s now, but she's incredible. She's revered and known all over Alaska and she developed this workshop that really was culturally relevant for domestic violence and I think that's something that's hard, making it culturally relevant and something that applies to you. So she incorporated song and drumming and, for me, that was really, really beautiful because it's something that I've wanted to be… I wanted to be there and also I could see how much it changed the 12 people that were there. We connected so well and we carried the conversation on, so having that conversation and being able to share it with other people has really created a lot of change.

Develop Common Language for Prevention

. . . We went to a training on message matters, about how to talk about sexual and domestic violence so that people will listen and one of the things they talk about is that one of our challenges has been that we've been selling tickets to the Titanic. And so we, we go in and we tell people, "It's bad. It's so bad." And then people are like, "I don't want to get on your boat, because it sucks."

Another important idea that came up repeatedly in the focus groups was the need to develop a common language or vocabulary to use when doing prevention work around sexual violence. The secrecy and taboos around sexual violence are reflected in the way people talk about it, or rather, do not talk about it. In each group, we asked participants to provide a one-word response to what they think when they hear the term "sexual violence." The responses from all 11 focus groups were compiled and assembled into a word cloud (Figure 1). The more times a word was used, the larger it appears in the cloud.

Participants spoke of the liberating and healing power of being able to talk about sexual violence and the necessity of naming what has long been unspeakable. Participants said that if there is a common language, people will feel more comfortable talking about sexual violence, that survivors will feel less isolated, and that a snowball effect will occur, with more and more people speaking out. Barriers to developing a common language are the discomfort that many people have about using anatomical names and talking about

Figure 1. Word cloud representing responses from participants in eleven focus group regarding the term "sexual violence," 2014-2015.

sex in general. As a way to address these challenges, participants suggested taking a positive approach that focuses on healthy relationships, healthy sexuality, and consent. Participants felt this could be successful in a variety of contexts and may be a way to do prevention work in communities and settings where it has previously been difficult.

Promising and Successful Prevention Strategies: Next Steps for New Mexico

Across the focus groups, there was much agreement about successful and promising strategies for prevention. The approaches most often mentioned included developing partnerships with groups whose missions are not directly related to sexual violence, increasing male involvement, and developing culturally relevant public campaigns. Ideas regarding partnerships included the necessity of obtaining buy-in from community leaders; working with local businesses and faith communities; and

engaging male-centered "places" such as sports teams, barber shops, and fraternal organizations. Focus groups with young participants or service providers who work with youth emphasized the importance of peer leadership.

Public campaigns were also suggested by all groups both to increase awareness of sexual violence and to comprise part of the effort to create a common language that would make it easier to engage people across the state in a conversation about sexual violence. Participants recognized that, underlying all these strategies, is the need to focus on changing sociocultural norms around gender identity and expression; to address power and inequality related to gender, race, ethnicity, class, sexual orientation, ableism and ageism; and to demonstrate and cultivate healthy relationships that include an understanding of active consent to sexual activity.

FOCUS GROUPS WITH A SUBSET OF PRIORITY POPULATIONS

Focus groups conducted with priority populations demonstrated that the same challenges and ideas for future prevention work mentioned in all the groups were also relevant for these populations. In addition, these focus groups provided insight into the unique characteristics that must be addressed for prevention work to be successful in populations that are at an increased risk of sexual violence.

Rural

Because New Mexico is a rural state, characteristics, challenges and opportunities related to rural communities and sexual violence were staples of conversation in almost all the focus groups. Even in the groups conducted in an urban setting, participants often worked with rural populations, and they agreed that rural communities must be a focus in New Mexico. The strengths and challenges of rural communities are sometimes the same. The idea that everyone knows each other makes communities "small enough to steer" but also potentially difficult to maneuver if there is opposition among community leaders to taking up sexual violence prevention work. Passionate people working in small communities can have a big impact, but efforts may depend on them alone. Many structural challenges were also mentioned, primarily long travel distances, access to resources, and a lack of sufficient funding.

Social challenges mentioned were the secrecy and stigma related to sexual violence, and often, denial that it happens "in a place like this." As in larger urban communities, there was a range of readiness and comfort with the topic of sexual violence, and many participants noted that there was a deep discomfort in rural communities about sex education in schools. Suggested prevention strategies included developing strong relationships with community and institutional leaders to provide opportunities for sexual violence efforts in schools, clubs, churches, and developing positive, comprehensive frameworks, such as healthy relationships, to allow sexual violence to be addressed. Although many agreed that culture change can begin with working with children (from toddlers to adolescents), others talked about the necessity of bringing parents into the discussion in order to break the cycle.

> " I see as a lack in our area and in all rural areas is that we need to get the information out into the rural areas. It's great all this stuff that's going on in the school systems. But some of these parents who are out there need that information so that they can communicate it to their children. And so some way we need to get out into the rural areas, because they're isolated and that just [allows] the secrecy and the abuse to continue, unless we get out there into the rural areas. And we'll need funding in order to do [that], to get resources out there. "
>
> -Focus Group Participant

Lesbian, Gay, Bisexual, Transgender and Queer/Questioning Community

Participants in the LGBTQ focus group agreed that changing sociocultural norms around gender identity and expression and addressing social inequities at all levels were key to addressing sexual violence. Participants felt that educators, health care and service providers must receive training that includes awareness and sensitivity to LGBTQ people and issues. In addition, services must be equally accessible to LGBTQ people. One participant described a situation with shelters: "Clearly there aren't as much support service for people who are transgender so that you know, normally someone calls the hotline and they say, 'Well why don't you go to the shelter?' And then the shelter says, 'We don't have a bed for you because we don't know where to put your bed.' It's a whole other outrageous level of discrimination that non-transgender people don't ever have to deal with."

Participants felt strongly that prevention education must include discussions of active consent with an explicit awareness of how power, inequality and marginalization can impact the consent process. Participants were interested in recognizing many kinds of marginalization and intersections of different identities, that may increase the risk of sexual violence, including race, gender expression, class, immigration status, disability, age, incarceration and previous incarceration, rural residency, youth and, in particular, how identifying as LGBTQ combined with these other categories further increases risk. In addition, participants in this group discussed the necessity of, and strategies for, bringing marginalized people to the table in sexual violence prevention work.

Immigrant/Border Communities

One of the focus groups was conducted in a border community in southern New Mexico and was composed of Spanish-speaking immigrants. The overarching concern in this group was the safety of people reporting or disclosing sexual violence. Participants said that people feel unsafe reporting sexual violence to law enforcement because they fear it will endanger themselves or others in their family who are undocumented. In addition, as in other focus groups, a commonly discussed issue was increasing awareness among men that consent is required in committed or married relationships.

> " What happens is that they are scared to report them because they are threatened. And like she said, "If my husband abuses me, what am I going to do?" We have had cases where we see the husband abuses the wife and she says, "If I report him, what are they going to do? They're going to put him in jail and who is going to support me?""
>
> -Focus Group Participant

Participants thought that prevention efforts should be focused on making sexual violence easier to talk about, eliminating embarrassment and shame about the topic, and creating a common language to facilitate discussion. Participants advocated for prevention efforts targeting families and involving men in discussions of sexual violence and making them feel welcome in prevention efforts. Participants also spoke of raising awareness within the immigrant population about laws that protect disclosure and reporting, regardless of immigration status, and building trust between community members and law enforcement. Another important element of prevention that was discussed was providing safe environments for women to come together and talk about sexual violence.

Native Americans

Participants in this focus group underlined the importance of considering generations of unresolved historical trauma and its effects on awareness, reporting, and community readiness to address sexual violence. Sexual violence was historically a weapon of colonizers. Moreover, its prevalence in Native American communities was recognized by participants, despite gaps in data about rates in such communities. Participants discussed the intergenerational aspects of sexual violence and the pressure to keep it within the family. They also discussed barriers to response such as matrilineal family structures that may lead mothers to protect sons, tribal leadership's denial or unwillingness to acknowledge and address the issue, and the complex legal structures (tribal, state, federal) that impede reporting and efforts to bring perpetrators to justice.

> " *"You need to stay together," I mean, for the kids, for whatever reasons and I think that generations before us, if there was domestic violence and sexual assault being a big piece of that relationship and if they were counseled to stay together, that kind of gets passed on generationally. So let's say a daughter went to their mom and said this has happened, because the mom stayed, she has that belief, "Well, I stayed, so you have to stay. If I stuck it out, you have to stick it out as well," and it's just this cycle. I think there's a lot of shame around it, too, because communities are so small, people don't want their dirty laundry, so to speak, to be out there or even for other people to know that there's problems that exist within the relationship or within the family. So it kind of just continues to get swept under the rug.* "
>
> -Focus Group Participant

Promising practices described by participants were culturally relevant educational materials that address sexual violence and historical trauma directly and explicitly contextualize it in relation to the community. Engaging men was also a key issue: participants emphasized using men as mentors and building on social norms that recognize men as protectors. In addition, discussing sexual violence in a forthright yet culturally sensitive way can work to diminish secrecy around the issue, help raise awareness, and mobilize leaders and community members to address the issue. Suggestions for moving forward were engaging tribal leadership and gaining commitments; developing prevention programming that incorporates respected and charismatic leaders who can speak from personal experience; and incorporating healing practices such as music, art, dance, storytelling and traditional medicine.

Men

We conducted one focus group with young men at UNM. The purpose was to determine how to engage more men and boys in preventing sexual violence. Because of the increasing attention being paid to sexual violence on campus and in the military, the men in this group were familiar with the topic but only a few had worked on the issue directly. Most were Reserve Officer's Training Corps members or members of athletic teams. Participants were willing and eager to talk about sexual violence prevention and shared ideas about engaging this population. All agreed that starting at a young age was a good idea. They thought ongoing education that was mandatory and integrated into the curricula was a good idea. They felt keys to success included peer education and developing a language and vocabulary that makes it "cool" to talk about sexual violence prevention. They also agreed that discussions of active consent and what it means in various contexts was important, especially in situations in which alcohol is involved. Responding to a video about *Coaching Boys Into Men*, focus group participants thought that such interventions had promise when used among boys and young men who participated in organizations and were receptive to messages from authority figures. Several pointed out that it is also important to reach young men who identify as anti-authoritarian and find role models—for example, musicians and artists—who can reach those who are not part of organized sports or clubs. Participants also discussed the potential for men and boys to engage in more bystander intervention and suggested techniques for increasing the willingness and effectiveness of such intervention. One participant commented, "Another thing is that we need to focus on our strengths that prevent sexual violence, not on our weaknesses. . . . So we need to be talking about the real moments like check your friends and making sure you're all straight when you go home right now, you check all your buddies or you check everybody you need to and they let them check you and call you."

CONCLUSION

Listening to voices of community members and providers who work to prevent sexual violence in our communities was a critical component in developing *New Mexico – Sexual Violence Free*. The focus group data were combined with advice from subject matter experts and used by the strategic plan advisory group to create a vision, mission, goals, and objectives relevant to the diverse communities in New Mexico. Most participants were enthusiastic about sharing their experiences and ideas, some were skeptical that we could create a plan that would cover the entire state, and others were anxious about the immediate next steps. The intention of the strategic planning process was to inspire prevention of sexual violence across the state and provide a roadmap for accomplishing it. The goals and objectives are sufficiently flexible to enable organizations and communities to respond in ways that honor the unique strengths and challenges of their communities and contribute to an overall prevention strategy for the state that is evidence-based. The resultant plan will provide a framework for directing primary prevention of sexual violence in New Mexico for the next 5 years.

VISION

Safe communities that are free from sexual violence.

MISSION

To prevent sexual violence through education, communication, collaboration and community action. To achieve our goal, we will focus on healthy relationships, gender equity, cultural strengths, and respect for others.

GOALS AND OBJECTIVES

Goal 1: Change norms surrounding the acceptability of sexual violence in New Mexico.

Objective 1:1 Engage members of priority populations, intervention communities and other key stakeholders in identifying the level of readiness for addressing root causes of sexual violence through an anti-oppression framework that emphasizes historical and gender-based trauma

Activities under this objective would result in increased numbers of sexual violence professionals trained to use an anti-oppression framework to address historical and gender-based trauma; improved understanding among prevention practitioners about root causes of sexual violence; increased numbers of sexual violence prevention staff trained in conducting community readiness assessments; increased partnerships for sexual violence prevention planning; and increased integration of community readiness best practices in local prevention programming.

Objective 1:2 Decrease risk factors for sexual violence perpetration and increase protective factors that help prevent sexual violence victimization within families, relationships and communities through implementation of primary prevention programming in school- and community-based settings

Activities under this objective would result in an increase in organizations implementing primary prevention strategies according to effective prevention principles; integration of prevention strategies aimed at changing cultural norms; and implementation of prevention programming that is linguistically and culturally appropriate and adapted for use within specific populations (e.g., Native American, LGBTQI, rural).

Objective 1:3 Reduce statewide acceptance of sexual violence through targeted messaging strategies

Activities under this objective would result in development of a state-level strategic communications plan; access to prevention messaging tested with New Mexico audiences; and integration of media strategies in overall efforts to reduce sexual violence in New Mexico.

Goal 2: Create safer environments through changes to organizational policies and infrastructure in New Mexico.

Objective 2:1 Promote identification and development of environmental and organizational policies that decrease risk factors for sexual violence perpetration and victimization, and increase protective factors that help prevent sexual violence perpetration and victimization

Activities under this objective would result in identification and development of policy and environmental strategies aimed at reducing sexual violence with a focus on priority settings (e.g., campuses, group homes, nursing homes, homeless shelters, residential treatment facilities, churches, youth-serving organizations, jails and prisons) and expanded local partnerships for addressing sexual violence through policy and environmental changes.

Objective 2:2 Promote implementation of environmental and organizational policies that decrease risk factors for sexual violence perpetration and increase protective factors that help prevent sexual violence victimization within priority settings (e.g., campuses, group homes, nursing homes, homeless shelters, residential treatment facilities, churches, youth-serving organizations, jails and prisons)

Activities under this objective would result in increased numbers of New Mexico organizations, state agencies and institutions implementing policy and environmental strategies to reduce sexual violence; reduced numbers of individuals reporting experiencing and perpetrating sexual violence and sexual violence-related behaviors (e.g., rape, sexual harassment, homophobic slurs) in priority settings; and increased numbers of organizations, state agencies and institutions integrating policy-level work into prevention strategies.

Goal 3: Increase use of the public health approach in statewide sexual violence prevention efforts in New Mexico.

Objective 3:1 Continue to build statewide infrastructure to support primary prevention of sexual violence

Activities under this objective would result in increased recognition of the role of oppression in sexual violence; improved statewide leadership for sexual violence prevention efforts; enhanced coordination of sexual violence prevention programs; increased numbers of sexual violence prevention programs evaluated for effectiveness; increased numbers of trained sexual violence prevention practitioners and partners; increased funding for sexual violence prevention efforts; increased numbers of research projects in New Mexico related to sexual violence prevention; increased dissemination of sexual violence prevention efforts, outcomes, and surveillance findings through

presentations and research papers; and overall enhanced evaluation of sexual violence prevention efforts.

Objective 3:2 Enhance statewide sexual violence-related data collection

Activities under this objective would result in increased sexual violence surveillance; improved consistency of statewide data collection related to sexual violence indicators (e.g., rape myth acceptance, bystander behavior); increased identification of appropriate instruments and methods for data collection; improved data sharing among agencies; increased research related to sexual violence prevention, perpetration, and protective factors; increased funding for population-based surveillance related to sexual violence; and identification of additional data gaps.

Objective 3:3 Expand partnerships at the state and local level for sexual violence prevention efforts

Activities under this objective would result in identification of organizations and agencies whose missions, programs, and activities impact risk and protective factors for sexual violence; increased statewide collaboration with organizations and agencies around sexual violence prevention efforts; improved planning and resource-sharing related to reducing sexual violence in New Mexico; and an elevated status of sexual violence as a significant public health issue in New Mexico.

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APPENDICES

Appendix A: The Public Health Approach to Violence Prevention

Appendix B: The Socioecological Model

Appendix C: The Spectrum of Prevention

Appendix D: Focus Group Guide

Appendix A: The Public Health Approach to Violence Prevention

The Public Health Approach to Violence Prevention

The public health perspective asks the foundational questions: Where does the problem begin? How could we prevent it from occurring in the first place? To answer these questions, public health uses a systematic, scientific approach for understanding and preventing violence[1]. While violence prevention practitioners may not be involved in all steps, understanding each step and why they are necessary to assure the desired impact on community health is helpful in selecting and/or developing prevention strategies.

The Public Health Approach

There are multiple steps in the public health approach, with each step informing the next. Many people, organizations, and systems are involved at each step along the way. Think of it as a relay team for prevention. The prevention practitioner usually takes up the baton in the fourth step, but overall success depends upon all of the other teammates and how they run their legs of the race

The Public Health Approach

In **step one**, the problem is defined. This involves systematically collecting data to determine the "who", "what, "where," "when," and "how." Data are typically gathered from a variety of sources such as death certificates, medical or coroner reports, hospital records, child welfare records, law enforcement or other records. Data can also be collected using population-based surveys or other methods.
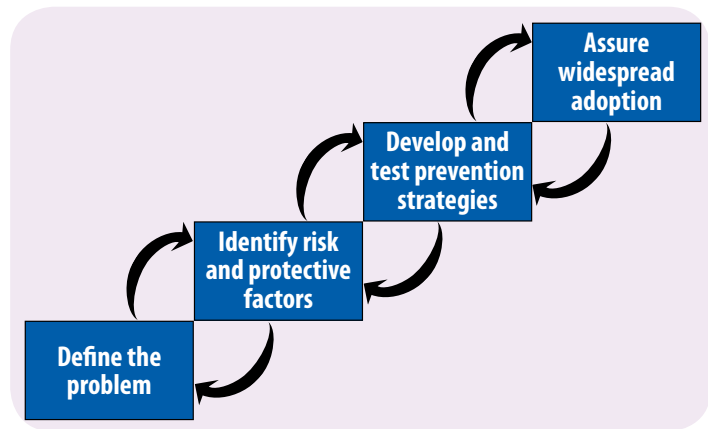
In **step two**, the reasons why one person or community experiences violence while another does not are explored. Scientific research methods are used to identify the factors that increase the risk for violence (risk factors). Factors that may buffer against these risk factors are also identified; these protective factors decrease the likelihood of violence in the face of risk. The goal of violence prevention is to decrease risk factors and increase protective factors.

In **step three**, prevention strategies are developed and rigorously tested to see if they prevent violence. This information is shared with others, usually through activities related to step four.

Step four is where the rubber meets the road. The strategies shown to be effective in step three are disseminated and implemented broadly. While many prevention practitioners may not have the skills or resources necessary to conduct steps one, two, and three, knowing where to look for the findings of others, such as registries for evidence based practice in the field, will satisfy similar goals for implementation. Training and/or technical assistance often is offered to practitioners when implementing effective strategies or programs to ensure that the strategies are implemented as they were intended. Though this is considered the final step of the public health model, it doesn't mean that the process is complete. Additional assessments and evaluation are done to assure that all components of the strategy fit within the particular community context and have the desired effect of preventing violence.

Putting it all together

So what does this mean for the decision making process on the ground? How does knowing about the four steps help in selecting prevention strategies? One way to look at it is that the Public Health Approach offers a framework for asking and answering the right questions. The tool on the next page will help you to do just that.
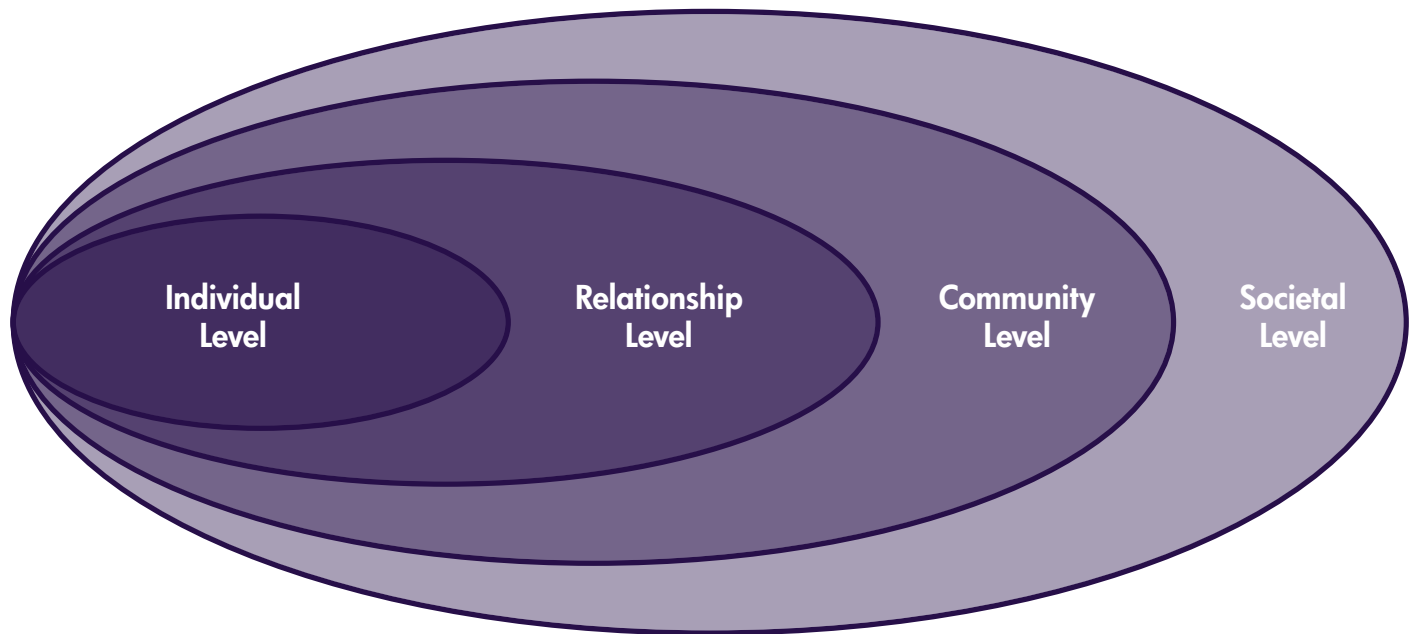
1. Mercy, J., et. al. (1993). Public Health Policy for Preventing Violence. Health Affairs. 12(4), 7-29.

National Center for Injury Prevention and Control
Division of Violence Prevention

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Use the tool below to think through a violence-related problem you would like to impact in your community or organization. The issue of Shaken Baby Syndrome, one form of abusive head trauma, is used as an example to demonstrate the tool. Fill in the shaded areas on the table with examples from your community or organization.

Using the Public Health Approach			
Steps	**Guiding Questions**	**Potential Resources**	**Example/Exercise**
Step One Define the Problem	What (violence-related) problem do I want to prevent? What data are available to describe the scope and burden of the problem? • How many people are affected by the identified problem? • Who is experiencing the problem? • When and where is the problem occurring?	National Violent Death Reporting System - http://www.cdc.gov/ViolencePrevention/NVDRS/index.html Web-based Injury Statistics Query and Reporting System (WISQARS) - http://www.cdc.gov/injury/wisqars/index.html Kids Count Data Center - http://datacenter.kidscount.org/?gclid=CMHYql_7oqMCFcpd2godz3wZ4Q ALSO: State and local crime statistics, health statistics, child welfare data, etc.	*Example: Abusive head trauma (AHT), including Shaken Baby Syndrome (SBS) is a leading cause of child abuse deaths in the United States. According to a study of North Carolina AHT cases, as many as three to four children a day experience severe or fatal head injury from child abuse in the United States.* *Your turn:*
Step Two Identify Risk and Protective Factors	Where do I find research to answer: • What are the risk factors for the problem? • What are the protective factors for the problem?	Division of Violence Prevention (NCIPC/CDC) - http://www.cdc.gov/ViolencePrevention/index.html	*Example: Caregiver frustration or anger resulting from inconsolable crying and limited social supports are primary risk factors for shaking a baby.* *Your turn:*
Step Three Develop and Test Prevention Strategies	Where do I find information to answer: • Are there existing, effective strategies based on best available evidence? • If none exist, what resources do I need to develop a new strategy based on what was learned in steps one and two? • Where can I find research partners to help evaluate the selected strategy? • Is the strategy effective – did it do what was intended?	The Community Guide to Prevention Services - http://www.thecommunityguide.org/about/methods.html Blueprints for Violence Prevention - http://www.colorado.edu/cspv/blueprints/ California Evidence-Base Clearinghouse http://www.cachildwelfareclearinghouse.org/scientific-rating/scale Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence - http://www.nrepp.samhsa.gov/about-evidence.asp	*Example: A promising or model home visitation program. http://ibs.colorado.edu/cspv/blueprintsquery* *Your turn:*
Step Four Assure Widespread Adoption (Dissemination and Implementation)	• Who would benefit from this strategy (parents, educators, policy makers, etc.)? • How do I get this strategy to the people who need it? • Where can I find assistance and support for implementing an effective strategy and on-going monitoring and evaluation of the strategy?	National Implementation Research Network - http://www.fpg.unc.edu/~nirn/ FRIENDS National Resource Center - http://www.friendsnrc.org/ University of Kansas Community Toolbox - http://ctb.ku.edu/en/default.aspx	*Example: Implementation of a home visitation program that includes a focus on specific parental behaviors and modifiable environmental conditions associated with adverse outcomes for children.* *Your turn:*

Appendix B: The Socioecological Model

Individual Influences:
attitudes and beliefs that support sexual violence; impulsive and antisocial behavior; childhood history of sexual abuse or witnessing violence; alcohol and drug use; hostility toward women.

Relationship Influences:
association with sexually aggressive peers; family environment that is emotionally unsupportive, physically violent or strongly patriarchal.

Community Influences:
general tolerance of sexual assault; lack of support from police or judicial system; poverty; lack of employment opportunities; weak community sanctions against perpetrators.

Societal Influences:
larger, macro-level factors, including gender equality/inequality, religious or cultural belief systems, societal norms, and economic or social policies.

Appendix C: The Spectrum of Prevention

Strengthening individual knowledge and skills. Enhancing an individual's capability of preventing injury or crime.	• Provide multiple session skill-building programs that teach healthy sexuality and healthy and equitable relationships skills to high school students • Build the skills of bystanders to safely interrupt behavior such as sexist and homophobic harassment • Teach parents to address attitudes and behaviors in their children that support sexual violence
Promoting community education. Reaching groups of people with information and resources to promote health and safety.	• Hold religious and political leaders accountable for providing clear and consistent messages that sexual violence is not appropriate • Foster media coverage of sexual violence with a focus on underlying factors and solutions • Develop awards programs to publicly recognize responsible media coverage and community leadership to prevent sexual violence
Educating providers. Informing providers who will transmit skills and knowledge to others.	• Train little league coaches to build skills to interrupt and address athletes' inappropriate sexual comments and behaviors • Train prison guards on rape prevention • Train nursing home providers on sexual violence prevention practices
Fostering coalitions and networks. Bringing together groups and individuals for broader goals and greater impact.	• Foster partnerships between community providers and researcher/academics and to strengthen evaluation approaches • Engage grassroots, community-based organizations and sectors of government, including social services, health, public health, law enforcement and education • Engage the business sector to foster workplace solutions and build support among their peers
Changing organizational practices. Adopting regulations and norms to improve health and safety and creating new models.	• Implement and enforce sexual harassment and sexual violence prevention practices in schools, workplaces, places of worship and other institutions • Implement environmental safety measures such as adequate lighting and emergency call boxes, complimented by community education and enforcement of policies • Encourage insurers to provide healthy sexuality promoting resources and materials
Influencing policy and legislation. Developing strategies to change laws and policies to influence outcomes in health, education and justice.	• Promote and enforce full implementation of the Title IX law • Establish policies at universities to provide sexual violence prevention curriculum to all students and training to all staff, and include funding as a line item in the university's budget • Pass middle and high school policies to offer comprehensive sex education programs that include sexual violence prevention and address contributing factors in the school environment
Source: Sexual Violence and the Spectrum of Prevention: Toward a Community Solution.	

Sexual Violence Prevention Statewide Strategic Plan
Focus Group Guide

Focus group introductory statement:

My name is _____ and I work at _____. This is my colleague, _____, who works at _____. The New Mexico Department of Health, the New Mexico Coalition of Sexual Assault Programs, and the University of New Mexico Prevention Research Center are collaborating with people from around New Mexico who already work in sexual violence prevention, and others interested in the topic, to develop a 5-year, statewide, Sexual Violence Primary Prevention Strategic Plan.

The purpose of this focus group is to help us understand more about the primary prevention of sexual violence in your community, in your work, and in New Mexico. We'd like to get your input in order to create a strategic plan for the state. You are being asked to participate in this process because of the information you can provide to help guide the development of the plan's goals and objectives. We don't expect you to know everything about what we ask you today, but we know that you know a lot about what is happening in your community. We also know that not everyone agrees about sexual violence prevention. That's okay. It is helpful for us to hear a range of opinions and voices. We want to encourage the respectful expression of different perspectives on the topics we discuss today.

We are conducting focus groups around the state with different communities and groups. We will present the information and ideas we hear to an advisory board we are working with that has agreed to oversee the development of the strategic plan—they will incorporate the ideas gathered from around the state into the plan.

The focus group will last about an hour and a half to two hours. Your involvement is voluntary. You may choose not to answer any question, not to participate at all, or to stop participating at any time without any negative consequences. We will be recording the focus group only to assist us in accurately capturing the information you are providing. The results of this focus group may be published, but no quotes will be associated with your name or a specific description that will identify you.

We understand that some things may be discussed today that you might want to discuss more with peers, colleagues, or potential partners in order to prevent sexual violence in your community. We also expect that some personal or sensitive discussions might occur. Please feel free to discuss ideas generated from our conversation today, but please do not discuss sensitive or personal material or disclose the identity of people who have shared this kind of information. Although we hope that people will comply with this request, we cannot guarantee confidentiality. However, in terms of the information we collect, the audio

recordings and our notes will be kept for three years following completion of the project. At the end of three years the recordings and notes will be destroyed.

Our discussion may bring up some difficult topics that may cause some participants distress. If this happens for you, and you would like to talk to someone, here are the names and numbers of people who you can call in [community – provide local rape crisis/sexual assault resource information].

We would like to establish some ground rules for our discussion today: only one person should speak at a time, please be respectful of differing opinions, and please turn your cell phones off for the duration of the discussion. If you need to take a call, please leave the room to do so. If at any time I use any words that are not familiar or you unsure of, stop me and I will explain what I am trying to say.

Do you have any questions about what I've just reviewed?

If, after today you have any questions about our session or this project please don't hesitate to contact me. My contact information is on the flip chart here. You can also contact us by being in touch with [the person who organized the session]. We won't take any formal breaks during the discussion, so please feel free to get up when you need to stretch, use the restroom, or get a snack.

Because we are focusing on primary prevention as part of a comprehensive approach to sexual violence prevention in our discussion today, I want to read a definition of primary prevention to keep in mind during the discussion.

"Primary prevention is a systematic process that promotes healthy environments and behaviors and reduces the likelihood of sexual violence from happening in the first place" *(source: Prevention Institute).* Examples of primary prevention work include programs with multiple educational sessions that may include discussion of things like gender roles and active consent. Another example of primary prevention is bystander intervention (equipping people to notice, identify and act in situations where sexual violence is occurring or at risk of occurring). Work that is NOT considered to be primary prevention includes single-session educational interventions, or responding to sexual violence once it has already occurred. While these are important, and we recognize that these activities are essential components of a comprehensive response to sexual violence, they are not our focus today. We may refer again to this definition during our discussion.

Participant Introductions

Many of you may know each other, but we would like to spend some time introducing ourselves to each other. I'd like everyone to say your name, what organization or community you work with, your favorite thing to do in the [season], and one thing you *know* about sexual violence. Who would like to start?

[Moderator: Make sure everyone introduces themselves before moving forward.]

SVP Efforts in Community
A "community" can be defined as a group of people living in the same place or having certain characteristics, or doing certain activities in common. Many of us feel like we do not have just one, but multiple communities—for example, we may have a work community, an ethnic community, a community around a hobby, or around a school. Sometimes these communities overlap and sometimes they don't. In our discussion today the focus will be on sexual violence prevention and/in [name of community (e.g. men; LGBTQI communities; faith-communities)], but we recognize that there is diversity within every group, so please feel free to provide multiple or different perspectives as well. It will be helpful for us to be specific about which communities we are talking about, whether it is generally related to [town/city] or to a particular sub-groups or other community.

Q1. To get things started we thought we would begin by everyone just throwing out some ideas. So, keeping in mind that there are no wrong or right answers: when you hear the term sexual violence, what is one word that comes to mind? [Moderator will write words on flip chart].

 [Moderator: After collecting answers, summarize briefly. Next, refer to flip chart page with CDC definition of sexual violence.]

Now I'd like us to take a look at the CDC definition of sexual violence: "Sexual violence (SV) is any sexual act that is perpetrated against someone's will. SV encompasses a range of offenses, including a completed nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment)." What do you think about this definition? Does this change the way you view sexual violence?

I also wanted to show you what sexual violence looks like in New Mexico. [Moderator: Show data on flip chart: 1. In New Mexico, one in four women and one in 20 men will experience attempted or completed rape in their lifetime. 2. The majority of rape survivors in New Mexico were 18 years old or younger at the time of the assault. 3. In 2011, service providers reported that sexual violence offenders were known to their victims in 83% of the cases. 4. [Additional data point specific to community/population]. What do these data tell us?

Q2. How does sexual violence affect your community? What are the ways in which you think [name of specific community or communities (e.g. town/city; men, LGBTQI communities, rural communities, faith-based communities)] is/are unique with respect to sexual violence? How can we address those unique characteristics through primary prevention strategies?

Q3. What do you think are some challenges in/among [name of specific community or communities (e.g. town/city; men; LGBTQI communities; rural communities; faith-based communities)] that need to be addressed when working to prevent sexual violence? (Probe: What do you think are the causes of sexual violence? How is this different than what your community in general thinks are causes?)

Q4. What do you think are some strengths of [name of specific community or communities (e.g. town/city; men; LGBTQI communities; rural communities; faith-based communities)]? How can these be built upon when doing work in the primary prevention of sexual violence?

Q5a. [For center-based focus groups:] How do you involve community partners whose mission may not be directly or obviously related to sexual violence prevention? What benefits have you found or do you anticipate working with new partners? What are the challenges you have found or do you anticipate?

Q5b. [For specific population groups:] What would help engage *more* [name specific group] in sexual violence prevention? What do you think limits their involvement?

Q6. What do you think are some steps that can be taken in [name of specific community or communities (e.g. town/city; men; LGBTQI communities; rural communities; faith-based communities)] to move forward with primary prevention of sexual violence? (Probe: What resources do you need in order to successfully do this work – for example funding, technical assistance, training, partnerships? How much funding?)

Strategic Plan Advice

We want to make sure that the plan we are developing covers the entire state, and reflects your ideas about what needs to be done to prevent sexual violence from happening in the first place.

Q7. What goals do you think we should include in the statewide strategic plan? (Probe: Are there goals specific to [community or population?])
[Moderator: write on flip chart.]

Q8. Which of these ideas are possible over the next five years? What challenges do you expect?

Q9. We recognize that not all men are perpetrators of sexual violence, yet most perpetrators are men, so we would like to hear what you think can be done with boys and men in your community to prevent sexual violence.

Q10. When thinking about preventing sexual violence in [community], what would success look like? How would you know if we had achieved it? (Probe: How would you know if we were making progress? What would be signs of success?)

Wrapping up

Moderator and Assistant Moderator: Identify key themes that emerged from the discussion and give participants opportunity to refine. Identify differences of perspective, contrasting opinions and areas of agreement.

Our discussion will be wrapping up in a few minutes, but I wanted to give everyone a chance for final comments.

Q11. Does anyone have any final thoughts or something they wanted to contribute before we end?

Thank you so much for participating. Your ideas and perspectives are greatly valued and will contribute to making the strategic plan. If this discussion brought up some personal issues or concerns around sexual violence that might cause you distress, remember that there are people you can talk to here in [community – refer to the list of resources].

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NEW MEXICO
DEPARTMENT OF
HEALTH

New Mexico Department of Health
Epidemiology and Response Division
Injury and Behavioral Epidemiology Bureau
Office of Injury Prevention

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