Southwest Ohio Regional Prevention Council
Prevention Plan Summary

Contents

Background

Synopsis of Need: A review of the literature suggests children at greater risk for abuse and neglect have families that deal with considerable amounts of stress, such as from poverty, substance abuse, and chronic health issues. Southwest Ohio shows higher levels of concern versus the rest of the State. The domestic violence rate is growing faster in Highland and Adams counties, along with 15 other Ohio counties, than any other counties in Ohio. One in four Southwest adults and parents experienced 4+ categories of traumatic stress as children (such as family violence, sexual abuse, caregivers with substance abuse patterns, etc.) versus 17% in California, for example. These adults have 4- to 12-fold increased risks for alcoholism, drug abuse, depression, and suicide attempt. The drug overdose mortality rate in Southwest Ohio is the worst in Ohio, with every county but two having rates in the highest tier, and Brown County with the highest rate in Ohio. A key challenge is the children; half of all Ohio children taken into custody last year had parents using drugs, a majority of which were opiates. Adams and Hamilton counties have the highest rates of infant mortality in Ohio, and Ohio is among the worst in the U.S., while one-third of mothers in Southwest Ohio are receiving no first trimester prenatal care. Children with a physical, cognitive, or social delay or disability are at greater risk for child abuse and neglect. The rate of children on an IEP (one measure for such challenges) indicates Adams County has the 11th highest rate in Ohio.

Summary of Proposed Strategies: The ultimate goal of this data-driven prevention plan is to increase the capacity of communities, parents, and caregivers to improve the well-being of children, so that every child in Southwest Ohio has the opportunity and resources to grow up safe and healthy.

Target population and Projected Numbers Served: The main secondary populations targeted in this prevention plan are caregivers to and children with special needs; caregivers to and children with behavioral challenges; kinship caregivers and children in kinship care; high poverty zip codes in rural areas; and family-serving institutions and agencies.

Description of the Needs Identified for the Southwest Region

The Southwest Ohio prevention planning process relied on data from multiple sources, both qualitative and quantitative, to identify child abuse and neglect prevention priorities. Over 650 households in Southwest Ohio participated in a protective factors and adverse childhood experiences (ACEs) survey; more than 50 service providers and prevention specialists participated in an online survey and a community forum; and five focus group sessions were held with vulnerable populations. Secondary quantitative data analysis used data sources related to child maltreatment and well-being from federal, state, and local sources.

Overview

The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum:

- "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation"; or
- "An act or failure to act which presents an imminent risk of serious harm."

Child neglect is the leading form of child maltreatment in the United States and occurs when a caretaker fails to provide for a child's basic needs, which include adequate food, clothing, shelter, education, supervision, and medical care or safekeeping.[1]

According to a national report on child maltreatment recently released by the Administration for Children and Families, there were 3.6 million referrals alleging maltreatment involving 6.6 million children across the U.S. in 2014. In the same year there were 1,546 child deaths due to abuse and neglect. This equates to a rate of 2.13 deaths per 100,000 children.[2] Ohio had just under 170,000 referrals and 45 child deaths reported in that year and an 11.9% increase in the number of investigations and alternative responses associated with those referrals.[3]

While the number of investigations in Ohio has increased since 2010, the number of child deaths due to abuse and neglect has steadily decreased from a high of 83 deaths in 2010 (i.e., a 46% decrease).[4] Some have attributed improvements in the prevention of child maltreatment to the Surgeon General[5] who made child abuse and neglect a top priority, and many credit the subsequent public health model approach which includes better monitoring of the problem,

[1] U.S. Department of Health & Human Services, Administration for Children and Families, "Child Abuse," Federal Child Abuse Prevention and Treatment Act of 2010, (2010), N. P.
[2] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). *Child maltreatment 2014*. Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment
[3] Ibid
[4] Ibid
[5] Office of the Surgeon General. (2005, March). Surgeon General's workshop on making prevention of child maltreatment a national priority: Implementing innovations of a public health approach. Workshop conducted at the National Institutes of Health, Bethesda, MD. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK47482.

identifying risk and protective factors, developing and testing prevention strategies, and ensuring widespread adoption of strategies.[6]

The table below presents the reports of child abuse and neglect for Southwest Ohio and the counties that comprise it. The federally-funded Fourth National Incidence Study (NIS) of Child Abuse and Neglect found that 2.5 times as many children are maltreated each year as are actually reported to child protective service agencies, estimating one child in every 25 in the U.S. is maltreated.[7] As a result, the number of child victims in Southwest Ohio is estimated closer to 10,500 as opposed to 4,735, with the number of reports of child abuse or neglect above 26,000.

Child Abuse and Neglect Reports (Rate per 1,000 Children), 2014

County	Reports of Child Abuse or Neglect*	Number of Child Victims	Substantiated Reports of Neglect	Substantiated Reports Physical Abuse	Rate of Child Abuse/Neglect Reports per 1,000
Southwest Ohio Region	***10,458***	***4,735***	***1,549***	***2,824***	***24.6***
Adams	248	89	43	31	35.2
Brown	288	196	59	116	26.9
Butler	2,325	981	263	644	25.4
Clermont	1,077	614	261	287	21.7
Clinton	430	289	156	138	42.0
Hamilton	5,271	2,149	557	1,388	28.1
Highland	282	112	74	59	26.5
Warren	537	305	136	161	9.3

Source: Ohio Department of Public Safety

*Pertains to reports that have been accepted for investigation and does not include referrals

Universal and Targeted Need to promote/provide Community and Caregiver Supports and Education

A review of the literature suggests children at greater risk for abuse live in communities with high levels of violence, are younger than four years old, are living in households with intimate partner violence, and whose families deal with considerable amounts of stress, due to poverty, substance abuse, or chronic illness.[8] Indicators such as unemployment or perceived material hardships can be predictive of child neglect. In addition, children in single parent families may be more susceptible to turbulent economic conditions than two parent families.

[6] Centers for Disease Control and Prevention. (n.d.). Public health approach to violence prevention. Retrieved from http://www.cdc.gov/violence prevention/overview/publichealthapproach.html.

[7] Fourth National Incidence Study of Child Abuse and Neglect, Report to Congress Executive Summary, 2010.

[8] Troiano, M. (2011). Child Abuse. *Nursing Clinic of North America.* 46. 413-422.

Parents, across focus groups convened for this Southwest Ohio effort, re-iterated the challenges they face daily. One participant detailed the exhaustive and cyclical issue of facing poverty. She noted that being just above the poverty line precludes many families from receiving certain critical resources because they no longer qualify, but still cannot afford said resources on their own.

Beyond analyzing these risk factors, the Southwest Ohio Comprehensive Needs Assessment also included a study of Adverse Childhood Experiences (ACEs) that contribute to adult stress. Over 650 adults in Southwest Ohio including 314 parents were interviewed for this study of traumatic stress.

Parental Stress and Adverse Childhood Experiences (ACEs) among Southwest Ohio Adults

Stress among adults is the eighth most prevalent risk factor for child abuse and neglect in Ohio[9] and is a foundational child abuse and neglect issue for many parents and adults in the region. Parenting stress, stress related to fulfilling the parenting role,[10] can be understood as the negative emotional reactions individuals experience vis-à-vis the demands of being a parent.[11] At the individual level, maternal psychological functioning and child health and behavior are risk factors for parenting stress. ***The more risk factors women experience, the more they report parenting stress.***[12]

At the family level, parenting stress is linked to parenting difficulties and is associated with harsher and more inconsistent parental discipline and less parental warmth.[13] Parenting stress impacts associations between family-level stressors, such as poverty, divorce and intimate partner violence (IPV), and negative child outcomes.[14] Moreover, it is correlated with contextual factors, such as neighborhood conditions.[15]

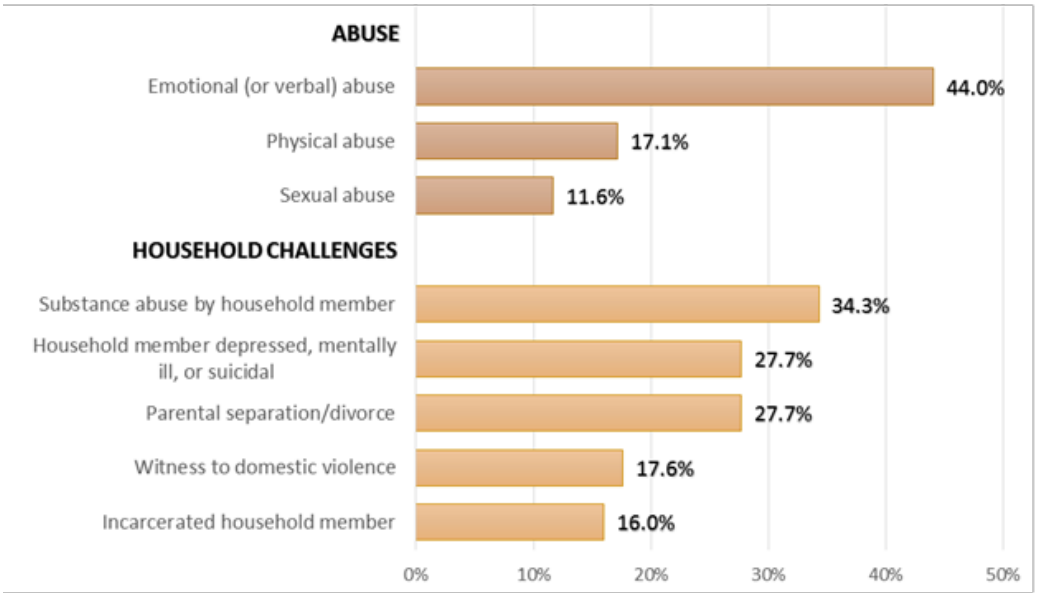
While parents can overcome minor episodes of stress by tapping into their body's natural defenses to adapt to changing situations, excessive chronic stress, which is constant and persists over an extended period of time, can be psychologically and physically debilitating.

One strong proxy for measuring the prevalence of this kind of chronic stress for adults is to identify those who have experienced four or more ACEs. Research has demonstrated a graded relationship between the number of categories of childhood exposure to adverse experiences and adult health risk behaviors and diseases. [16] Adults who experienced four or more categories of childhood exposure to caregivers with multiple behavioral and/or mental health risk factors (such as family violence, sexual abuse, substance abuse, etc.) compared to those who had

[9] Ohio Needs Assessment for Child Welfare Services, Ohio Department of Job and Family Services, January 2016
[10] Abidin, R. R. Parenting Stress Index. 3d ed. Psychological Assessment Resources, Odessa, FL, 1995.
[11] Deater-Deckard, K. Parenting Stress. New Haven, CT: Yale University Press, 2004.
[12] Ibid
[13] Deater-Deckard, K. Parenting Stress. New Haven, CT: Yale University Press, 2004.
[14] Lamis, D., et al., "Neighborhood Disorder, Spiritual Well-Being, and Parenting Stress in African American Women," Journal of Family Psychology; 28(6): 769–778, 2014.
[15] Ibid
[16] https://www.cdc.gov/violenceprevention/acestudy/about.html

experienced none, have 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt. Furthermore, high numbers of ACEs have strong correlations with involvement in the child welfare system.[17] In California (data unavailable for Ohio), a person with four or more ACEs is 12.96 times as likely to have been removed from her home as a child as compared to a person with no ACEs.[18]

Most Common Adverse Childhood Experiences (ACEs) among Southwest Ohio Adults



Nearly one-quarter (23.5%) of all adults in Southwest Ohio between the ages of 18 and 60 experienced four or more ACEs as children versus 17% in California as one available example.[19] The percentage of adults who are parents, grandparents raising grandchildren, and other adults caring for children in their homes is nearly identical (23.8%). These adults have 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt. And each of these conditions is a risk factor for child abuse and neglect. Applying the ACEs result for all adults ages 18-60 in Southwest Ohio indicates a population of 232,765 adults having four or more ACEs, which certainly supports the need for prevention strategies that reach everyone. Further, 25% of all survey respondents experienced some form of physical and/or sexual abuse as children. "Research suggests about **one-third of all individuals who were abused or neglected as children will subject their children to maltreatment**. This cycle of abuse can occur when children who either experienced maltreatment or witnessed violence between their parents or caregivers learn to use physical punishment as a means of parenting their own children."[20]

[17] "A Hidden Crisis: Findings on Adverse Childhood Experiences in California," Center for Youth Wellness, 2014.
[18] Ibid
[19] "Protective Factors and Adverse Childhood Experiences Survey of Southwest Ohio Adults Ages 18-60," Wright State University, Applied Policy Research Institute, 2016
[20] "Cycle of Abuse," Child Welfare Information Gateway, accessed 10/26/2016

ACEs for All Southwestern Ohio Adults, ages 18-60

ACEs	Frequency	Valid Percent
0	168	26.2%
1	153	23.8%
2	89	13.9%
3	81	12.6%
4 or more	151	23.5%
Total	642	100.0%
Refused	11	
Total Respondents	653	

ACEs for Parents, Grandparents, other Caregivers, ages 18-60

ACEs	Frequency	Valid Percent
0	79	25.7%
1	75	24.6%
2	33	10.9%
3	46	14.9%
4 or more	73	23.8%
Total	306	100.0%
Refused	8	
Total Respondents	314	

Research argues there is not one specific risk factor that predicts child abuse, but the co-occurrence of many risk factors and stressors creates even greater risk of maladaptive responses by parents and caretakers. Lack of parenting knowledge and child development information also increases the likelihood of neglect and abuse.[21]

According to the Centers for Disease Control and Prevention (CDC), abused and neglected children are at a higher risk for health problems once they become adults. These problems include alcoholism, depression, drug abuse, eating disorders, obesity, high-risk sexual behaviors, smoking, suicide,[22] hypertension, diabetes and bone fractures.[23] As children, they **may suffer from brain injuries resulting in learning disabilities, seizures and motor skill problems. They could also exhibit behavioral and psychological problems including aggression and anxiety**. The literature suggests a cycle of continued abuse (re-victimization and/or becoming abusers) throughout an individual's life.

The focus on parent-level strategies is reinforced by the Ohio Department of Job and Family Services' (ODJFS) Ohio Needs Assessment for Child Welfare Services, where researchers conducted a systematic literature search, surveyed national experts, and studied case files, and identified that **parenting services is the service demonstrating the largest service gap**, exceeding the need for psychotherapy services, for example, by more than 200%. The table below also demonstrates that parenting services is the needed service for caregivers with parenting difficulties, cognitive difficulties, where young children are involved, where there is caregiver stress, and in cases where there has been known child abuse and neglect. In other words, parenting services address multiple risk factors.

[21] Strengthening Families Protective Factors Framework basic tenet
[22] Centers for Disease Control and Prevention. (2014). Understanding Child Maltreatment: Fact Sheet.
[23] Gupta, R., Berkowitz C., Pearson, R. (2011). Child Physical Abuse. *ClinicalKey*.

Services Needed, Provided, and Service Gaps for Adults

Adult Concerns	Services								
	Psycho-therapy	Domestic Violence	Medical	Parenting	Drug Diagnostic	Drug In- or Out-Patient	Financial Support	Sight, Hearing, Speech	Child Education
Domestic Violence	■	■							
Emotional Illness	■		■						
Parenting	■			■					
Physical Illness			■						
Cognitive Difficulty	■			■					
Substance Abuse			■		■	■			
Financial							■		
Homelessness							■		
Self-protection	■			■					
Stress	■			■					
Abuse, Dependency, Neglect	■			■					
Total Services Needed	33,978	12,735	17,870	33,473	11,506	11,506	9,522		
Total Services Provided	21,660	4,472	25,351	4,302	5,488	7,729	5,969		
Service Gap	12,138	8,263	(7,481)	**29,171**	6,018	3,777	3,553		

Source: Ohio Department of Job and Family Services' Ohio Needs Assessment for Child Welfare Services

Protective Factors for Southwest Ohio Parents, Grandparents, and other Caregivers

The Protective Factors and Adverse Childhood Experiences Survey of adults in Southwest Ohio also explored questions from the FRIENDS National Center's Protective Factors Survey. Conducting this survey with the adult population created measures of adult isolation and parenting norms/beliefs. The survey uncovered the following pertaining to isolation (a risk factor for child abuse and neglect) when child caregivers were asked their level of agreement with the protective factors statements.

Isolated Child Caregiver Factors	Disagree or Slightly Agree
I have others who will listen when I need to talk about my problems.	12%
When I am lonely, there are several people I can talk to.	17%
If there is a crisis, I have others I can talk to.	13%
I would know where to turn if I had trouble making ends meet.	21%

A series of questions from the FRIENDS Protective Factors Survey address parenting/caregiver norms and beliefs. **Results for Southwest Ohio child caregivers indicate some misguided beliefs that may create risk factors for child abuse and neglect.**

Child Caregiver Risk Factors	Agree
There are many times when I don't know what to do as a parent.	27%
My child misbehaves just to upset me.	21%
When I discipline my child, I lose control.	4%
I don't know how to help my child learn.	1%

Effective parental education strategies to prevent child maltreatment include: modeling, role-playing, Socratic dialogue, home practice, and home visits.[24] When a multi-level prevention model is used, effective intervention is demonstrated at every level of the model, including improvements in (a) parenting skills, (b) developmentally appropriate interventions, (c) developmentally appropriate beliefs, (d) negative affect, (e) acceptance of a responsible parent role, (f) acceptance of a nurturing parent role, and (g) self-efficacy.[25]

Community-based strategies incorporate school programs to educate students on recognizing dangerous situations and providing skills to protect themselves. Other community-based strategies include interventions to change attitudes, behaviors, and norms of the community, as well as societal changes that influence policies and systems. Child abuse and neglect prevention awareness campaigns are other examples of community-level strategies that the Southwest Ohio Prevention Plan will implement.

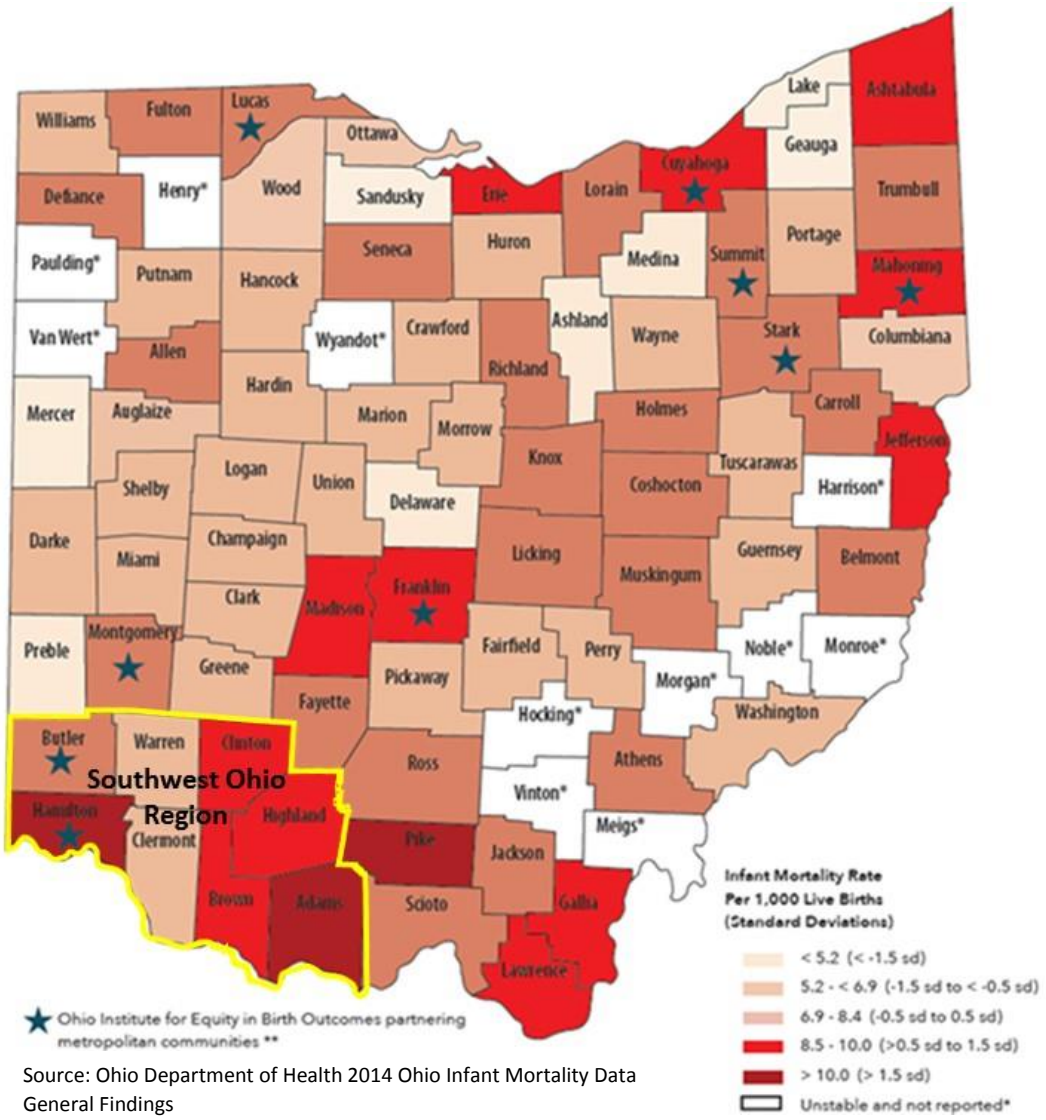
Children At-Risk and the Need for Targeted Social Emotional Supports

Infant Mortality

Southwest Ohio has counties with the highest rates of infant mortality in Ohio (see counties shaded in the darkest color of red in the map), while Ohio has one of the highest rates of infant mortality in the U.S. Experts cite emerging trends in the growth in infant mortality as related to the opioid epidemic. National Child Abuse and Neglect Data System (NCANDS) data for 2014 demonstrated that 70.7% of children who die due to abuse or neglect are younger than 3 years; 44.2% are younger than 1 year.[26] Infant mortality is an important measure to inform communities about child health and well-being. The Ohio Institute for Equity in Birth Outcomes is an initiative designed to strengthen the scientific focus and evidence base for realizing equity in birth outcomes in nine of Ohio's major metropolitan areas (indicated by a star on the map) to prevent infant deaths. Two of those major metro areas are in Southwest Ohio.

[24] Peterson, L., Tremblay, G., Ewigman, B., Saldana, L. (2003). Multilevel Selected Primary Prevention of Child Maltreatment. *Journal of Consulting and Clinical Psychology.* (71) 3. 601-612.
[25] Ibid
[26] "Child Abuse and Neglect Fatalities 2014: Statistics and Interventions," Child Welfare Information Gateway

Ohio Infant Mortality Average 10-Year Rate by County (2005-2014)



Source: Ohio Department of Health 2014 Ohio Infant Mortality Data General Findings

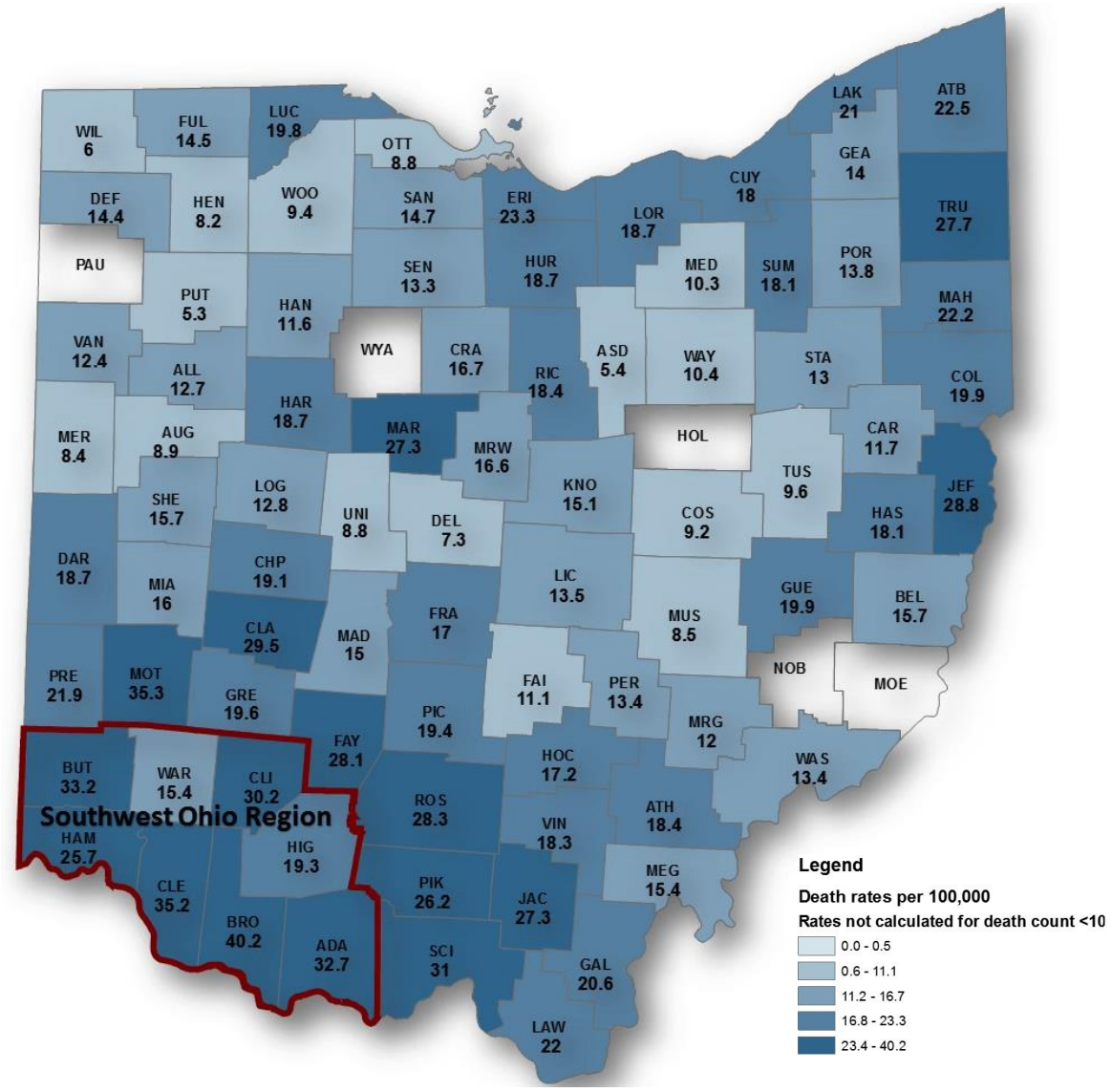
<u>Poor Health</u>

Communities in Ohio are becoming overwhelmed by the prevalence of drug overdose deaths. A key challenge is attending to the children of adults who both overdose and die or who are abusing heroin or opioid painkillers. A recent survey by the Public Children Services Association of Ohio[27] found that at least half of all Ohio children taken into custody last year had parents using drugs, a majority of which were opiates. **Children Services tries to find an appropriate relative to care for a child if the child's removal from parents who abuse opioids becomes**

[27] Tiltz, T. "These States are Struggling with a Drug Addition-Fueled Crisis in Foster Care," PBS News Hour, October 7, 2016.

necessary for the health and safety of the child. If they cannot find a kinship provider, they place the child with foster families; however, many counties and communities are facing a shortage of foster families. Another emerging area of increased numbers of at-risk youth pertains to children who are victims of placement disruption due to family instability (substance use, etc.). This is currently a very prevalent problem as reflected in the increased child welfare placement numbers and kinship placements. **In the majority of instances, however, a child's residency with kin is through informal means.**

Average Age-Adjusted Unintentional Drug Overdose Mortality Rate per 100,000 Population, by County, Ohio Residents, 2010-2015



Source: Ohio Department of Health, Bureau of Vital Statistics; Analysis by ODH Injury Prevention Program; U.S. Census Bureau (population estimates). Includes Ohio residents who died due to unintentional drug poisoning (primary underlying cause of death ICD-10 codes X40-X44).*Rate suppressed if < 10 total deaths for 2010-2015

Each year in the U.S., an estimated 40,000 babies are born with a Fetal Alcohol Spectrum Disorder (FASD); while neonatal abstinence syndrome (NAS) is on the rise nationally and in Ohio. NAS is a group of problems that occur in a newborn who was exposed to addictive opioid drugs while in the mother's womb. These infants have difficult-to-manage conditions (such as high pitched screaming and excessive crying), which increase their risk for child abuse and neglect.

Many studies have been conducted associating physical and mental health disabilities in children with child maltreatment; children with disabilities are at greater risk for child abuse and neglect.[28] The prevalence of children diagnosed with neuro-and other developmental disabilities, as well as behavioral challenges or disorders is increasing at an alarming rate. About 1 in 6 children in the U.S. have one or more developmental disability or other developmental delays. About 2 to 3 percent of children are considered to have an intellectual disability. Since 2000, the estimated prevalence of Autism Spectrum Disorder (ASD) in the U.S. increased from approximately 1 in every 150 children to 1 in every 68 children in 2012. ASD is 5 times more common among boys than girls. Furthermore, nearly 12% of Ohio's 4 to 7 year olds have a current diagnosis of attention-deficit/hyperactivity disorder (ADHD); ADHD is also more prevalent in boys.

Further research indicates that children with **conduct disorders, moderate to severe learning disorders, and speech and language disorders are at higher risk for abuse**, but children with autism or sensory disorders were not at greater risk.[29]

During the two focus group discussions with parents of children with disabilities, the challenges they expressed underscore and amplify the research. Several parents agreed that children in the disabilities community are oft-neglected because "they simply don't have a voice or they don't have a voice that is valued."

Moms of children with disabilities discussed **child safety concerns in schools**. Moms described situations where teachers have created their own procedures and practices, such as locking a child in a room for the school day, or leaving a child sit in feces in a separate room because the school is not required to clean him. All of the moms in the focus group had children who experienced such abuse or neglect at school for which they have involved legal authorities.

Suggestions by the Moms for improvements to better support them include greater parent support, especially for parents who are former child abuse victims, those with their own history of mental illness, and those who have cognitive delays. Another request pertained to better geographic disbursement of services, the need to lessen the burden of "proof of need" and the requirement of time on parents to take off work, and better coordination between agencies. Moms agreed, "**Better technology and supports and empowerment can only lead to a better, safer life for our children**." And there should be **standard training and practice**--"Even within

[28] "The Risk and Prevention of Maltreatment of Children with Disabilities," Child Welfare Information Gateway, 2012
[29] Spencer, N., et al. (2005), Disabling Conditions and Registration for Child Abuse and Neglect: A Population-Based Study. *Pediatrics.* 116. 609 – 613.

the same school district, there is great discrepancy between school buildings of what is offered to children with developmental disabilities." A Mom said, "Safety in the disabilities community has been ignored for far too long. The intervention happens only after the abuse occurs." And another said, "**Where is there representation of parents** within the schools? Parent mentors are hired by the schools, so they are vested in the schools and not objectively advocating for the parent."

Social Emotional, Physical Well-being and Motor Development

The **child protective factors include social-emotional development, nurturing, attachment, and resilience.** One broad measure of child social emotional competence is in the Kindergarten Readiness Assessment, which shows that kindergarten children in Brown, Hamilton, and Highland Counties are assessed as *approaching* rather than demonstrating social-emotional competence (referred to as "social foundations" which include social and emotional development, and approaches toward learning).

Kindergarten Social Foundations & Physical Well-being

County	Social	Physical Well-being
Southwest Ohio Region	***268.8***	***268.8***
Adams	273.2	268.7
Brown	267.1	268.9
Butler	270.2	270.0
Clermont	270.7	270.4
Clinton	271.1	271.5
Hamilton	266.5	266.7
Highland	266.6	267.5
Warren	272.3	272.2

Scores: Demonstrating (270-298); Approaching (258-269); Emerging (202-257)

Source: Ohio Department of Education

Physical or Mental Health Disabilities and Developmental Demands

The Individualized Family Service Plan (IFSP) is a written plan for providing Early Intervention (EI) services to an infant or toddler with a disability and to the child's family. The figure below presents the number and proportion of children in Southwest Ohio receiving early intervention services. While the average is 1.9% of 0-3 year olds serviced by an IFSP, the minimum value is 1.3% in Highland County versus 3.3% in Clinton County. This statistic provides another insight as to the number of young children at-risk for child abuse and neglect due to a developmental disability.

Individual Family Service Plan Children Served, Birth to 3 Years of Age, 2016

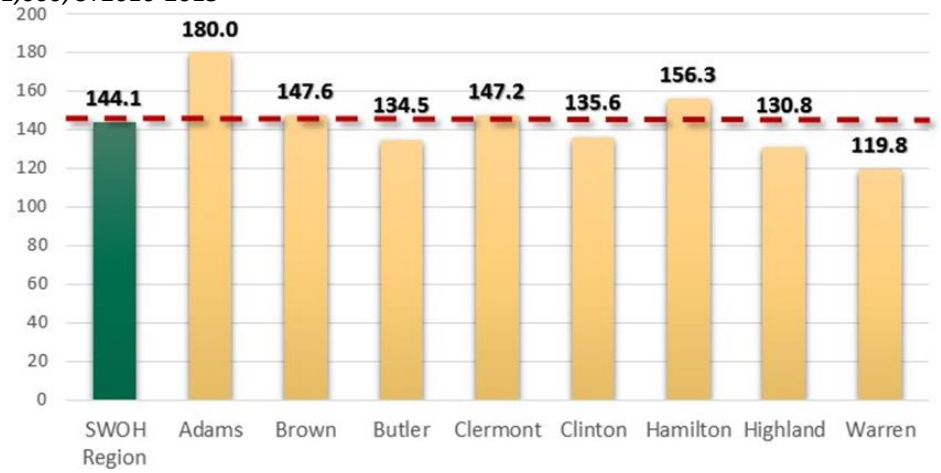
County	2016	Total 0-3	Proportion Receiving IFSP
Southwest Ohio Region	1,635	88,490	1.8%
Adams	32	1,313	2.4%
Brown	36	1,943	1.9%
Butler	453	18,153	2.5%
Clermont	229	9,424	2.4%
Clinton	70	2,148	3.3%
Hamilton	580	43,091	1.3%
Highland	27	2,124	1.3%
Warren	208	10,294	2.0%

Source: Ohio Department of Developmental Disabilities, Early Intervention (EI)

Moving from the early intervention program to public schools occurs after age 3, and is a most stressful transition for the parent and the child. "[This is a] crucial transition point, you leave your protected EI phase and it stops. All representation and familiar faces are gone, and you go to public education and sit at a table where you are far outnumbered." A Developmental Disabilities staff person in a focus group said, "It's almost like parents are dropped after the Early Intervention phase. And there isn't always an answer."

The IEP or Individualized Education Program is a plan that explains what help/services a child will receive in special education beyond age 3. The figure below presents the percent of students on an IEP for each county in Southwest Ohio, with the red line in the chart indicating the average percentage. **Adams and Hamilton counties have rates substantially higher than the regional average**, while Adams County has the 11th highest prevalence among all 88 counties.

Students with Disabilities Receiving Individualized Education Program Services, 6-year Average Rate per 1,000, SY2010-2015



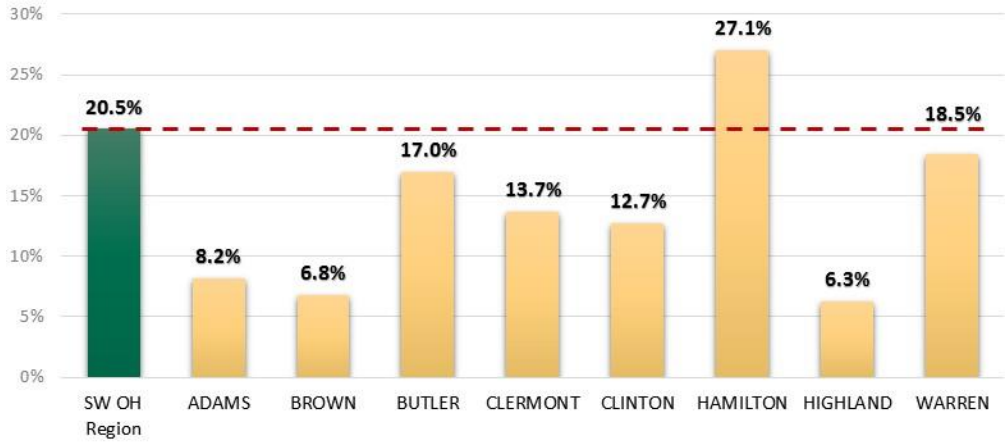
Source: Ohio Department of Education

Quality Child Care

At the community-level, quality child care is one means of building protective factors in children and parents/caregivers. Two measures of quality ratings for child care facilities are the Step Up to Quality Ratings and the certification of child care facilities. In Southwest Ohio, **of the 1,498 child care facilities only 231 (or 15%) participate in the Step up to Quality program**. In terms of licensed child care facilities in Ohio, about half have some type of certification (NAEYC, NECPA, NACCP, NAFCC, COA, and/or ACSI certification). There is a great deal of variation in child care facilities across the counties in Southwest Ohio, where there are only 7 child care facilities in Adams County (2 have a least one certification), and 12 in Highland (3 have at least one certification) and Brown Counties (5 have at least one certification) versus 1,082 in Hamilton County (668 have at least one certification).

The figure below compares the proportion of all children ages 0-14 to the maximum child care capacity of providers in Southwest Ohio, indicating that, depending on the county, only 6%-27% of children could be served.

Maximum Day Care Capacity vs. Population under 14 Years of Age, 6-Year Average, 2010-2015



Source: Ohio Department of Job and Family Services

Summary of Primary Prevention Problem Statement:

Across the region, multiple initiatives are addressing child well-being, but there is no central leadership, data, communications, or cross-agency guidance for the Strengthening Families Protective Factors Framework.

Data/Indicators to Track Progress on a Regional Prevention Agenda:

- **Measures of child well-being tracked across the region.**
- **Protective Factors Surveys conducted of parents/caregivers in the region-at-large are compared to survey results for parents/caregivers participating in prevention plan strategies.**

- **Standard training and practice measures being used across agencies (because at its heart, Strengthening Families is about changing how service providers interact with families to support them in building protective factors (CSSP)).**

Summary of Secondary Prevention Problem Statement:

The prevalence of children diagnosed with neuro-and other developmental disabilities, as well as behavioral challenges or disorders is increasing at an alarming rate, while caregivers and educators lack the training, technological and other supports for optimal child development and care.

Indicators to "Move the Needle" for Targeted At-risk Populations:

- **Children with special needs meeting all or more of their IEP goals.**
- **Re-enrollment trends for children with behavioral challenges (such as young children experiencing early academic failure).**
- **Educational milestones such as math and reading attainment for children in kinship care and in high-poverty rural areas.**

Southwest Ohio Prevention Plan Impact Areas, Objectives, and Strategies

The purpose of the prevention plan is to communicate the Council's vision and plan for preventing child abuse and neglect in Southwest Ohio. The prevention plan is a blueprint describing current and future priorities.

Vision**:** Every child grows up safe and healthy.

Mission: To inform and empower communities and families so that child abuse and neglect are prevented.

Goal: Increase the capacity of communities, parents, and caregivers to improve the well-being of children.

Impact Area 1: Increase community, parent, and caregiver knowledge to promote optimal child development and reduce child abuse and neglect. Protective factors directly targeted are:

- Knowledge of Parenting and Child Development
- Parental Resilience
- Social Connections

Objectives and Strategies

Objective: Awareness of child abuse and neglect and its prevention will be increased across Southwest Ohio through global awareness campaigns that reach both vulnerable populations and general members of the community.

Strategy: Deliver universal prevention awareness campaigns…all people have both the obligation and the privilege to protect children from harm.

- Promote protective factors and the role each person can play to support families and prevent child abuse and neglect.
    - Promote how to recognize and refer parents who are struggling, prior to child abuse and neglect occurring.
    - Spread awareness about child abuse and neglect first, then provide consistent messaging about child abuse and neglect.
- Ensure culturally competent messaging that communicates well to all vulnerable populations: parents, racial and ethnic minorities, children and adults with disabilities, homeless families and those at risk of homelessness, unaccompanied homeless youth, adult former victims of child abuse and child neglect or domestic violence, members of other underserved or underrepresented groups, fathers, and any other special populations that meet local and regional needs.

Background and Rationale: Success in engaging the broader community requires greater awareness throughout the community.[30] There may be some members of the community that feel just far enough removed from the problem of child abuse and neglect that they don't immediately make the connection to what role they may have as a teacher, church member, or other community member in preventing abuse and neglect. By honing in on the message that everyone has a role to play in preventing abuse, and then creating awareness through media placements, billboards, social media, and other digital media, the Council will be able to educate and engage the community at large. This awareness campaign will include a call to action so that community members can find out where to find more information, or get more involved.

Target Population: This is a primary prevention strategy; the aim is to communicate to the general population.

***Projected Numbers to be Involved*:** Awareness above current regional baseline (to be established using current outreach metrics across region). Aim is to meaningfully market to 10% of the population, which equates to about 180,000 people.

***Outcomes*:** Increased awareness of child abuse and neglect and its prevention.

[30] Child Welfare Information Gateway. Public Awareness & Creating Supportive Communities. https://www.childwelfare.gov/topics/preventing/communities/

Evaluation Mechanism*:* Reach and distribution for all campaign materials (billboards with a phone number to call so that calls may be counted), social media metrics, website hits and online surveys, print and email distribution); survey to test recollection of published materials and what impact it may have had.

Alignment with OCTF Outcomes and Evaluations**:** Increase awareness of evidenced-based practices designed to reduce child abuse and neglect at the community level.

Objective: In 18 months at least 1,000 parents/caregivers will engage in approaches that strengthen families, wherein 80% of them will have indicators of improved resilience & 70% will have increased access to supports in times of need. This approach may be replicated in subsequent years based on performance and outcomes with an expected 700 parents involved each year.

Strategy**:** Build the capacity of parents and caregivers to have nurturing and responsive caregiving relationships with children.

Background and Rationale: Building parent/caregiver resilience, social connections, and awareness of concrete supports is a core element of the Strengthening Families Protective Factors Framework. To this end, this strategy is directly aimed at parents/caregivers, providing them with training and an environment for respectful involvement, giving them lead roles in carrying out key activities with service provider staff assisting as partners. The focus is strength-based. Parent leaders receive training on the Protective Factors Framework, and other essential elements of the intervention so that they have the tools to serve as leaders. Interventions to carry out this strategy are connected to other protective factor building efforts. Parents/ caregivers are partners, and should be able to independently select and implement a range of positive strategies to meet goals that they set for themselves and their children. As a result of participation in interventions, parents develop beliefs that they can be effective, have strategies to implement their chosen goals, and assess their own progress toward their goals.

Target Population**:** Use community-based and population-based methods to recruit parents/caregivers from the community-at-large.

Projected Numbers to be Served: 3,100 parents/caregivers till 6/30/21 participating across the 8 counties. The aim for total numbers to be served by county are: Adams, 50; Brown, 74; Butler, 663; Clermont, 353; Clinton, 74; Hamilton, 1,383; Highland, 78; and Warren, 425.

Outcomes**:** 80% of parents/caregivers develop practices that promote parental/caregiver resilience; 70% of parents/caregivers have increased access to supports during times of need; 75% of community-based cohorts develop a sustainability plan to keep the program running.

Evaluation Mechanism**:** Pre and post parent evaluations and FRIENDS National Resource Center Protective Factors Surveys will be administered to parents participating in this program.

***Alignment with OCTF Outcomes and Evaluations*:** Increase in parental knowledge of behaviors that promote healthy child and family well-being, building protective factors, the importance of children's social and emotional development; increase in behaviors designed to build protective factors; increase in natural positive supports.

Objective: Within 18 months, at least 500 teachers and professionals in early childhood development organizations will participate in training that will result in expertise in strength-based strategies for connecting with and partnering with parents. This approach may be replicated in subsequent years based on performance and outcomes. After the first 18 months, at least 800 teachers/professionals per year will participate.

***Strategy*:** Train professionals in early childhood development organizations to support parents'/caregivers' ability to parent effectively. This may be accomplished via learning community networks among early care and education programs, to enable these professionals to learn more about how to achieve good outcomes for children and engage parents/caregivers effectively.

- Offer the Protective Factors Framework to current training providers to leverage existing training capacity.
- Strength-based, two-generation strategies are preferred.
- Reinforce training with follow-up support, such as reflective supervision and ongoing mentoring.
- Have access to online training and/or e-learning opportunities.

Background and Rationale: This strategy makes explicit the important front-line role that early care and education providers play in preventing child abuse and neglect. The purpose of this strategy is to advance the use of the Strengthening Families Protective Factors Framework by working with early childhood development organizations so that they become exemplary providers and build protective factors into their day-to-day work with families. Early childhood programs – including after-school programs, home visiting programs, family resource centers, etc., can reduce stress for the families they serve if they have training and supports, including trauma-informed care training. Their mission of healthy child development makes them ideal coaches for parents and caregivers. Practice implementation tools, such as self-assessments (e.g., Strengthening Families self-assessment tool for community based programs), coaching, and technical assistance can help early care and education programs identify specific changes they can make to enhance their ability to support and strengthen families.

***Target Population**:* This is a primary prevention strategy recognizing that teachers and professionals in early childhood development organizations can influence hundreds of parents/caregivers and children across the 8 counties. The ACEs research conducted by the Council uncovered that 74% of all parents and caregivers suffered from at least one adverse

childhood experience (ACE). 25% experienced childhood physical or sexual abuse. One-third of all individuals who were abused or neglected as children will subject their children to maltreatment. These data indicate the wide prevalence of need for prevention strategies that can influence as many parents and children as possible.

***Projected Number to be Served**:* At least 500 teachers/professionals in the first 18 months, 800 annually thereafter. The aim for total numbers to be served by county through 6/30/21 are: Adams, 46; Brown, 70; Butler, 621; Clermont, 331; Clinton, 70; Hamilton, 1,293; Highland, 73; Warren, 397.

***Outcomes**:* 75% of teachers and early childhood professionals identify strength-based strategies for connecting with parents.

***Evaluation Mechanism**:* Strengthening Families Staff Survey and DECA checklist.

Alignment with OCTF Outcomes and Evaluations: Increase use of evidence-based practices designed to reduce child abuse and neglect; increase coordinated efforts designed to reduce child abuse and neglect.

Objective: Within 18 months, at least one tangible support will be made available for targeted community needs. This approach may be replicated in subsequent years based on performance and outcomes with at least 25 specialists involved each year in innovations.

Strategy: Invest in tangible, high quality supports for early childhood education environments and build networks of support, such as:

- Contributing to building resilient families by building or testing online training or e-learning opportunities.
- Using e-learning to enable individuals to become highly trained Strengthening Families specialists in their communities, and serving as mentors for others, training the trainers.
- Then circle around to having trainers train parents so that this initiative builds community capacity to serve families.
- Communities that have access to networks and ongoing connections to a hub of experts.

Background and Rationale: Community and societal barriers can impact the availability and accessibility of tangible supports that parents and children may need. Examples include a lack of local resources, the inequitable distribution of services, a lack of a high-quality workforce, having to travel long distances to access services, or services that are not well coordinated or are not strengths-based or trauma-informed. Building community capacity is the focus of this strategy. Accomplishing this strategy will require innovative solutions, such as telehealth or distance technologies and workforce enhancement curricula and training models (that may be used across systems). If new programs or products or training curricula/materials are to be developed, then they will need to be reviewed and tested with experts/members of the

targeted population(s) for feedback, and to develop measures of reliability and validity. The Council estimates that such products will need to be validated with many experts, not less than 25. These 25 experts, having reviewed and used the innovation, will become specialists who commit to providing train the trainer programs to family services providing agencies and the parents/caregivers they serve.

***Target Population*:** In focus groups, parents/caregivers repeatedly pointed to a lack of training, lack of communication, and lack of awareness of trauma-sensitive responses by family-serving agencies. The initial target population for this strategy is a cohort of specialized trainers who will help produce distance learning training modules, and then train parents/caregivers, so that they, in turn, can train other parents. Specialists will be involved from each of the 8 counties.

Projected Numbers to be Served: At least 25 specialists that commit to conducting additional train the trainer programs annually.

Outcomes: Tangible supports to build community capacity that may influence multiple users.

Evaluation Mechanism: Tangible supports that have been tested and applied, creating a cadre of specialists each year who then train the trainers.

Alignment with OCTF Outcomes and Evaluations: Increase in safe environments for children; increase of community capacity to make available, accessible, and affordable the high quality services needed to maximize healthy family functioning.

Impact Area 2: Facilitate the social-emotional development of children who have challenges. Protective factors directly targeted are:

- Knowledge of Parenting and Child Development
- Parental Resilience
- Social Connections
- Social and Emotional Competence of Children

Objectives and Strategies

***Objective*:** In 18 months at least 200 parents/caregivers of at-risk children will engage in approaches that strengthen families, wherein 80% of them will have indicators of improved resilience & 70% will have increased access to supports in times of need. This approach may be replicated in subsequent years based on performance and outcomes with an expected 300 parents involved each year.

***Strategy*:** Build the capacity of parents and caregivers of children with special needs, behavioral challenges, in kinship care, and/or in high poverty zip codes in rural counties to have nurturing and responsive caregiving relationships with children.

***Background and Rationale*:** Building parent/caregiver resilience, social connections, and awareness of concrete supports is a core element of the Strengthening Families Protective Factors Framework. To this end, this strategy is directly aimed at parents/caregivers, providing them with training and an environment for respectful involvement, giving them lead roles in carrying out key activities with service provider staff assisting as partners. The focus is strength-based. Parent leaders receive training on the Protective Factors Framework, and other essential elements of the intervention so that they have the tools to serve as leaders. Each successive year, parent leaders will be coached and provided with resources to engage more parents, with the vision of having one parent leader per 600 to 3,000 residents.

***Target Population*:** Recruit parents/caregivers from organizations and agencies in each of the 8 counties that work with parents/caregivers facing selected risk factors including caring for a young child experiencing early academic failure (e.g., preschool expulsion), caring for a child with special needs, being a kinship care provider, and/or rural high poverty zip codes.

***Projected Numbers to be Served*:** 1,100 parents/caregivers until 6/30/21 participating across the 8 counties. The aim for total numbers to be served by county are: Adams, 100; Brown, 100; Butler, 150; Clermont, 100; Clinton, 100; Hamilton, 350; Highland, 100; and Warren, 100.

***Outcomes*:** 80% of parents/caregivers develop practices that promote parental/caregiver resilience; 70% of parents/caregivers have increased access to supports during times of need; 75% of community-based cohorts develop a sustainability plan to keep the program running.

***Evaluation Mechanism*:** Pre and post parent evaluations and FRIENDS National Resource Center Protective Factors Surveys will be administered to parents participating in this program.

***Alignment with OCTF Outcomes and Evaluations*:** Increase in parental knowledge of behaviors that promote healthy child and family well-being, building protective factors, the importance of children's social and emotional development; increase in behaviors designed to build protective factors; increase in natural positive supports

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***Objective*:** Solely-focused expert attention on educational environments serving at-risk children, resulting in increased ability to apply strength-based strategies for early childhood development organizations and increase concrete supports. This approach may be replicated in subsequent years based on performance and outcomes involving 600 early childhood education providers in the first 18 months and 500 annually.

***Strategy A*:** Provide training, guidance and coaching to professionals in early childhood development organizations who care for at-risk children, on how to promote children's development of targeted social-emotional skills.

- Train teachers in trauma-informed prevention strategies for classroom use.

Strategy B: Invest in tangible, high quality supportive early childhood education environments and build networks of support in areas of targeted need.

***Background and Rationale*:** The objective focuses on building the capacity of early childhood development organizations as well as on building community supports. The focus in this section is on addressing those people and resources that serve children who are at greater risk for child abuse and neglect. This section recognizes the unique and multiple needs of at-risk children, who require multiple services and supports. In a focus group with mothers of developmentally disabled children, mothers described the complex processes for navigating services for their children.

Strategy A: In Early Intervention programs (as one example), there is opportunity to upskill existing special instruction providers, where credentialing processes can provide the Strengthening Families Framework common knowledge and skill sets across the interdisciplinary teams that serve children. Interventions in this section may enhance the ability of this critical workforce to form meaningful relationships with families and for them to assist families in building strengths and in locating recommended services and supports. This work may be accomplished in the form of learning communities or networks.

Strategy B: Investing in tangible, high quality supportive early childhood education environments and networks of support may pertain to interventions for at-risk child populations.

***Target Population*:** This strategy targets early childhood education environments in rural high poverty zip codes or in the 8 county region that serve a higher than average proportion of

children with special needs, with behavioral challenges (young children experiencing early academic failure), or in kinship care.

***Projected Numbers to be Involved*:** 600 representatives from early childhood education providers in the first 18 months, and 500 annually until 6/30/21. The aim for total numbers to be served by county at minimum are: Adams, 34; Brown, 50; Butler, 450; Clermont, 240; Clinton, 50; Hamilton, 935; Highland, 53; and Warren, 290.

Outcomes: Tangible supports for teachers and their increased knowledge and awareness

Evaluation Mechanism: For Strategy 2.2.A, 90% of early childhood education professionals identify strength-based strategies for connecting with parents/caregivers of at-risk children. The DECA checklist may also be used. For Strategy 2.2.B, supports that have been tested and applied by local educators/early childhood education professionals serving at-risk children are widely available.

Alignment with OCTF Outcomes and Evaluations: Increase partnerships and alliances that are providing integrated services for families; increase coordinated efforts designed to reduce child abuse and neglect; increase the capacity of the community to make available, accessible, and affordable the high quality services needed to maximize healthy family functioning; increase in safe environments for children.

Objective: Within 18 months, significantly enhance social emotional competence of 750 children in high poverty zip codes in rural areas, or children across the 8-county region who have special needs, behavioral challenges (young children experiencing early academic failure), or are in kinship care. This approach may be replicated in subsequent years based on performance and outcomes.

Strategy: Provide instruction in social skills and emotional regulation to at-risk children.

- "Teach" children social emotional skills (friendship skills, emotional literacy, and development of empathy, impulse control, and problem solving).
- Promote and invest in strengths-based protective factor approaches to supporting children which will also benefit families.

***Background and Rationale*:** There is increasing evidence that addressing social and emotional development should be a priority for parents, policymakers, early childhood educators, pediatricians, and more. Social and emotional competence of children is one of the five protective factors, and acquiring social and emotional competence is the primary developmental task of early childhood—as important as cognitive competence. Environments that are safe and encourage developmentally appropriate play and opportunities to explore and learn by doing are factors that promote such competence. This becomes an even greater

imperative when serving vulnerable and highly stressed young children experiencing the biologic harms following toxic stress, and given the potential for positive impact in the future. There are many evidenced-based programs and methodologies that promote social emotional competence in at-risk children, including processes that teachers and parents/caregivers can use to promote self-regulation and build the capacity of children.

***Target Population*:** Children in high poverty zip codes in rural areas, or children across the 8-county region who have special needs, behavioral challenges (e.g., young children experiencing early academic failure), or are in kinship care.

***Projected Numbers to be Involved*:** 750 children in the first 18 months, and 1,200 children annually beginning 7/1/18. The aim for total numbers to be served through SFY 2021 by county are: Adams, 70; Brown, 104; Butler, 931; Clermont, 496; Clinton, 104; Hamilton, 1,940; Highland, 109; Warren, 596.

***Outcomes*:** 80% of children involved will demonstrate improvement in social, emotional and behavioral functioning; children meet appropriate educational attainment milestones.

Evaluation Mechanism: Parent and teacher surveys to measure the increase in child pro-social behaviors and reduction in behavior problems.

Alignment with OCTF Outcomes and Evaluations: Improve social and emotional development in children; improve protective factors for children.