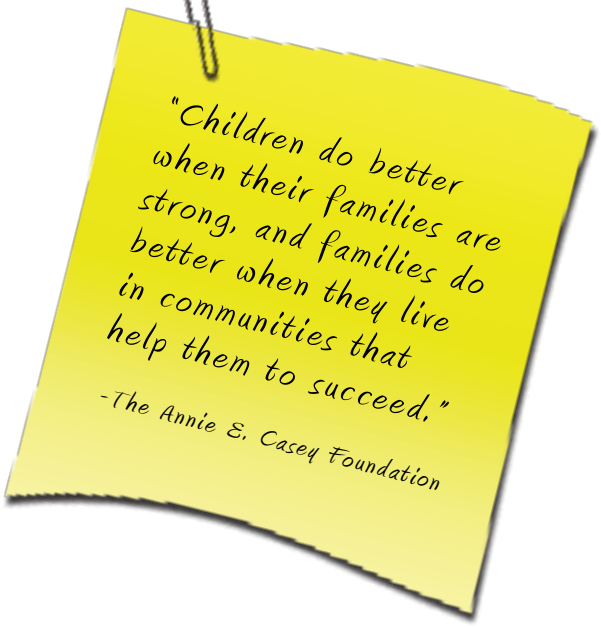
Oklahoma State Plan for the Prevention of Child Abuse and Neglect, 2010-2013

The Oklahoma Interagency Child Abuse Prevention Task Force
Office of Child Abuse Prevention, Oklahoma State Department of Health



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Dear Reader:

Child abuse and neglect are everyday tragedies for hundreds of children in Oklahoma. Maltreated children not only suffer immediate physical and emotional trauma, but the adverse experiences they undergo can affect them for the rest of their lives, can affect their families on a long-term basis, and can have a negative impact on Oklahoma. These children are more likely than other children to do poorly in school, to commit crimes as adolescents and adults, to struggle with drug and alcohol addictions and to abuse their own partners and children when they become adults.

There is a growing body of evidence concerning the effects of child abuse and neglect and an increasing understanding of the effectiveness of preventive interventions. As this knowledge base has developed, it has become clearer that allowing abuse and neglect to occur is unconscionable.

We have learned what children need to be healthy and how to support parents with formal and informal systems. In terms of economics, we know that an ounce of prevention really is worth a pound of cure; early investments in children and families yield significant returns. We know that Oklahomans see child abuse and neglect as a major social problem, but most feel they don't know what they can do to make a difference. It is time for all Oklahomans who care about the well-being of our children to rethink how we support children and their families. They are all working to combat child abuse. When mental health workers provide services to families, they are combating child maltreatment. When faith groups collect clothes, food, and toys for families, they are combating child maltreatment. When strangers smile at a fussy child in the store and show understanding for parents trying to complete their shopping, they are combating child maltreatment. Now, more than ever, Oklahoma needs to make a commitment to invest in prevention – to support strategies that have shown to be effective and to be open to new approaches that are effective in preventing child abuse and neglect.

Sincerely,

Lawrence L. Langley, J.D.

INTRODUCTION

The Oklahoma State Department of Health is pleased to submit this State Plan for the Prevention of Child Abuse and Neglect for the time period of July 1, 2010 through June 30, 2013. This State Plan is to serve as a practical tool in identifying the service needs of Oklahoma children and families, existing services across the state and collaborations directed towards Oklahoma's child abuse prevention efforts.

While it is true that Oklahoma is currently implementing some of the Nation's most researched and recognized early childhood and child abuse prevention programs, these programs do not always have adequate resources to meet the needs of families and children. In addition, there are several types of services that are extremely limited or do not exist within our state, such as parent leadership opportunities and sexual abuse prevention programs.

The past year has resulted in significant changes – some negative and some positive. To offset the recent economic downturn, the American Recovery and Reinvestment Act provided funds to states to help minimize job losses and cuts to many social service programs. While this effort has perhaps lessened the effects, state agencies and programs face difficult budget decisions while also dealing with increasing demands for services by struggling families.

On the other hand, there is a strong emphasis nationally on evidence-based and evidence-informed programs that support families in raising healthy, productive children. There are proposed increases in federal funding for childcare, child nutrition programs, and Head Start. Applications for a new federal home visitation grant are anticipated in the summer of 2010. States are being challenged to improve their education systems and prepare the future workforce.

While Oklahoma's challenges are great, the state has focused on implementing the best practices and models from across the nation. Careful planning and programming go hand-in-hand as the following examples illustrate:

1) Preparing for a Lifetime

The infant mortality rate, defined as the number of deaths to infants less than 1 year of age per 1,000 live births, is one of the most important indicators of the health of Oklahoma and the nation. It is associated with a number of factors such as maternal health, parenting practices and socioeconomic conditions.

The top three causes of infant mortality in Oklahoma are congenital defects, disorders related to low birth weight and short gestation and Sudden Infant Death Syndrome. Although child abuse and neglect may not be listed as one of the specific top three causes of infant death, some of the same positive parenting practices that often keep parents from being abusive or neglectful are the same behaviors that decrease the likelihood of a child dying during infancy from a variety of causes.

The Oklahoma State Department of Health Commissioner's Action Team on Reduction of Infant Mortality was convened in May 2007. It has expanded to engage state and community partners in a statewide initiative, "Preparing for a Lifetime, It's Everyone's Responsibility," with strategic planning, data analyses and targeted interventions. Example subject matters being addressed include breastfeeding, premature births, smoking during pregnancy, infant safe sleep practices and preventing infant injuries – many subject matters that overlap with child maltreatment prevention.

2) The Oklahoma Health Improvement Plan (OHIP)

The Oklahoma State Department of Health, along with its numerous partnering agencies and organizations, developed the Oklahoma Health Improvement Plan in 2009. Many key priorities and outcomes that will support health improvement throughout the state are outlined in the OHIP. The OHIP was mandated by the Oklahoma Legislature in 2008 by Senate Joint Resolution 41 and directed the State Board of Health to prepare a report that outlined a plan for the "general improvement of the physical, social and mental well being of all people in Oklahoma through a high-functioning public health system."

The OHIP addresses improving health outcomes in three targeted "flagship initiatives:" 1) child health, 2) tobacco use prevention, and 3) obesity reduction. The OHIP recognizes the critical need to increase the public health infrastructure's effectiveness and accountability. The OHIP also discusses approaches to addressing the social determinants of health – factors such as poverty, education, access to health services, housing and transportation – that often impact an individual's ability to stay healthy or be-

come ill. These flagship issues tie closely to the efforts of the prevention of child abuse. An example of the overlap between the OHIP and child abuse prevention is found in Oklahoma's home visiting programs. Home visitation programs provide education on a myriad of parenting and health-related topics as well as referrals that directly impact the flagship issues and the risk of child maltreatment. OHIP's focus on the physical, social and mental well-being of all Oklahomans complements this state plan and supports the continued efforts of the Interagency Child Abuse Prevention Task Force as well as its partners in preventing child abuse and neglect.

3) The Centers for Disease Control and Prevention Public Health Leadership Initiative

The Public Health Leadership Initiative is a three-year project focusing on identifying best practice models for the prevention of child abuse and neglect within state public health systems and the promotion of safe, stable and nurturing relationships (SSNRs) for children.[1] Oklahoma was chosen as one of only five states to receive further review as a case study for the rest of the nation because of our exemplary efforts.[2] Consultants with the CDC spent days in Oklahoma interviewing staff from a variety of agencies and programs about their participation in the child abuse prevention network. Oklahoma was noted for:

- having designated child abuse prevention staff;
- adopting a strategic plan for the prevention of child maltreatment;
- placing a high level of importance on child abuse prevention efforts within public health;
- providing public health leadership in the area of child abuse prevention;
- obtaining state, federal and private resources to fund child abuse prevention efforts;
- continuing evaluation and quality improvement efforts; and
- developing effective collaborations, particularly with the Maternal and Child Health Service (the federal Title V Program within the Oklahoma State Department of Health).

While Oklahoma is recognized for efforts in the area of child abuse prevention, there is much more to do in the field. It is time for to rethink our approach to the well-being of Oklahoma's children and families. The fundamental elements of successful families are safe, stable, nurturing relationships, financial stability, positive connections and

[1] *Promoting safe, stable and nurturing relationships is the Center for Disease Control and Prevention's strategic direction for the prevention of child maltreatment.*

[2] *Alaska, Florida, North Carolina, Minnesota*

opportunities. While all families have strengths, some have significant barriers that inhibit them from escaping their disadvantageous situations. Our responses to such families are often problem-oriented and narrow in focus. Instead, our approach must be multi-faceted. We must draw upon the family strengths as well as public and private services provided by competent and caring professionals and volunteers.

The findings are clear. Gains have been made, but they are limited. The job of preventing child maltreatment is not yet done.

The recently released issue brief titled "Child Abuse Prevention: A Job Half Done"[3] by acclaimed child abuse prevention researcher Deborah Daro, Ph.D., noted that although rates of child maltreatment have dropped since 1993, they remain substantially higher than those documented in 1980 and again in 1986. The report highlights that while sexual abuse, physical abuse and emotional abuse rates have dropped, no significant changes were documented in the rate of child neglect, the most common form of child maltreatment.

Key findings from the report include:

- The rate of children experiencing maltreatment is 75% higher than the rate observed in the 1980 national incidence study.
- Rates of emotional neglect, including children experiencing chronic or extreme spousal abuse, increased by 83% during this period.
- The incidence of cases in which a child was killed or suffered injury did not decline significantly.

Over the past 30 years, a myriad of changes have occurred in policy, economic and social landscapes to move child abuse and neglect numbers. During the 1980s, the focus was on preventing child maltreatment through public safety messages, trainings for professional staff and parenting resources. In essence, child maltreatment was about raising the awareness of child abuse. Businesses such as MasterCard, the National Basketball Association and Target all wanted to promote the issue. States established Children's Trust or Prevention Funds such as Oklahoma's Child Abuse Prevention Fund. New prevention ideas were being fostered and young professionals with a desire to work in the field were inspired.

The focus through the 1990's was on providing support to new parents. Most of the efforts concentrated on engaging mothers, particularly at the time they became pregnant or shortly after delivery of the child. Fostering a strong parent-child relationship during this period was recognized as foundational to a child's health and emotional development. Working with new parents seemed to be a

3Daro, D. (2010). Child Abuse Prevention: A Job Half Done. Chicago: Chapin Hall at the University of Chicago.

logical strategy because infants are particularly vulnerable and their safety and development is typically dependent upon their parents ability to care for them.

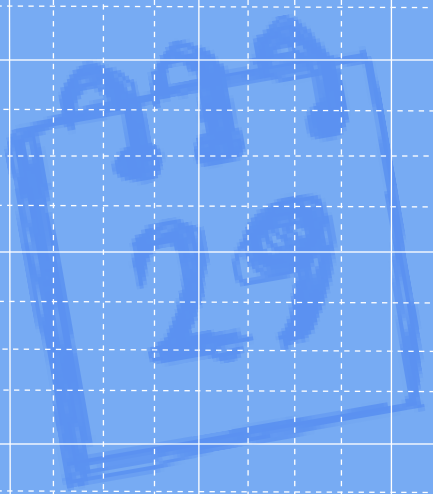
It is thought today that enlightened public policy and the replication of high-quality interventions are only a few of the strategies needed if the number of child abuse incidents is to be reduced. In addition, Daro suggests the following interventions also be considered:

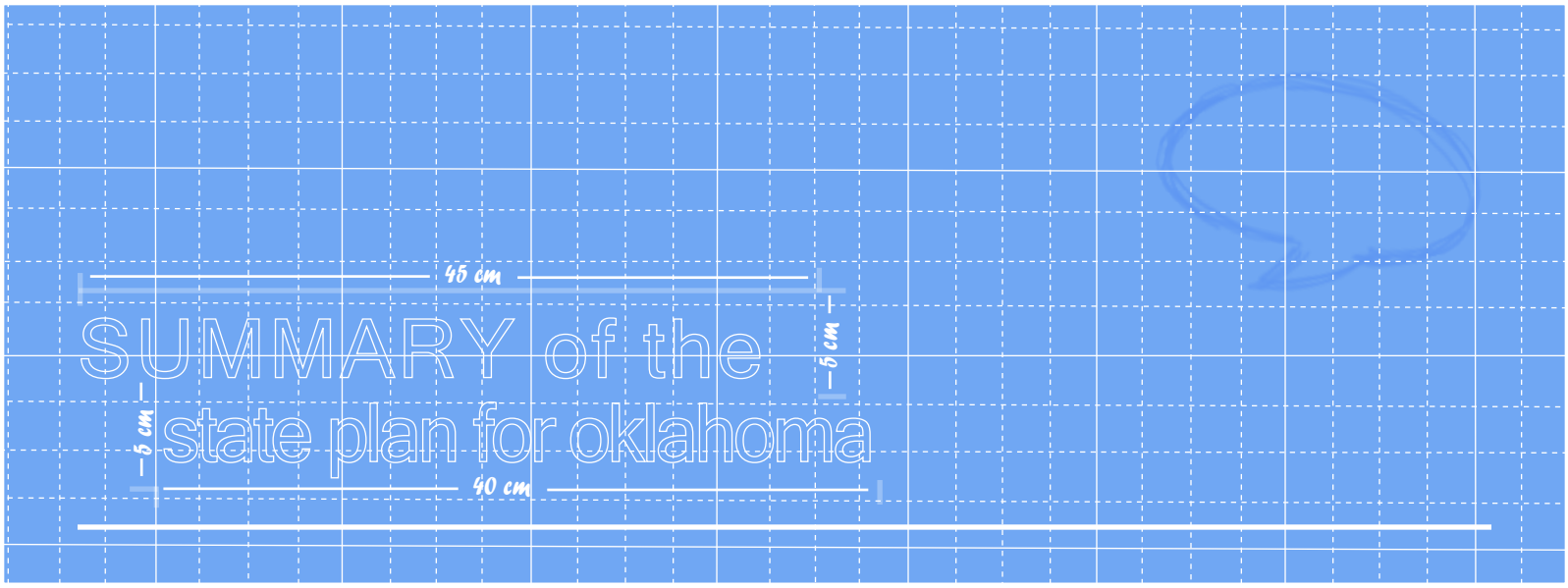
- Identification of specific parental behaviors or actions that need to change.
- Education of general populations about expected behaviors and actions toward children.
- Universal education for all new parents.
- Universal assessments of all new parents to determine parental capacity to provide for a child's safety.
- Linkages between families and services commensurate with the families' needs.
- Child welfare systems that: 1) have the capacity to work with parents to insure children's safety; and 2) will remove children in those cases in which parents are either unwilling or unable to care for their children.

Daro's issue brief concludes with this statement: "Until the problem is owned by all individuals and all communities, progress will be stymied and children will remain at risk."[4]

4Ibid.

executive SUMMARY





INFRASTRUCTURE

Goal 1: Increase the capacity, ownership and leadership within the child abuse prevention professional community.

Strategy 1: The OSDH and the Interagency Child Abuse Prevention Task Force (ITF) will work collaboratively, continuing to stay informed and grow in their knowledge of current best practice, policies and models that positively impact the field of child abuse prevention and enhance the landscape for Oklahoma's children.

Strategy 2: The OSDH and the ITF will collaborate and provide technical assistance and training to professionals in related fields that have the ability to impact child abuse prevention.

Goal 2: Establish a Parent Advisory/Leadership group.

Strategy 1: The OSDH and the ITF will research, seek and secure speakers, training opportunities, technical assistance and information on the importance of a parent advisory/leadership group, the process to creating such a group, and how best to collaborate with said group once that is achieved.

Strategy 2: The OSDH and the ITF will take the necessary steps to institutionalize and operationalize a parent advisory/leadership group.

Goal 3: Support the evaluation of child abuse prevention services and other social services provided to children and families.

Strategy 1: Assure that evaluations are conducted in an objective fashion and that evaluation results are distributed freely.

PRIMARY PREVENTION

Goal 4: Create a culture of change that values the health, safety and well-being of all children.

Strategy 1: The OSDH and the ITF will educate and mobilize communities to change community norms so that child abuse and neglect is viewed as preventable and unacceptable.

Strategy 2: The OSDH and the ITF will support the implementation of quality early childhood programs through the Oklahoma Department of Human Services, Smart Start Oklahoma, the Oklahoma Department of Education, and Head Start.

Strategy 3: The OSDH and the ITF will strive to assure the six Strengthening Families Protective Factors,[3] developed by Center for the Study of Social Policy, are integrated into all prevention programs serving children and families.

Strategy 4: The OSDH and the ITF will engage non-traditional partners to get involved in and support child abuse prevention efforts (i.e., business community, libraries, civic groups, etc.).

[3] *1) parental resilience; 2) social connections; 3) knowledge of parenting and child development; 4) concrete support in times of need; 5) social and emotional competence of children; and 6) healthy parent-child relationships.*

Goal 5: Assure that general parent education and family support is universally available across the state.

Strategy 1: The OSDH and the ITF will engage others to work collaboratively in seeking and implementing various vehicles for providing educational information to parents and caregivers to assist them in providing safe, stable and nurturing environments for children.

Strategy 2: The OSDH and the ITF will assist parents and caregivers in meeting the basic needs (sometimes called "concrete needs") of their family/children.

Goal 6: Implement strategies to prevent child sexual abuse.

Strategy 1: The OSDH and the ITF will work with partners across the state to implement programs that emphasize adult education and responsibility in keeping children safe from sexual predators.

Strategy 2: The OSDH and the ITF will put training in place to provide age-appropriate education to children about child sexual abuse.

SECONDARY PREVENTION

Goal 7: Identify best practices, programs and models that show evidence of improving child health, safety and well-being.

Strategy 1: The OSDH and the ITF will seek and provide to interested partners best practice and evidence-based/evidence informed models on a continual basis to assure quality services are provided and prevention dollars are well spent.

Strategy 2: The OSDH and the ITF will continue to redefine the components needed for the comprehensive system of prevention programs as the child abuse prevention field evolves.

Goal 8: Work towards the establishment of a comprehensive system of prevention programs available across the state to families with risk factors for child abuse and neglect.

Strategy 1: The OSDH and the ITF will work with partners across the state to increase the number and quality of center-based parent support groups and parent education programs.

Strategy 2: The OSDH and the ITF will work with partners across the state to increase the number and quality of home visitation services.

TERTIARY PREVENTION

Goal 9: Include in the comprehensive system, prevention programs focused on serving families identified by the child welfare, mental health, substance abuse, and/or domestic violence systems.

Strategy 1: The OSDH and the ITF will support the Oklahoma Department of Human Services, Child Welfare, as they continue to implement the new Practice Model and Standards emphasizing child safety.

Strategy 2: The OSDH and the ITF will provide support in increasing the number and quality of mental health services available to both adults and children.

Strategy 3: The OSDH and the ITF will provide support in increasing the number and quality of substance abuse treatment services for both adults and children.

Strategy 4: The OSDH and the ITF will provide support in increasing the number and quality of domestic violence services.

Strategy 5: The OSDH and the ITF will continue to explore the overlap between child abuse and domestic violence incidents and investigations, as well as best practices for prevention and intervention.

Goal 10: Promote and/or provide culturally appropriate services that maximize the participation of various cultural and ethnic populations.

Strategy 1: The OSDH and the ITF will seek and provide to interested partners best practice and evidence-based/evidence informed models on a continual basis to assure appropriate services are available to culturally diverse populations.

Strategy 2: The OSDH and the ITF will continue to redefine the components needed for the comprehensive system as child abuse prevention programs' populations evolve.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understanding
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PREVENTION
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Child Abuse Prevention

A general definition for prevention is "an action that stops something from happening." Child abuse prevention programs provide support to families and reduce the likelihood of poor outcomes. These services mitigate risks such as domestic violence, substance abuse, mental illness and poverty while boosting known protective factors such as social connections, knowledge of effective parenting, and access to support in times of need.[1] This balance of risk and protective factors influences the likelihood that a parent will harm his or her child.

Often we hear of prevention occurring at different levels. Oklahoma statutes,[2] as well as child abuse prevention leaders such as the Centers for Disease and Prevention (CDC), have defined or categorized child maltreatment into three distinct levels:

Primary Prevention (Universal): focuses on strategies for the general public; raises public awareness about child maltreatment; and implements policies that protect, reduce risk factors and enhance protective factors for families. Primary prevention as outlined in Oklahoma statutes means programs and services designed to promote the general welfare of children and families.

Examples include: public advertising campaigns, parenting education accessible to all, a parent warmline, and parenting resources on websites.

Secondary Prevention (Selected): targets families with risk factors for abuse and neglect through early identification; provides an intervention to stop the problem from occurring. Oklahoma statutes define secondary prevention as the identification of children who are in circumstances where there is a high risk that abuse will occur; and assistance, as necessary and appropriate, to prevent abuse or neglect from occurring.

Examples include: home visitation programs for families that meet certain eligibility criteria and respite services for families that are overly stressed or on the verge of a crisis.

Tertiary Prevention (Indicated): encompasses treatment for families who have been identified as abusive or ne-

[1] *Protective Factors Literature Review: Early Care and Education Program and the Prevention of Child Abuse and Neglect. Carole Horton, CSSP 2003.*
[2] *Title 63 Oklahoma Statute Section 1- 227.1.*

glectful. Oklahoma statutes define such services as those provided after abuse or neglect has occurred, which are designed to prevent the recurrence of abuse or neglect.

Examples include: services to parents reported to DHS, but not court involved (known as alternative or differential response services), or therapy for traumatized children.

What is the social-ecologic model?

The field of public health also provides a framework for the prevention of child maltreatment commonly known as the "Social-Ecologic Model." This framework ranges from the individual to the societal level. In order to prevent child maltreatment, various strategies ranging from working directly with the family to broader public awareness activities must be utilized.[3]

The factors that put families at risk of abuse and neglect are well known, and our state and local systems have the potential to bring about family and community well-being by supporting and strengthening families. Prevention strategies, at all levels, have been proven to enable families and communities to reduce the likelihood of abuse and neglect.

Individual Level: A number of factors determine an individual's parenting style including some combination of developmental history, personality factors, social interactions or social networks, familial relationships, and the child's characteristics.[4] Parents draw on their experiences within their family, support and advice from friends, and information and services available in making decisions on how to parent.

In addition to these common factors, prevention efforts have been found to produce significant and substantial impacts on parenting behavior, child health and well being.[5] By initiating parent education programs at birth or earlier, these interventions are in a position to help shape these early parent-child interactions. Although the field is relatively young, several prevention models and programs have been evaluated for their effectiveness. For example, CDC behavioral scientists have conducted a meta-analysis of current research literature on parent education to identify components associated with more effective and less effective programs.[6]

[3] *PREVENT Institute, The University of North Caroline, Injury Prevention Research Center*
[4] *Belsky & Vondra, 1990; Sameroff & Chandler, 1975 and Sander, 1979.*
[5] *Ramey and Ramey 1998.*
[6] *"Parent Training Programs: Insights for Practitioners," United States Department of Health & Human Services, Centers for Disease Control and Prevention 2009.*

The consequences of not educating or assisting parents can be highly negative for children. The Adverse Childhood Experiences Study (ACE Study)[7] provides insight into how childhood experiences evolve into risky behaviors, which in turn, often evolve into disease and death. Child maltreatment leaves children vulnerable, actually disrupting the normal development of the brain. The ACE Study suggests that children and adolescents adopt risky behaviors as a means of coping with or covering their pain. The more trauma they experience, the greater the likelihood of adopting multiple risk behaviors such as alcohol or drug abuse, smoking, overeating and promiscuity.[8] Some of these behaviors may very well be carried into adulthood.

[7] *ACE Issue Brief 2: Child Maltreatment; Oklahoma KIDS COUNT Factbook, 2006-2007; Issue Brief 2 of 5.*
[8] *Ibid.*

Interpersonal/Family Level: Children most often live within families. Knowing that abuse and neglect typically occur within families, strengthening and supporting families through specific strategies that increase positive outcomes for families makes sense. Most recently, the field of prevention has incorporated the elements, principles and practices of the family support approach.[9] Oklahoma must focus on family strengths, increase knowledge/skills of parenting and child development, and connect families to their communities – all leading to stronger, safer and healthier families. It is recognized that families are responsible for the well-being of their children. It is recognized, too, that all families need additional support from time to time – formal or informal.

One of the most highly touted prevention efforts that addresses the needs of families is the "Strengthening Families through Early Care & Education" Initiative from the Center for the Study of Social Policies (CSSP).[10] Many states, including Oklahoma, are striving to promote the "Five Protective Factors" identified within exemplary family support programs across the country. These Protective Factors can be implemented within a variety of settings including, but not limited to, child care, social services and child welfare. The Protective Factors are:

Parental resilience: the ability to cope and bounce back from all types of challenges;

Social connections: friends, family members, neighbors and other members of a community who provide emotional support and concrete assistance to parents;

[9] *Family Strengthening Writ Large: On Becoming a Nation that Promotes Strong Families and Successful Youth. National Human Services Assembly. December 2007.*
[10] *http://www.cssp.org/*

Knowledge of parenting and child development: accurate information about raising young children and appropriate expectations for their behavior;

Concrete support in times of need: financial security to cover day-to-day expenses and unexpected costs that come up from time to time, access to formal supports like TANF and Medicaid and informal support from local social services; and

Nurturing and attachment: a child's early experiences of being nurtured and developing a bond with a caring adult.

Community/Organization Level: Children need their communities to understand the factors that lead to abuse and neglect. Broad-based partnerships, working across systems, are necessary to create lasting change in how communities think about prevention and support families. Working together provides greater opportunities to identify strategies for ensuring that all parents in a community have the skills, supports and resources needed to competently and lovingly care for their children.

The ordinary citizen also has a critical role to play in the community of family support and child abuse prevention. Oklahoma is fortunate to have a mandatory reporting law. Many citizens understand they have a duty to report child abuse and neglect once it has occurred. However, an unfortunate by-product of our reporting system may be that individuals believe this is the only way they can intervene in a child or family's life. There are programs designed to create supportive, caring communities such as the "Creating Parenting-Rich Communities Initiative" from the Child Welfare League of America and "The Front Porch Project" promoted by the American Humane Association. Programs such as these should be explored for Oklahoma.

Society/Culture Level: Many lessons can be learned from other public health initiatives when attempting to engage the public at large. Initiatives to reduce tobacco use or increase seatbelt use have been effective by working in two arenas:

1) enacting or modifying laws, policies and regulations; and

2) educating the masses through social marketing campaigns.

A variety of prevention efforts have been mandated by state legislation. One example would be the laws passed in New York, Minnesota and Massachusetts that require Abusive Head Trauma (previously known as Shaken Baby Syndrome) training for parents and/or child care providers in order to reduce the number of injured babies.

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child abuse & neglect:

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THE PROBLEM

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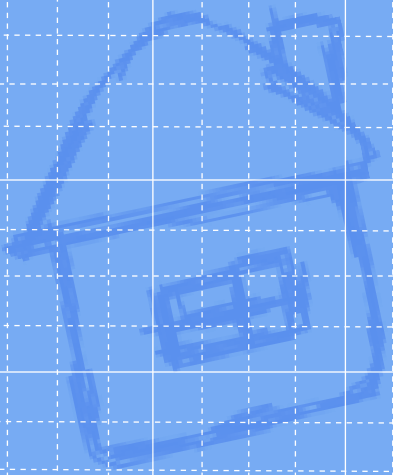
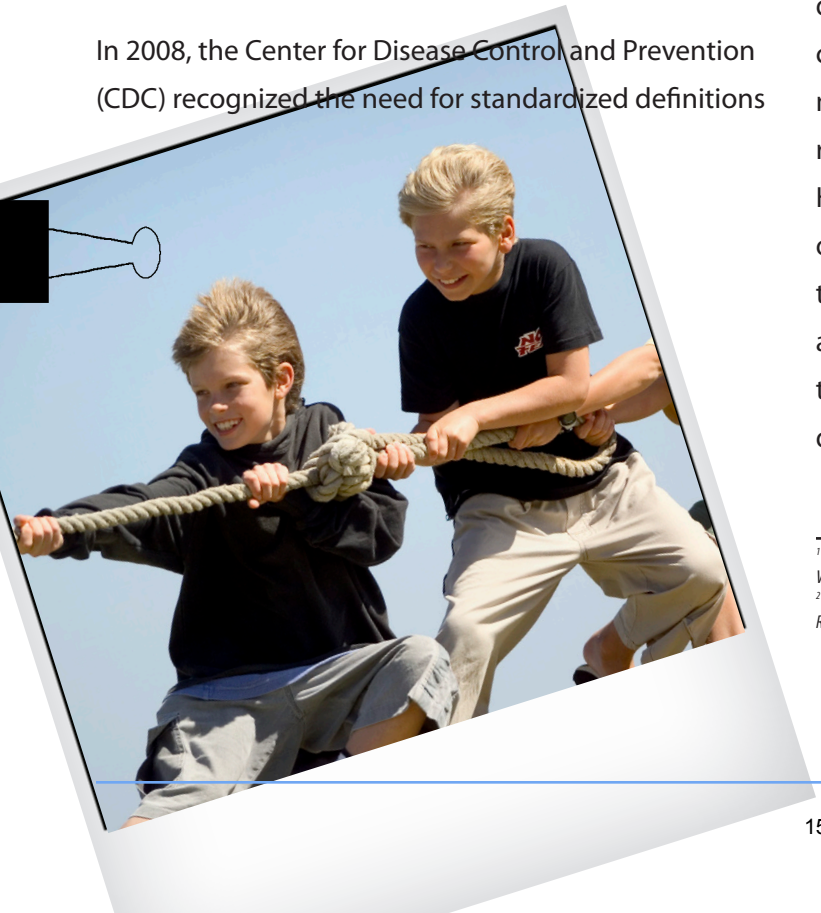


ABUSE & NEGLECT
the problem in oklahoma

There appears to be no single, consistent definition for child abuse and neglect in the United States. The federal Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003, sets a minimum standard for child abuse and neglect, which is "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."

In 2008, the Center for Disease Control and Prevention (CDC) recognized the need for standardized definitions and offered suggestions for five categories in a report.[1] Most states are fairly consistent with the CDC definitions – at least in a general sense. However, states are allowed to develop their own definitions and the details in the definitions vary widely. Differences in how states define maltreatment, as well as the manner in which states handle reports of maltreatment, make it difficult to compare state maltreatment rates.



Oklahoma's statutes defining child abuse and neglect are quite broad. Certain types of incidents or deaths may be categorized as abuse and/or neglect in Oklahoma, but may not be in other states. In addition, Oklahoma's statute requires all citizens to notify the Oklahoma Department of Human Services when they believe a child is being harmed or is threatened with harm.[2] These reasons, coupled with the high number of Oklahoma families with risk factors associated with abuse and neglect, often cause Oklahoma to rank poorly in the areas of child abuse and neglect incidents, removals from homes and child deaths.

[1] *R.T. Leeb and others, Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0 (Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2008).*

[2] *2 10A O.S. Section 1-2-101: Duty to Report Abuse or Neglect of Child Under Eighteen-Statewide Centralized Hotline-Failure to Report-False Reports*

Prevalence of Child Abuse and Neglect in Oklahoma

The Oklahoma Department of Human Services (OKDHS) received 64,293 reports of abuse in State Fiscal Year 2009. Of those, 31,224 reports were investigated or assessed for child maltreatment and 8,555 children were confirmed as victims. In Oklahoma, even with the economic downturn, child abuse and neglect rates appear to be on the decline for the third year in a row. More than 6,000 less children were alleged to be victims of child abuse and neglect in SFY 2009 as compared to SFY 2008.[3]

[3] *Oklahoma Department of Human Services; Oklahoma Child Welfare Overview; Child Health Panel Meeting; April 28, 2010. Number of children reported in SFY 2008: 114,688. Number of children reported in SFY 2009: 108,511.*

The distribution of maltreatment rates has not changed much over the years. However, it is important to note that typically more than 80% of all confirmations involve neglect. Neglect is the most common form of maltreatment in Oklahoma and in the Nation.

Neglect

Because neglect is the most common reason for a person to make a report to OKDHS, it is important to know the actual causes that are included in the category of neglect. During SFY 2009, the category of "threat of harm" (19.69%) surpassed the category of "substance abuse by a caretaker" (19.27%) as the leading cause for a neglect report. "Failure to protect" and "exposure to domestic violence" were the next leading causes.

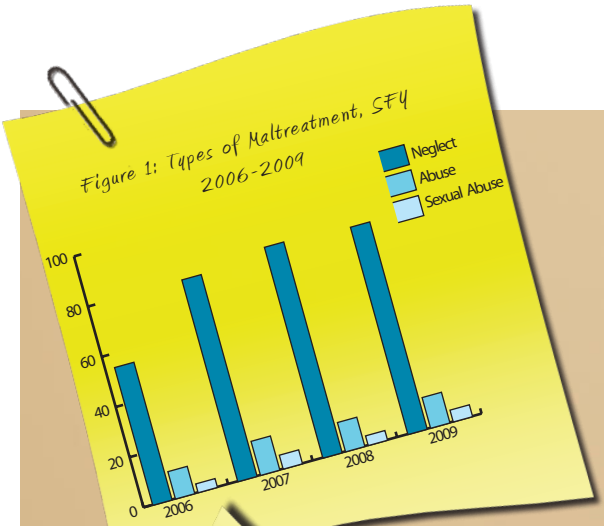


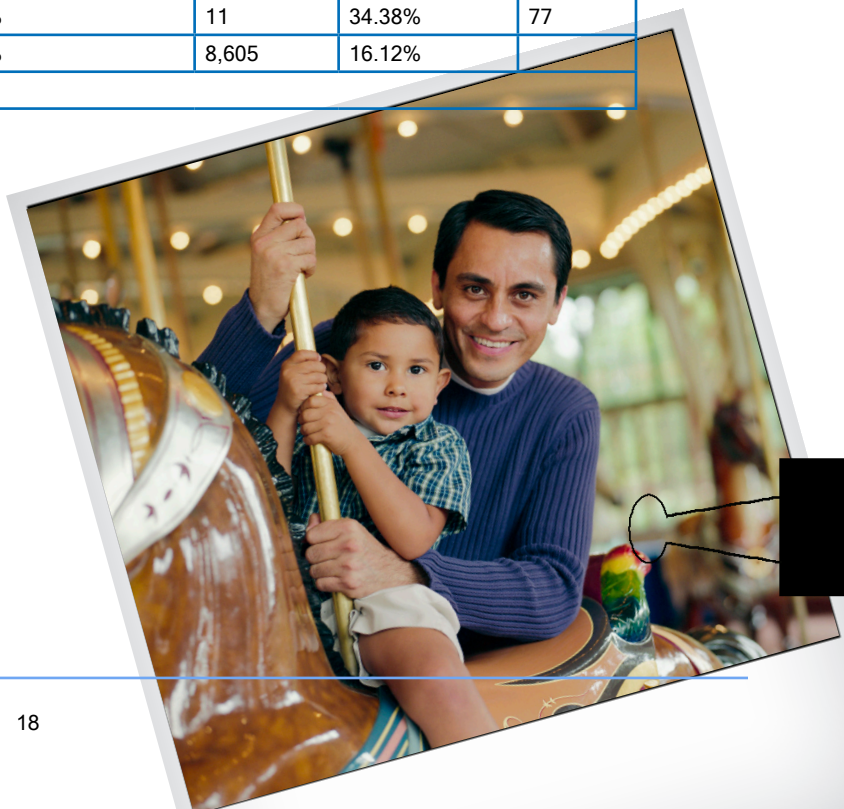
Table 2: Reasons for Maltreatment Confirmation Findings

	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Leading Cause	Sustance Abuse by Caretaker (20.01%)	Threat of Harm (20.30%)	Substance Abuse by Caretaker (19.17%)	Threat of Harm (19.69%)
Second Leading Cause	Threat of Harm (16.97%)	Substance Abuse by Caretaker (19.15%)	Threat of Harm (18.90%)	Substance Abuse by Caretaker (19.27%)
Third Leading Cause	Failure to Protect (16.50%)	Failure to Protect (18.32%)	Failure to Protect (17.77%)	Failure to Protect (18.96%)
Fourth Leading Cause	Exposure to Domestic Violence (11.33%)	Exposure to Domestic Violence (9.49%)	Exposure to Domestic Violence (9.52%)	Exposure to Domestic Violence (9.32%)
Fifth Leading Cause	Inadequate or Dangerous Shelter (9.37%)	Lack of Supervision (8.10%)	Inadequate or Dangerous Shelter (9.20%)	Inadequate or Dangerous Shelter (7.82%)

Table 1: OKDHS 2009 Child Abuse and Neglect Reports, Assessments and Investigations, and Confirmations

County	Reports	Assessed or Investigated	Percent of Reports Assessed or Investigated	Confirmed	Confirmation Rate	Rank
Major	132	93	70%	0	0.00%	1
Kiowa	214	128	60%	5	3.91%	2
Love	171	137	80%	6	4.38%	3
Ellis	48	40	83%	2	5.00%	4
Ottawa	777	630	81%	43	6.83%	5
Jefferson	123	101	82%	7	6.93%	6
Washita	206	176	85%	13	7.39%	7
Choctaw	357	612	171%	48	7.84%	8
Kingfisher	133	136	102%	11	8.09%	9
Haskell	244	207	85%	17	8.21%	10
Alfalfa	67	72	107%	6	8.33%	11
Washington	1,338	825	62%	71	8.61%	12
Noble	160	89	56%	8	8.99%	13
Cleveland	3,412	2,225	65%	203	9.12%	14
Marshall	382	259	68%	24	9.27%	15
Coal	196	205	105%	19	9.27%	16
Lincoln	551	490	89%	46	9.39%	17
Okmulgee	738	592	80%	56	9.46%	18
Wagoner	816	826	101%	79	9.56%	19
Murray	226	182	81%	18	9.89%	20
Craig	338	264	78%	27	10.23%	21
Nowata	170	178	105%	20	11.24%	22
Sequoyah	669	584	87%	66	11.30%	23
Comanche	1,717	1,681	98%	194	11.54%	24
Cherokee	839	641	76%	74	11.54%	25
Creek	1,093	861	79%	107	12.43%	26
Pushmataha	280	193	69%	24	12.44%	27
Carter	1,207	825	68%	106	12.85%	28
Grady	863	539	62%	70	12.99%	29
Beaer	59	60	102%	8	13.33%	30
LeFlore	827	743	90%	100	13.46%	31
Atoka	352	371	105%	50	13.48%	32
Logan	581	444	76%	60	13.51%	33
Seminole	623	531	85%	72	13.56%	34
Cimarron	28	22	79%	3	13.64%	35
Delaware	737	744	101%	102	13.71%	36
Osage	650	493	76%	68	13.79%	37
Blaine	285	239	84%	34	14.23%	38
Garfield	1,182	787	67%	116	14.74%	39
Hughes	376	286	76%	43	15.03%	40
Pontotoc	746	528	71%	80	15.15%	41
Jackson	734	613	84%	94	15.33%	42
Kay	1,078	780	72%	120	15.38%	43
Woodward	367	342	93%	53	15.50%	44
Greer	155	148	95%	23	15.54%	45
Texas	196	159	81%	25	15.72%	46

County	Reports	Assessed or Investigated	Percent of Reports Assessed or Investigated	Confirmed	Confirmation Rate	Rank
Pottawatomie	1,567	1,152	74%	183	15.89%	47
Bryan	1,029	1,010	98%	161	15.94%	48
Caddo	611	506	83%	81	16.01%	49
(The counties below this line have a confirmation rate above the state average. State Average = 16.12%)						
Stephens	939	710	76%	115	16.20%	50
Cotton	121	123	102%	20	16.26%	51
Payne	1,413	637	45%	105	16.48%	52
Latimer	206	248	120%	42	16.94%	53
Custer	488	385	79%	66	17.14%	54
Woods	166	134	81%	23	17.16%	55
Pawnee	342	203	59%	35	17.24%	56
Rogers	933	886	95%	154	17.38%	57
Okfuskee	207	168	81%	30	17.86%	58
Garvin	600	411	69%	74	18.00%	59
Adair	580	515	89%	94	18.25%	60
Pittsburg	1,106	1,066	96%	197	18.48%	61
Tulsa	8,787	6,583	75%	1,248	18.96%	62
Canadian	1,582	1,691	107%	322	19.04%	63
Oklahoma	12,065	12,072	100%	2,334	19.33%	64
McCurtain	753	684	91%	135	19.74%	65
McClain	437	313	72%	63	20.13%	66
Johnston	236	231	98%	47	20.35%	67
Beckham	661	563	85%	116	20.60%	68
Muskogee	1,688	1,486	88%	323	21.74%	69
Grant	38	27	71%	6	22.22%	70
McIntosh	317	252	79%	60	23.81%	71
Dewey	44	4	9%	1	25.00%	72
Tillman	164	89	54%	23	25.84%	73
Mayes	619	371	60%	98	26.42%	74
Harmon	56	37	66%	10	27.03%	75
Harper	41	25	61%	7	28.00%	76
Roger Mills	54	32	59%	11	34.38%	77
State Totals	64,293	53,394	83%	8,605	16.12%	
*all figures provide a duplicated count of children.						



Reporters

Law enforcement has been the most frequent reporting source of child maltreatment over the four most recent years (21% - 24% of all reporters). Social workers and/or public social agencies are the next leading reporting source (15% - 18% of all reporters). Interestingly, neighbors, physicians and childcare providers make up a small percentage of reporters in any given year – typically less than 2.5% each

Child Abuse and Neglect Victims

During SFY 2009, abuse and neglect of Oklahoma boys and girls occurred almost equally (boys=48.69% and girls=51.31%). The most common age of victims is 3-6 years old (27.23%) followed by 7-11 year olds (21.88%), children under one year old (17.34%), children 1-2 years old (17.20%), and finally children over 12 years old represent (16.26%) of victims. The majority of child victims were white (65.13%), African American (17.93%), American Indian (16.37%), Asian (0.44%), and "unable to determine" (0.13%). These proportions have remained fairly constant over recent years.

Child Abuse and Neglect Perpetrators

During SFY 2009, women were more often named as perpetrators of abuse and neglect of children than men (54.58% : 45.42%). Among the perpetrators, the mother of the child was confirmed in 44.19% of all abuse and neglect cases. The father was found to be the perpetrator in 29.53% of cases. The remaining 26% was made up of stepparents, grandparents, foster parents, adoptive parents, and other relatives, live in friends, child care providers, and teachers. Perpetrator statistics have remained fairly static over the past five years. The largest proportion of perpetrators is over 31 years of age (48.73%), followed by 26-30 year olds (25.26%), 22 -25 year olds (16.92%) and under 21 year olds (9.09%). The majority of perpetrators are white (70.69%), followed by African Americans (16.75%), American Indians (11.54%), Asians (0.68%) and "unable to determine" (0.33%).

Table 2: Child Deaths

	SFY 2005	SFY 2006	SFY 2007
Number of Deaths	40	32	39
Caused by Neglect	72.5%	59.37%	56.41%
Caused by Abuse	10.0%	18.75%	28.21%
Caused by Neglect and Abuse	17.5%	21.88%	15.38%
Victims Under Two Years of Age	75.46%	78.12%	69.23%
Boys	50.0%	65.62%	58.97%
Girls	50%	34.38%	41.03%
White	45.0%	71.87%	53.85%
Black/African American	15.0%	12.5%	20.51%
American Indian/Alaskan Islander	0.0%	3.13%	0.0%
Hispanic	2.5%	9.37%	10.26%
Native Hawaiian/Pacific Islander	0.00%	3.13%	0.00%
Mother as Perpetrator	56.67%	54.16%	40.3%
Father as Perpetrator	30.0%	29.17%	38.6%
Leading Cause of Death	Drowning	Drowning	Drowning
Second Leading Cause of Death	Head Trauma	Hyper-thermia	Unsafe Sleeping Arrange-ments / Asphyxia-tion
Third Leading Cause of Death	Environ-mental Neglect	Head Trauma	Gunshot

Child Deaths in Oklahoma, SFY 2007

In SFY 2007, OKDHS data shows 39 children died in Oklahoma in 2007 due to child abuse and/or neglect. The most current data on child deaths in Oklahoma due to abuse and neglect is from SFY 2007.

The most common age of children that died from abuse or neglect in Oklahoma in SFY 2007 were children under 1 year old, followed by children age 1-2 years. In aggregate, newborns to two year olds represent 69.23% of Oklahoma child deaths from abuse and or neglect.

The leading cause of death among children in Oklahoma in 2007 was a tie between head trauma and improper sleeping arrangements resulting in asphyxiation (each=17.95%). In 2007, the largest proportion of child deaths were due to neglect (53.13%), followed by abuse (28.12%), and finally abuse and neglect combined (18.75%). Over the last three years of child death reports, death due to neglect is declining while death due to abuse or both abuse and neglect is on the rise.

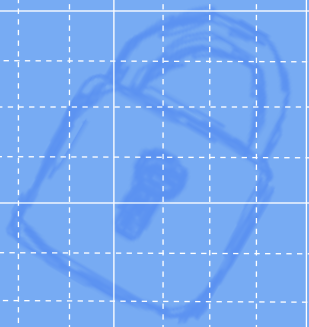
During SFY 2007, the perpetrators of Oklahoma child deaths were the biological mother (56.67%), biological father (30%), and others including a male live in friend, step father, foster mother, grandmother and child care provider (14%).

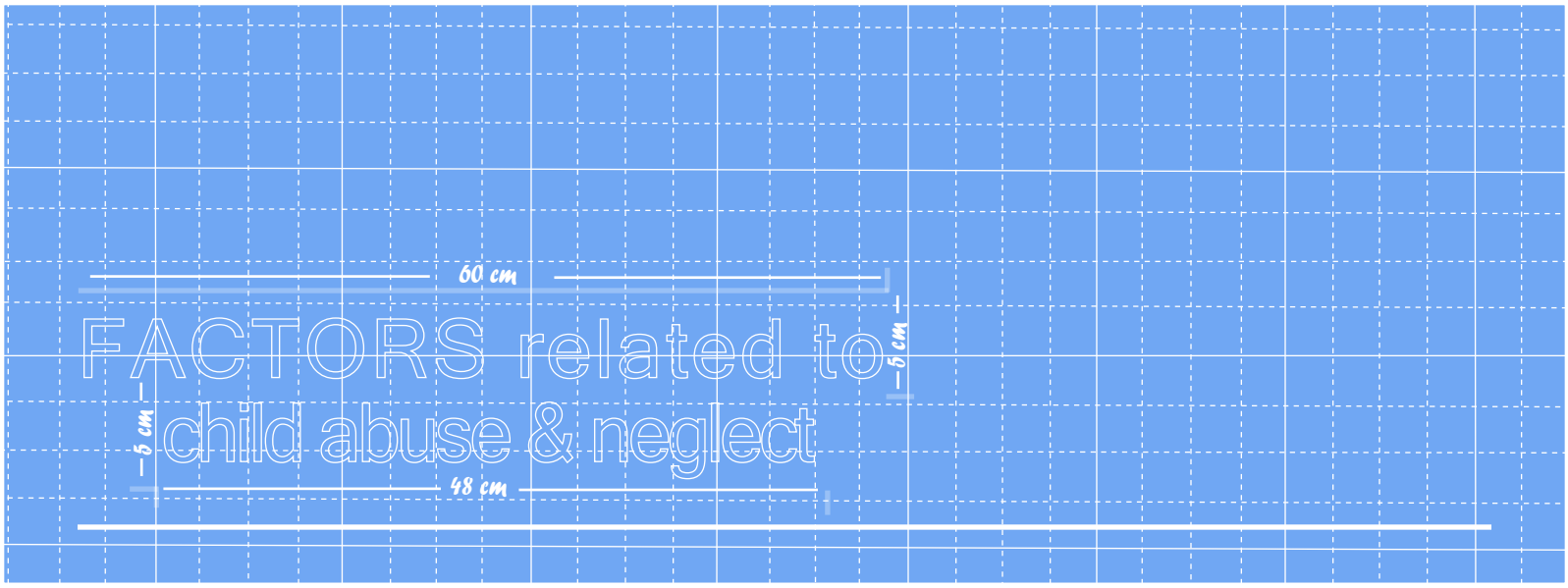
Child Near Deaths in Oklahoma, SFY 2007

In 2007, there were 32 near-death confirmations for Oklahoma Children. The greatest number of near-deaths was in the under-one-year-old category (15 confirmations, 46.88%). One to two year olds represented 28.13% of these near-death incidents (9 children). Together, this means that 75% of all near deaths were to children under age two. Among the 32 near deaths in 2007, neglect accounted for 53.1%, abuse contributed to 28% and both abuse and neglect was 18.75%. Over the last three years, child near deaths due to neglect have been variable. Near deaths due to abuse appear to be increasing.

Table 2: Child Near Deaths			
	SFY 2005	SFY 2006	SFY 2007
Number of Near Deaths	37	30	32
Caused by Neglect	56.76%	36.67%	53.13%
Caused by Abuse	13.51%	20.00%	28.12%
Caused by Neglect and Abuse	29.73%	43.33%	18.75%
Victims Under Two Years of Age	72.97%	80.00%	75.01%
Boys	56.76%	53.33%	65.62%
Girls	43.24%	46.67%	34.38%
White	54.05%	50.00%	40.62%
Black/African American	21.62%	6.67%	25.00%
American Indian/Alaskan Islander	10.81%	23.33%	18.75%
Hispanic	13.51%	20.00%	12.5%
Native Hawaiian/Pacific Islander	0.00%	0.00%	3.13%
Mother as Perpetrator	50.79%	47.84%	52.18%
Father as Perpetrator	31.75%	30.44%	34.79%
Leading Cause of Death	Head Trauma	Head Trama	Head Trauma
Second Leading Cause of Death	Vehicular Accident - Substance Abuse	Shaken Impact	Medical Neglect
Third Leading Cause of Death	Medical Neglect	Medical Neglect	Near Drowning

FACTORS related to child abuse & neglect





Factors Related to Child Abuse & Neglect

Adveriose Childhood Experiences Linked to Unhealthy Behaviors

Child advocates have known for decades that children who suffer from abuse and neglect are more prone to a myriad of emotional and developmental challenges than those who do not. However, The Adverse Childhood Experience Study now adds an additional element to this mix: a direct correlation between the traumas and maltreatment suffered in childhood with unhealthy behaviors by adults that is believed to ultimately lead to poor adult health status.

The ACE Study originated from the observations of Dr. Vincent Felitti while he was conducting a weight loss program at Kaiser Permanente. He noticed that some of the patients who were most successful at losing weight were dropping out of the program. In follow-up interviews, he made a series of startling discoveries: child sexual abuse was very common among these patients and typically preceded the onset of their obesity. Dr. Felitti reported that for many of these patients, obesity was not simply a problem, but rather a protective mechanism for dealing with a history they could not discuss.

The ACE Study affirmed the long-held belief that risk factors do not occur in isolation. They often are interrelated and appear in clusters. The study draws an unsettling connection between ACEs and a myriad of risky adult behaviors (i.e., smoking, obesity, alcoholism, substance, abuse, etc.). The greater the number of harmful experiences suffered by a child, the higher the likelihood the child will adopt one or several of these risky behaviors later in adulthood as a means to cope with pain.

For years, the public health system has attempted to reduce negative behaviors by asking people to simply change those behaviors. These efforts have been successful with people who took up a risky habit for social reasons. However, the ACE Study suggests that for some people, smoking or overeating is a form of self-medication. Efforts to reduce their consumption will not be successful without first understanding and intervening with the underlying reasons for their behavior.

Traumatic Childhood Connected to Adult Physical Health

The Centers for Disease Control and Prevention have found that adults who experienced considerable trauma during childhood were more likely to have poor health and die prematurely.

The CDC's study was one of many utilizing data from the Adverse Childhood Experiences Study. The study involved over 17,000 adults, members of the Kaiser Permanente health care system, who completed a voluntary questionnaire about 10 types of "adverse childhood experiences" (aka childhood traumas). Adverse childhood experiences included:

- Three types of abuse (sexual, physical and emotional);
- Two types of neglect (physical and emotional); and
- Five types of family dysfunction (having a mother who was treated violently, a household member who was a substance abuser, was imprisoned, diagnosed with mental illness or parents who were separated or divorced).

Researchers found three significant findings:

1) Adverse childhood experiences are common; 64% of the study participants had experienced one or more types of trauma listed on the questionnaire.

2) There is a strong link between adverse childhood experiences and adult onset of chronic illness. Those with ACE scores of 4 or more had significantly higher rates of heart disease and diabetes than those with ACE scores of zero. The likelihood of chronic pulmonary lung disease increased 390%, hepatitis 240%, depression 460%, and suicide 1,220%.

3) Study participants with six or more ACEs died nearly 20 years earlier on average than those without any ACEs – 60.6 years versus 79.1 years.[11]

[11] *In this particular analysis, "neglect" ACE scores were not included.*

In a separate study, Audrey Tyrka and her colleagues from Butler Hospital and Brown University found that child abuse possibly causes children to show signs of age more quickly. Tyrka examined the DNA of adults that appeared to be healthy. Some of these apparently healthy adults had a history of childhood maltreatment. She discovered that those with maltreatment histories had shorter telomeres – a region of repetitive DNA at the end of the chromosome indicating greater deterioration – than those who did not experience child maltreatment.

Telomere length is a measure of biological aging because telomeres shorten progressively with each cell division. Shorter telomere lengths have been linked to a variety of aging-related medical conditions including cardiovascular disease and cancer. Tyrka further concludes "early developmental experiences may have profound effects on biology that can influence cellular mechanisms at a very basic level.[12]

Impact of Poverty on Family Economic Success and Stability

In 2008, 23% of Oklahoma children lived in poverty with 83,000 of those children living in extreme poverty.[13] Poverty impacts many, if not all, aspects of family life. Economic disadvantage is often associated with the struggle for survival, unemployment, underemployment, low wages, substandard housing, unreliable transportation, "emergency only" health care, and a chronic shortage of food and necessities with no reserves.

According to a recent Harvard report, "It constrains parents' ability to provide rich learning opportunities for their children and often forces parents to choose among lower-quality child care, which we know can compromise the relationships children need for healthy development. It can mean growing up in a neighborhood that's more dangerous and lacks the kind of community resources to which more affluent families have access. It can mean the burden of overtime work, multiple jobs, or a split-shift job that limits parents' interaction time with their children. It can lead parents to be one event or one sick child away from losing their job."[14]

The current national economic downturn has left many families in financial situations that are unexpected, deteriorating and, perhaps, even dire. An increasing number of families have experienced job loss. There has also been an increase in the number of foreclosures which typically leaves families with limited and inadequate options for housing. Debt, especially credit card debt, continues to grow. When families try to relieve the financial pressure by borrowing from local money lenders at high rates of interest, the result can be even greater financial challenges that become difficult to overcome.

The pressure of financial inadequacies can negatively affect the level of stress families experience. Feelings of distress, depression, and anger often impact marital and parenting relationships. Stress and conflict are associated with "parenting practices that tend to be more punitive, harsh, inconsistent, and detached as well as less nurturing, stimulating, and responsible to children's needs."[15] When the stress reaches toxic levels, parents are not able to

[12] *"Childhood Maltreatment and Telomere Shortening: Preliminary Support for an Effect of Early Stress on Cellular Aging. Biological Psychiatry, Volume 67, Issue 6 (March 15, 2010) Tyrka, A., Price, L., Kao, H., Porton, B, Marsella, S., Carpenter, L.*

[13] *National KIDS COUNT Program. The Annie E. Casey Foundation. KIDS COUNT Data Center Online Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2008 American Community Survey*

[14] *Harvard University, Center on the Developing Child. The long reach of early childhood poverty: Pathways and Impacts. Q & A with Drs. Greg Duncan, Katherine Magnuson, Tom Boyce and Jack Shonkoff. National Scientific Council on the Developing Child. National Forum on Early Childhood Policy and Programs www.developingchild.harvard.edu*

[15] *Harvard University, Center on the Developing Child. The long reach of early childhood poverty: Pathways and Impacts. Q & A with Drs. Greg Duncan, Katherine Magnuson, Tom Boyce and Jack Shonkoff. National Scientific Council on the Developing Child. National Forum on Early Childhood Policy and Programs www.developingchild.harvard.edu*

provide the experiences their children need for healthy brain development. Excessively stressful conditions early in childhood may compromise the development of brain architecture and circuitry which can have a lifelong impact on future learning ability.

Low socioeconomic status has been identified as a risk factor associated with parents who abuse and/or neglect their children. Childhood history of maltreatment has also been linked to poverty in adulthood. "Adults who were physically abused, sexually abused, or severely neglected as children were significantly more likely to be unemployed, living below the poverty line, and using social services than people without a history of maltreatment. "[16]

Poverty is a complex, multifaceted, and challenging issue. It is evident that children who grow up in an environment that is economically disadvantaged are more likely to experience undesirable outcomes in areas such as brain development, family stability and both physical and mental health. It is vital that policies be developed and services be provided to help ensure that all children have the opportunity to become productive members of our society.

[16] *Zielinski, D.S. Child maltreatment and adult socioeconomic well-being. Child Abuse Neglect. 2009 October 5. [Epub ahead of print] PubMed PMID:: 19811826*

Brain Development and Toxic Stress in Children

The science of brain development has identified the beginning of life, both prenatally and throughout early childhood, as the brain's most rapid period of development. During early childhood, the brain forms either a strong or weak foundation for future learning, health and behavior. This foundation, or architecture, is powerfully impacted by the influence of external experiences within the environment, positive and negative.

Adverse childhood events such as recurrent child abuse or neglect, severe maternal depression, parental substance abuse, and/or family violence can result in the production of 'toxic stress' in children. Research on the biology of stress indicates that major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body's stress response system on high alert. Toxic stress experienced early in life can have a lifelong impact on an individual's physical and mental health. "When early experiences are fraught with threat, uncertainty, neglect, or abuse, stress management systems are overactivated, and the consequences can include disruptions of developing brain circuitry as well as the establishment of a short fuse for subsequent activation of the stress response that leads to greater vulnerability to a host of chronic diseases."[17]

Advances in neuroscience indicate that services to reduce the impact of toxic stress must include relationship-based interventions. Babies and toddlers require dependable,

[17] *Shonkoff, Jack P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. Child Development,81, 359.*

stable, and caring interaction with nurturing adults to develop strong brain architecture. For children in situations where there are risk factors for toxic stress, early preventive intervention will be more efficient and produce more favorable outcomes than later remediation. "Science clearly demonstrates that, in situations where toxic stress is likely, intervening as early as possible is critical to achieving the best outcomes. For children experiencing toxic stress, specialized early interventions are needed to target the cause of the stress and protect the child from its consequences."[18]

Domestic Violence

Children are exposed to varying types and frequency of violence within their communities, families, and through the media. Violence crosses socioeconomic and cultural boundaries; however, children in low-income areas often experience what may be termed "chronic community violence."

In homes where domestic violence is present, children are 15 times more likely to be abused, according to one 2003 Children's Aid Society policy paper. The University of Oklahoma Center on Child Abuse and Neglect reports that 85% of batterers witnessed violence as children, and 50% of domestic violence victims were raised in violent homes. The typical American child will have seen 16,000 murders and 200,000 acts of violence through the media by the time they are 18 according to the American Psychiatric Association.

It is also important to note the high correlation between domestic violence and child abuse and neglect. The Avon

[18] *Harvard University, Center on the Developing Child (2007). The science of early childhood development. Working Paper series from the National Scientific Council on the Developing Child. www.developingchild.harvard.edu/content/publications.html*

Foundation for Women found, "in cases where victims experience severe forms of domestic violence, their children are also in danger of suffering serious physical harm."[19] Studies support the impact of domestic violence on children. The Avon Foundation also lists numerous effects such as long-term physical, mental, and emotional trauma. Children may be more disposed to unplanned pregnancy,[20] date violence,[21] alcohol and substance abuse,[22] and a myriad of other problems as the result of witnessing or experiencing domestic violence.

Links have also been shown between domestic violence and maternal depression as well as child abuse. Women in abusive relationships are "five times more likely to [suffer] postpartum maternal depression…"[23] Women in these situations are emotionally less likely to be able to provide ideal care for their children.

Possibly the most important protective resource to help a child cope with exposure to violence is a strong relationship with a competent and caring adult. Schools and communities can provide opportunities for children to benefit from the support of peers and adults that can reduce anxiety related to violence.

Finally, there remains a significant need to identify areas of our state lacking in resources available to support families with potential risks for domestic violence. The Children's Aid Society stresses that while

concern and support is needed for victims of domestic violence, the safety and well-being of children should not be neglected or compromised. The Oklahoma State Department of Human Services is currently taking steps to better assess a family situation before the removal of children in a domestic violence situation. The assistance and collaboration of other support agencies is further needed to provide a comprehensive system of care for families at risk.

Mental Health and Substance Abuse

Adults who suffer from poor mental health or struggle with substance abuse may be generally less able to nurture and provide reliable or effective parenting for their children. A 2003 report by the U.S. Department of Health and Human Services shows Oklahoma as having the highest rate of serious mental illness among adults (18 years and older) when compared to other states. It is estimated that between one third and two thirds of child abuse reports involve some type of substance abuse. One study reported by the National Clearinghouse on Child Abuse and Neglect

[19] *O.W. Barnett, C.L. Miller-Perrin and R.D. Perrin. (1997) Family violence across the lifespan: An introduction. Thousand Oaks, CA: Sage Publications*
[20] *R.F. Anda, V.J. Feletti, D.P. Chapman, J.B. Croft, D.F. Williamson, J. Santelli, P. Dietz, and J.S. Marks. (2001) Abused Boys, Battered Mothers, and Male Involvement in teen Pregnancy. Pediatrics. 107(2), 1-8*
[21] *M.H. Bair-Merritt, S.S. Crowne, L. Burrell, D. Caldera, T.L. Chang, and A.K. Duggan. (2008). Impact of Intimate Partner Violence on Children's Well-child Care and Medical Home. Pediatrics, 121(3), 473-80.*
[22] *J.G. Silverman, A. Raj, L.A. Mucci, and J.E. Hathaway. (2001) Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. Journal of the American Medical Association, 286(5), 572-579.*
[23] *M.H. Blabey, E.R. Locke, Y.M. Goldsmith, and K.A. Perham-Hester (2009). Experience of a Controlling or Threatening Partner Among Mothers with Persistent Symptoms of Depression. American Journal of Obstetrics & Gynecology. 201(2), 173.*

suggests that substance abuse was one of two major problems with which (high risk) families struggle.[24]

Statistics provided by the Oklahoma Department of Mental Health and Substance Abuse Services indicate that in Oklahoma, alcohol and other drug addiction contributes to 85% of all homicides, 80% of all prison incarcerations, 75% of all divorces, 65% of all child abuse cases, and 55% of all domestic violence assaults.

The barriers to dealing effectively with substance abuse or mental illness are many and varied. Often child welfare case workers are not trained adequately in substance abuse and mental illness issues.[25] At times, reunification plans are compromised when the recovery period for those who have had problems with alcohol or other drug addiction, in developing positive parenting skills, conflicts with court or legislative requirements.[26] Another problem in finding a solution to providing services for families at risk with issues of substance abuse and mental illness, is that services are extremely limited in many areas for both inpatient and long-term outpatient support. Furthermore, a main concern is that the focus tends to be responsive to obvious or outward symptoms as opposed to preventative or strength-based efforts.[27]

A parent or caregiver who is impaired and unable to care for their self, is not equipped to provide adequate care and support for a child. Prevention, intervention, and treatment methods need to address the whole family and provide support while the adult seeks services.

[24] *National Clearinghouse on Child Abuse and Neglect Information. (2003). Substance abuse and child maltreatment. Retrieved September 13, 2004, from http://nccanch.acf.hhs.gov/pubs/factsheets/subabuse_childmal.cfm*
[25] *National Center on Addiction and Substance Abuse (CASA). (1999). No safe haven: Children of substance abusing parents. New York: National Center on Addiction and Substance Abuse (CASA) at Columbia University.*
[26] *National Center on Substance Abuse and Child Welfare (NCSACW). Developing knowledge and providing technical assistance to federal, state, local agencies and tribes to improve outcomes for families with substance us disorders in the child welfare and family court systems. Retrieved November 1, 2004, from http://www.ncsacw.samhsa.gov/files/508/introNCSACW_31.htm*
[27] *National Mental Health Association. When a parent has a mental illness: Serious mental illness and parents. Retrieved November 1, 2004, from http://www.nmha.org/children/parenting.pdf*

Children with Special Needs

Available research has found that children with disabilities are more vulnerable to maltreatment than children without disabilities. One national study[28] found that children with disabilities were 1.7 times more likely to be maltreated than children without disabilities.

Children with special needs come from every social class and have the usual risk factors for child abuse such as dependence, vulnerability and family stress, but they can be intensified. Parents of children with disabilities have added risk factors as well. They may be stressed by ongoing health care needs, difficulties in finding suitable child care, financial burdens and social isolation, along with related difficulties such as depression and marital discord. Unfortunately, many families lack the necessary social supports or networks to work through the many concerns and situations that arise in providing care for their children and the rest of the family.

Almost 90,000 children and teens ages 9-17 suffer from mental or behavioral impairments as reported by Kids Count 2007-2008. The relationship between a child's exposure to trauma and their risk for developing mental illness, addiction disorder or behavioral disorder is well established. Parents often need extra support to help them cope with their child with special needs. Quality mental health services are necessary as well as support for parents and caregivers.[29]

Statistics indicate alcohol and drug addiction contributed to:

- 85% of homicides
- 80% of prison incarcerations
- 75% of divorces
- 65% of child abuse cases
- 55% of domestic violence assaults

[28] *(Crosse, Kaye & Ratnofsky, n.d.)*
[29] *(Fact Sheet: Vulnerable Young Children, compiled by Evelyn Shay and Sue Goode May 2008)*

Resiliency

Resilience is viewed as involving two distinguishable, yet related family processes:
1) adjustment, which involves the influence of protective factors in facilitating the family's ability to maintain its integrity and function in the face of adversity, and 2) adaptation, which involves the function of recovery factors in promoting the family's ability to "bounce back" and adapt in family crisis situations.[30] Family success and resiliency can be impacted and shaped in many ways.

Family Dynamics and Parenting

A number of influences determine an individual's parenting style. Efforts to model this process generally include some combination of developmental history, personality factors, social interactions or social networks, familial relationships, and child characteristics.[31] Parents draw on their experiences within their family, support and advice from friends and information from service providers when making decision about how to parent.

Strong and healthy families consist of family members that are committed to each other. The family members develop strategies to learn from and deal with stress. They are able to support and nurture each other in a variety of ways. In turn, the families need support from their communities through social relationships and feelings of connectedness.
The principles of family support are integral to every aspect of a strong prevention plan. The goal of family support is to promote the acquisition of knowledge and skills that make the family more competent, thus strengthening family functioning. Family support ensures that parents are engaged in policy and program decisions at every level. It requires providing the knowledge and skills to participate in the policy decisions that impact their children, families and neighborhoods.

[30](McCubbin & McCubbin , 1993, 1996)
[31](Belsky & Vonda, 1990; Sameroff& Chandler, 1975; and Sandler, 1979)

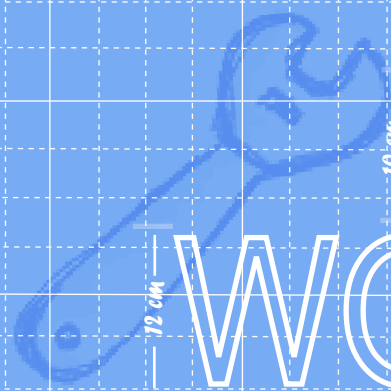
The Cost of Child Abuse and Neglect

Over the past decade, Oklahoma has been nationally recognized for investing in early childhood programs. Yet, when public resources are stretched thin, essential services for children are often reduced or eliminated in the governmental budgeting process. Such budget cuts can deprive children of a strong developmental start. The children are not the only ones to be deprived – society and tax payers suffer as well.

According to the Oklahoma Department of Human Services, an estimated 108,289 children were alleged victims of child abuse in 2009. Over 8,500 children were confirmed victims of abuse and/or neglect. Each one of these victims and their families experience related high costs, both direct (hospitalization, mental health services, child welfare services, law enforcement) and indirect (special education, juvenile delinquency, health and mental health care, adult criminal justice system, lost productivity to society), associated with their treatment.[32]

A 2007 study found the estimated annual cost of child abuse and neglect in the U.S. to be $103.8 billion. This figure is considered a conservative estimate, as it only includes victims who suffered maltreatment by a parent or caretaker and does not account for costs associated with treatment or intervention services for perpetrators and victims' family members, nor make considerations for the intangible losses suffered by those involved in such cases.[33]

32Total Estimated Cost of Child Abuse and Neglect in the United States. Wang, C, Holton, J. Economic Impact Study, September 2007.
33 Ibid.



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EVALUATION

Evidence Based Practice

The National Alliance of Children's Trust and Prevention Funds recently released a position paper on *Evidence Based Practice in Strengthening Families and Preventing Child Maltreatment*. In this paper, The National Alliance outlines their proposed guidelines for the funding of child maltreatment programs.

It is the National Alliance's position that evidence-based practice is the most effective use of funding for the prevention of child maltreatment. It is not to say, however, that they believe this to be the ONLY effective use of funding. In addition to recognizing evidence-based practice, they also draw attention to evidence-informed and some innovative or promising strategies.[1]

Evidence Based Practice by definition is a program that "uses a curriculum that when implemented with fidelity to the entire curriculum has been validated with research evidence". Validated, in this context, means that the program has been scientifically proven using rigorous evaluation of an experimental design.[2] An experimental design naturally includes a control or non-treatment group. These programs are also considered "demonstrated effective". Evidence-based practice involves complex and conscientious decision making based not only on available evidence, but also on family characteristics, situations and preferences.[3] It recognizes that care is individualized, changing and may involve uncertainty.[4] Using an evidence-based approach to social policy has a number of advantages because it has the potential to decrease the tendency to run programs which are socially acceptable (e.g. ,drug education in schools) but which often prove to be ineffective when evaluated.[5]

In a second level of practice called Evidence Informed Practice, programs are considered "reported effective." This may mean that while there has been evaluation, there may or may not have been a control group. This type of practice is also called a quasi-experimental design. While still a positive effort, the outcomes of such programs may not be considered definitive.

The third level of design is the Innovative or Promising group of programs. These programs offer new strategies that while noteworthy, may not have any evaluation component and do not have an underlying scientific hypothesis testing component. There is an importance

[1] *National Alliance of Children's Trust and Prevention Funds, 2009. Evidence Based Practice in Strengthening Families and Preventing child Maltreatment.*
[2] *Ibid.*
[3] *Ibid.*
[4] *Buysse, V., & Wesley, P.W. (2006). Evidence-based practice: How did it emerge and what does it really mean for the early childhood field? Zero to Three, 27(2), 50 – 55.*
[5] *Raines, J.C. (2008). Evidence-based Practice in School Mental Health. New York: Oxford University Press.*

in these models of being innovative, which in the ever-changing environment of child maltreatment is imperative.[6]

Due to varying community factors such as support networks, educational facilities and varied social norms, the importance of family wisdom when implementing interventions has been recognized. Therefore, The Alliance supports methods that are not solely restricted to randomized controlled trials, which may be unreasonably exclusive when selecting participant families. [7]

Additionally the National Alliance acknowledges the importance of strengthening families and solidifying relationships to build trust. This cannot be done without the input of parents. No program will be effective without the trust of the parents involved. To garner and grow trust with parent groups, they must be included in the design aspects and implementation of a practice model for the prevention of child maltreatment.[8]

[6] National Alliance of Children's Trust and Prevention Funds, 2009. Evidence Based Practice in Strengthening Families and Prevention Child Maltreatment.
7 Evidence Based Practice in Strengthening Families and Preventing Child Maltreatment. The National Alliance of Children's Trust and Prevention Funds, 2009.
[8] Ibid.

PRIMARY PREVENTION

Messaging

When people hear 'child abuse prevention', they hear "Child Abuse". For social change to occur, people should hear "Prevention" and have a clear understanding of what prevention means. According to Ben Tanzer, Senior Director of Strategic Communications, Prevent Child Abuse America, "Pictures in people's heads around child abuse and neglect and prevention are not the pictures you want them to have. And not just that, but those pictures, those ideas, undermine our ability to do good prevention work."

In 2007 there were 39 child deaths in Oklahoma, most occurring in children under 2 years of age, and there were over 8,605 confirmed cases of child abuse. In a recent opinion, percent of respondants concurred with the following statements:

- 74% Child abuse is preventable;
- 37% There is nothing I can do about child abuse;

- 75% I think it can be prevented but don't know how;
- 75% Better parent education can prevent child abuse;
- 32% Reporting to DHS can prevent abuse;
- 70% Public education about child abuse prevention would help;
- 74% Programs teaching coping skills would prevent abuse; and
- 75% said: Parent support groups can prevent child abuse.

The public can make social change happen around child abuse and neglect and be better engaged in the work of prevention when professionals in the field can successfully show people their responsibility. When communication is effective, people can see an issue from a different perspective.

It is reported that a third of abused and neglected children are less than four years of age, most of whom are in the child protection system for the first time. With young children being most vulnerable, we are focusing on innovative early intervention programs to prevent child abuse and neglect. Prevention programs help lay strong foundations for children's later growth and development, reduce child abuse and neglect, are cost effective and prevent lifelong effects on physical and mental health.[9]

Strengthening Families

Child abuse and neglect (CAN) represents a major social problem that threatens the basic health and well-being of an estimated 2.8 million children in the U.S. annually. Early care and education (ECE) programs, which

[9] *PCAA; Frame Works Institute, 2009; Federal Interagency Work Group on Child Abuse and Neglect, January 28th, 2010; Ben Tanzer, Senior Director of Strategic Communications, Prevent Child Abuse America*

serve approximately 60 percent of pre-kindergarten age children, have the potential to play an important role in the prevention of child maltreatment. A recent study that was the first to examine the relationship between ECE programs and CAN prevention found a 52 percent reduction in maltreatment among participating children by age 17. Through a national study of exemplary early care and education programs, the Center for the Study of Social Policy developed a strategy for preventing child abuse and neglect through actions that can be taken in early care and education programs. This Strengthening Families approach recommends that ECE programs incorporate five factors designed to prevent CAN into their programs. These include: 1) increasing parental resilience; 2) building the social connections of parents; 3) increasing knowledge of parenting and child development; 4) providing concrete supports in times of need; and 5) supporting the social and emotional competence of children. A sixth protective factor was 6) creating healthy parent child relationships, added by the Illinois Strengthening Families Initiative.[10]

SECONDARY PREVENTION

Home Visitation

Although seen as a new profession, utilizing home visitation as a way to deliver services to families in need is part of our nation's early history. Endorsed by Florence Nightingale, it has existed in the United States since at least 1880.

In the 1880's, home visitation was recognized that "social conditions could be wonderfully improved if, to every family in distress, could be sent a volunteer visitor, who would seek out and, with patience and sympathy, strive to remove the causes of need."[11] In 1895, Lillian Wald established the first public health nursing unit to address the needs of immigrant families living in settlement houses in New York. These settlement house programs were the beginning of the United States' family support movement. In the early 20th century, focus moved away from family support to parent education in which experts taught parents how to raise successful children.[12] Today we recognize the parent as the expert on his or her own child and that by partnering with parents through home visitation programs we can provide much needed support to children and families.

Home visitation programs and curriculums have been developed to address a myriad of family needs. Although

[10] *Carole Horton, 2003 Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect*

[11] *Mary E. Richmond. (1899) Friendly Visiting Among the Poor: A Handbook for Charity Workers. New York: The MacMillion Company.*

[12] *Carol S. Klass. (1996) Home Visiting: Promoting Healthy Parent and Child Development. Baltimore, MA: Paul H. Brookes Publishing Company, 3.*

the goals may be diverse, effective home visitation programs share a focus on the importance of early beginnings, the impact parents have in shaping their children's lives and the importance of meeting families in their environment. Home visits allow providers an opportunity to assess the family environment, gain a better understanding of the family's needs, tailor interventions to meet the needs and enlist all family members in the care and nurturing of the children. In 1993, *The Future of Children* examined the practice, policy, and research underlying effective home visitation for families with young children and concluded that results were promising enough to suggest that an expansion of home visiting was warranted.[13] The number of home visitation programs has increased dramatically since that time.

As the number of home visitation programs increased, so has the research concerning the effectiveness of these programs. Many of the programs such as Healthy Families America, Home Instructions for Parents of Preschool Youngsters, and Nurse-Family Partnership, utilize sophisticated evaluation methods to test their effectiveness. Several independent organizations have also performed systematic reviews of the scientific evidence concerning effective home visitation programs.

The Centers for Disease Control (CDC) Task Force on Community Preventive Services conducted a review of four programs to determine their effectiveness on preventing several forms of violence. Although their report acknowledged a need for additional research, they found "on the basis of strong evidence of effectiveness, the task force recommends early childhood home visitation for prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birthweight infants."[14]

The respected medical journal, The Lancet, performed a review of recent high quality research evidence for preventing child maltreatment and interventions to reduce the adverse effects of such exposures. They found home visitation and multi-component interventions as being the only potentially effective intervention to prevent child maltreatment. They identified two programs, the Nurse-Family Partnership developed in the USA and the Early Start Program developed in New Zealand, as showing significant benefits in preventing child maltreatment. One program, Triple P-Positive Parenting Program, showed positive effects on substantiated reports of child maltreatment and associated outcomes in one population trial.[15]

The Society for Research in Child Development (SRCD) issued a Social Policy Report Brief on home visitation. In their view, the policy implications are to: 1) create a unique and coordinated funding stream for home visitation services; 2) develop an integrated database to allow states to survey the models implemented to increase coordination and accountability; 3) invest in programs that conduct rigorous evaluations using diverse methods to assess effectiveness and demonstrate improved quality; and 4) consider the diversity in existing models and goals in addressing local needs.[16]

Rigorous social science evaluations of home visiting programs designed to reduce child maltreatment and improve child health outcomes provided the base for the Federal administration to initiate a multi-billion-dollar program to expand home visitation services. On March 23, 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was enacted to provide maternal, infant, and early childhood home visitation programs in the states. The Home Visitation Federal Grant Program will be administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF). HRSA and ACF believe that home visiting should be viewed as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health and development and that relies on the best available research evidence to inform and guide practice. The federal grant program will make $1.5 billion over a five-year period (FY2010-FY2014) available to states to provide quality home visitation programs. Grantees will be required to meet maintenance of effort standards based on previous spending by using new funds to supplement not supplant funds from other sources.

In order to obtain funding under the Home Visitation Federal Grant Program, states are required to perform a

[15] *Harriet L. MacMillion, et al., "Interventions to prevent child maltreatment and associated impairment," The Lancet (Published online December 3, 2008) DOI:10.1016/S0140-6736(08)61708-0.*

[16] *Jennifer Astuto and LaRue Allen, "Home Visitation and Young Children: An approach Worth Investing in?" Social Policy Report Brief, Volume 23, Issue 4, 2009.*

statewide needs assessment coordinated with other assessments required under Title V MCH and the Head Start Act. States are required to establish quantifiable, measurable 3-year and 5-year benchmarks in maternal and newborn health, prevention of child injuries, abuse or neglect, school readiness and achievement, reductions in juvenile delinquency or domestic violence, family self-sufficiency and improvements in referrals to needed services. At the 3rd and 5th year measurements, states must assess their progress in reaching their benchmarks. After the 3rd year, states must demonstrate improvement in at least 4 of 6 benchmarks. After the 5th year, states must demonstrate improvement in all 6 of the benchmarks.[17]

On June 10, 2010, The Oklahoma State Department of Health (OSDH) was designated as the lead agency for the ACA Maternal, Infant, and Early Childhood Home Visiting Program Federal Grant and will assume the obligations imposed by the terms and conditions of the grant. As the lead agency, OSDH will begin the process to obtain funding to supplement home visitation services in Oklahoma in collaboration with home visiting programs described in the 'Activities, Services & Programs' section of this document and agencies specified in the Funding Opportunity Announcement (HRSA-10-275).

TERTIARY PREVENTION

Tertiary prevention focuses on families that have already demonstrated the need for prevention and/or where maltreatment has already occurred, seeking to reduce the negative consequences of the maltreatment (e.g., social-emotional problems in children, lower academic achievement, decreased family functioning) and to prevent its recurrence. Tertiary prevention is at a higher level of concern than primary and secondary and different from 'prevention' through standard forms of family support.

[17] *The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) (P.L. 111-148 pages 216-225).*

Treatment is typically long-term and characterized by an ongoing relationship with a particular type of service provider, most often a counselor, mental health clinician, or medical professional.

In Oklahoma, tertiary prevention efforts include home visitation services for high risk parents, center-based services and other such things as mental health, substance abuse, and domestic violence services. Examples include:

- Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct disorders in young children (ages 2 ½ - 12 years) that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior.

- Comprehensive Home-Based Services (CHBS) offers specific services to help ensure and enhance, or ameliorate obstacles that impede, the safety, well being and social functioning of children and their families. CHBS target population includes children birth-18 years of age who are at risk of being removed from the home due to child abuse and neglect and/or exposure to parental drug/alcohol abuse. Families served have reported histories of alcohol and drug problems, medical conditions, and mental health issues and have had an active child welfare case wherein children have been determined unsafe.
- Mental Health Services, within the Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS), encompass a broad range of needs. The department operates a psychiatric hospital for adults, a facility with specific services for children and adolescents, along with a specialty center devoted to forensic services. In addition, ODMHSAS provides a variety of community mental health services through a statewide network of Community Mental Health Centers (CMHCs). For individuals in crisis, the department provides emergency assessment, mobile crisis, community-based crisis stabilization and inpatient hospitalization. Specialized programs in partnership with law enforcement (CIT) and the criminal justice system (Mental Health Court) have been highly successful, as have other targeted programs related to children and family services (Systems of Care) and community response (Project Heartland). ODMHSAS also provides funding for social and recreational services for individuals with mental illness who live in residential care facilities, as well as support for certain other community-based services such as assistance for mentally ill individuals who are homeless. State-funded services are available for adult Oklahomans in need of mental health and substance abuse treatment who are 200% of the poverty level or below and have no other means of pay. However, because of limited resources, there are illness severity criteria that must be met for adults to receive services. Eligibility requirements for children include those with no other means of payment. Individuals are free to seek services in any locale they prefer, regardless of service area of residence.

- Domestic Violence Services The Office of Attorney General contracts with twenty nine community-based programs, to provide services for victims of domestic violence, sexual assault and stalking. At

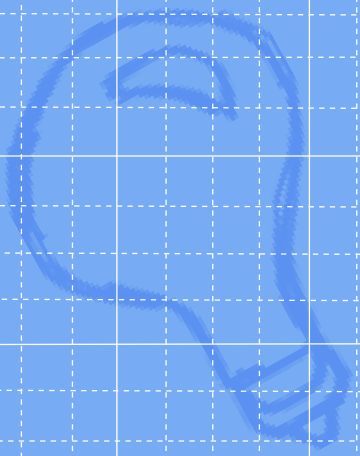
a minimum, they provide crisis intervention, safety planning and temporary shelter in a safe environment. Additionally these programs help battered women and their children navigate the court system, obtain protective orders, find legal counsel, seek jobs, childcare, new living arrangements, and locate additional community resources. The intervention strategies for the Domestic Violence Sexual Assault (DVSA) agencies working with adult domestic violence, sexual assault and stalking victims is to provide SAFETY from physical, emotional, financial, and psychological harm with the ultimate goal of eliminating violence from their lives and their children. DVSA agencies recognize and promote partnerships with community resources such as law enforcement and the courts in order to reduce violence within society, promote victim safety, reinforce abuser accountability, and advance the ethic of zero tolerance for domestic violence, sexual assault, and stalking in our communities.

- Systems of Care (SOC) is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Eligibility includes children birth to 21 years and their families who have a serious emotional disturbance, are involved in two or more child-serving systems and at risk for out of home placement. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life.

  Systems of Care is not a program — it is a philosophy of how care should be delivered. SOC is an approach to services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs.

- Child Advocacy Centers/Multi-Disciplinary Teams (CACs and MDTs) CACs are child-focused, center-based programs that work to prevent further victimization of children who have been sexually or physically abused or neglected. Centers work towards more immediate follow-up to reports of child abuse, efficient referrals to medical and mental health professionals, reduction of child interviews, increased successful prosecution, and support for the child and family. Centers work in conjunction with multidisciplinary child abuse teams. Nineteen of the multidisciplinary teams have full National Children's Advocacy Alliance Membership.

Primary, secondary, and tertiary prevention services are necessary for any community to provide a full continuum of services that decrease the devastating effects of child maltreatment.



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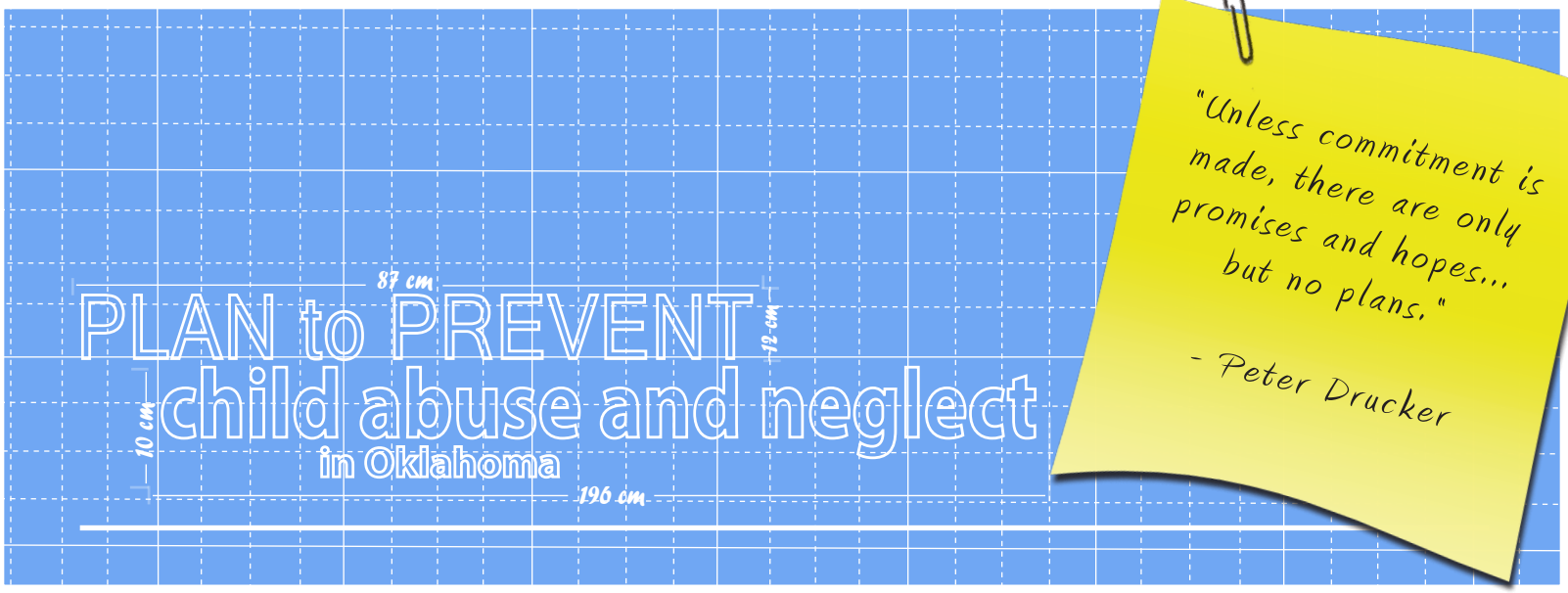


The Oklahoma State Plan for the Prevention of Child Abuse and Neglect is an opportunity to build upon Oklahoma's strengths and focus on PREVENTION. The 2010 – 2013 State Plan includes broad goals and needed strategies to achieve those goals. It may be that shifting resources or seeking additional resources will be required in order to implement some strategies. It may be that certain goals and/or strategies are not achievable because funding has been eroded or eliminated. These are very challenging times. The will to do the work may not be matched with the resources to see the tasks completed. However, the Oklahoma State Department of Health, the Interagency Child Abuse Prevention Task Force, and all prevention partners stand ready to employ the most current best practices to serve and support parents.

Infrastructure

The prevention of child abuse and neglect is broader than just programs. It is the responsibility of our communities and neighborhoods to keep all children safe, and caregivers to raise children in healthy, safe environments. Leadership takes a commitment at all levels to keep children safe and assure that they reach their optimal potential.

Leadership by Service Providers

Leadership is needed to engage a broad array of partners. These include traditional state and local partners such as social services, substance abuse/mental health, health and education as well as non-traditional partners such housing, finance and the private sector.

The Interagency Task Force to Prevention Child Abuse and Neglect is committed to leading our state in accomplishing the goals for the State Plan.

Goal 1: Increase the capacity, ownership and leadership within the child abuse prevention professional community.

Strategy 1: The OSDH and the Interagency Child Abuse Prevention Task Force (ITF) will work collaboratively, continuing to stay informed and grow in their knowledge of current best practice, policies and models that positively impact the field of child abuse prevention and enhance the landscape for Oklahoma's children.

Strategy 2: The OSDH and the ITF will collaborate and provide technical assistance and training to professionals in related fields that have the ability to impact child abuse prevention.

Measurable Outcomes:

1. Start Right programs funded for FY10 and beyond.
2. Presentations given on topics related to prevention of child abuse at each ITF meeting.
3. Training provided that increases the skills of providers delivering home visitation services in recognizing and responding to high risk, high stress families.

Parent Leadership

Meaningful Parent Leadership occurs when parents address the challenges of parenting, gain the knowledge and skills to function in meaningful leadership roles and represent a "parent voice" to help shape the direction of their families, programs and communities. Shared leadership is successfully achieved when parents and professionals build effective partnerships and share responsibility, expertise and leadership in decisions being made that affect families and communities.[1]

Goal 2: Establish a Parent Advisory/Leadership Group.

Strategy 1: The OSDH and the ITF will research, seek and secure speakers, training opportunities, technical assistance and information on the importance of a parent advisory/leadership group, the process to creating such a group, and how best to collaborate with said group once that is achieved.

Strategy 2: The OSDH and the ITF will take the necessary steps to institutionalize and operationalize a parent advisory/leadership group.

Measurable Outcomes:

Establish a functioning Parent Advisory Group that provides input and leadership in the area of the prevention of child abuse and neglect by June 30, 2011.

Evaluation:

Evaluation is a critical element of child abuse prevention program sustainability, as funders and policymakers increasingly ask for evidence of the effectiveness of the programs they fund. It is also necessary for child abuse and neglect prevention and family support programs to conduct evaluation activities as part of their ongoing quality assurance efforts.

Currently, there is widespread acceptance among many social science fields that the use of evidence-based or evidence-informed practices promotes the efficiency and effectiveness of funding, as there is an increased chance that the program will produce its desired result. In turn, research suggests that effective programs often have long-term economic returns that far exceed the initial investment.

There are various types of evaluation. Program evaluation is a systematic study that assesses how well a program is working; process evaluation assesses the extent to which the program is operating as intended; and outcomes evaluation, which assesses the intended results of the program. Evaluation of programs leads to replication that maintains model fidelity and uniformity of implementation thus achieving the intended outcomes that make a difference for children and families

1 www.parentsanonymous.org

Goal 3: Support the evaluation of social services including child abuse and neglect services and other social services provided to children and families.

Strategy 1: Assure evaluations are conducted in an objective fashion and evaluation results are distributed freely.

Measurable Outcomes:
Established process to review a program's evaluation and assess effectiveness.

Primary Prevention

Primary prevention activities are directed at the general population and attempt to stop maltreatment before it occurs. All members of the community have access to, and may benefit from, these services. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers and decision-makers about the scope and problems associated with child maltreatment.[2]

Create a Culture of Change

We must mobilize a critical mass of policy makers, employers, community leaders, educators and providers to act on a commitment to families and to the health and safety of all children.

A public engagement campaign can fuel this change and is a structured, organized initiative to garner public support for a problem as a way of achieving needed change and sustaining this change as a community norm.

Public engagement campaigns have been shown to mobilize communities, organizations and individuals to call for policy or program changes in order to deal with problems. Educating the public about an issue and giving them the information and course of action to address the problem has driven many of the social changes that have occurred in our country.

A public engagement campaign can focus on strategies ranging from media campaigns to policy changes and providers sharing the merits of their approaches to strengthening families or sponsoring community events focused on positive parenting

We must also recognize the informal supports offered in our neighborhoods and broader communities. Communities know best the needs of its families and the informal and formal resources available to meet their

[2] *Framework for Prevention Child Maltreatment, www.childwelfare.gov*

needs. Building the capacity of communities to support its families at all levels leads to safer, healthier communities with more productive citizens.

Goal 4: Create a culture of change that values the health, safety and well-being of all children.

Strategy 1: The OSDH and the ITF will educate and mobilize communities to change community norms so that child abuse and neglect is viewed as preventable and unacceptable.

Strategy 2: The OSDH and the ITF will support the implementation of quality early childhood programs through the Oklahoma Department of Human Services, Smart Start Oklahoma, the Oklahoma Department of Education, and Head Start.

Strategy 3: The OSDH and the ITF will strive to assure the six Strengthening Families Protective Factors,[3] developed by Center for the Study of Social Policy, are integrated into all prevention programs serving children and families.

Strategy 4: The OSDH and the ITF will engage non-traditional partners to get involved in and support child abuse prevention efforts (i.e. business community, libraries, civic groups, etc.).

Measurable Outcomes:

1. Policy agenda that defines needed resources for a comprehensive system focused on the prevention of abuse and neglect.
2. Quality early childhood programs available statewide.
3. Annual Child Abuse Prevention Day at the Capitol.
4. Statewide multi-media campaign implemented to recruit non-traditional partners.

Supporting Parents

All parents and caregivers need support in the job of raising healthy, productive citizens. Support can be informal, such as parents sharing information with each other, or formal, such as parenting classes or home visitation.

The continuum from prenatal to high school would include programs that strengthen parenting skills and improve outcomes in the following areas: parent-child interactions, effective communication, positive discipline, stress and anger management, self-awareness and empathy building, early learning and family literacy.

[3] *1) parental resilience; 2) social connections; 3) knowledge of parenting and child development; 4) concrete support in times of need; 5) social and emotional competence of children; and 6) healthy parent-child relationships.*

Goal 5: Assure that general parent education and family support is universally available across the state.

Strategy 1: The OSDH and the ITF will engage others to work collaboratively in seeking and implementing various vehicles for providing educational information to parents and caregivers to assist them in providing safe, stable and nurturing environments for children.

Strategy 2: The OSDH and the ITF will assist parents and caregivers in meeting the basic needs (sometimes called "concrete needs") of their family/children.

Measurable Outcomes:

1. Provide information regarding parenting and child development to parents and caregivers in various formats.
2. Families aware of and able to access formal and informal community resources and concrete supports.
3. Families receive referrals to specific individuals at service agencies as well as transportation to those services, if necessary and possible.
4. Develop parent website and warmline available 24 hours a day to provide information on parenting and child development.
5. Provide information on parenting and child development to all parents of newborns including abusive head trauma and safe sleep.

Prevention and treatment of sexual abuse is a special challenge, different in many of its dimensions from other types of child maltreatment. Enormous strides have been

made to understand the problem, educate the public and mobilize resources to address it. Recent research has indicated that current strategies may not be the most effective. Additional research and program development is needed to prevent initial harm to children and reduce occurrences.[4]

Goal 6: Implement strategies to prevent child sexual abuse.

Strategy 1: The OSDH and the ITF will work with partners across the state to implement programs that emphasize adult education and responsibility in keeping children safe from sexual predators.

Strategy 2: The OSDH and the ITF will put training in place to provide age-appropriate education to children about child sexual abuse.

Measurable Outcomes:

1. Child sexual abuse prevention programs in place and available statewide.
2. Information on prevention of child sexual abuse developed and distributed to various stakeholder groups.

Secondary Prevention

Secondary prevention activities with a high-risk focus are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities or neighborhoods that have a high incidence of any or all of these risk factors.

[4] *Guidelines for CBCAP Lead Agencies on Evidence-Based and Evidence Informed Programs and Practices: Learning Along the Way (Revised 11/13/07)*

Currently, there is an emphasis across human services that evidence-based or evidence-informed practices promote the efficiency and effectiveness of funding, as there is an increased chance the program will produce its desired result. In turn, research suggests that effective programs often have long-term economic returns that far exceed the initial investment[5]

Understanding what evidence-based or evidence informed practice is, and is not, is a necessary step for programs, as they continue to strive towards providing the best, most effective services. This focus on effective use of resources leading to positive outcomes for families will create a culture of accountability among all of those involved in the prevention of child abuse and neglect. The process of continually educating, evaluating and informing, not only professionals, but communities, will contribute to a focus on quality programs and services.

Goal 7: Identify best practices, programs and models that show evidence of improving child health, safety and well-being.

Strategy 1: The OSDH and the ITF will seek and provide to interested partners, best practice and evidence-based/ evidence informed models on a continual basis to assure quality services are provided and prevention dollars are well spent.

Strategy 2: The OSDH and the ITF will continue to redefine the components needed for the comprehensive system as child abuse prevention field evolves.

Measurable Outcomes:

1. Comprehensive Plan for the Prevention of Child Abuse and Neglect is completed and continued

5 *Guidelines for CBCAP Lead Agencies on Evidence –based and Informed Programs and Practices FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP) (2007)*

progress toward goals is reported.

2. Oklahoma implements programs with measurable outcomes that meet the needs of children and families.

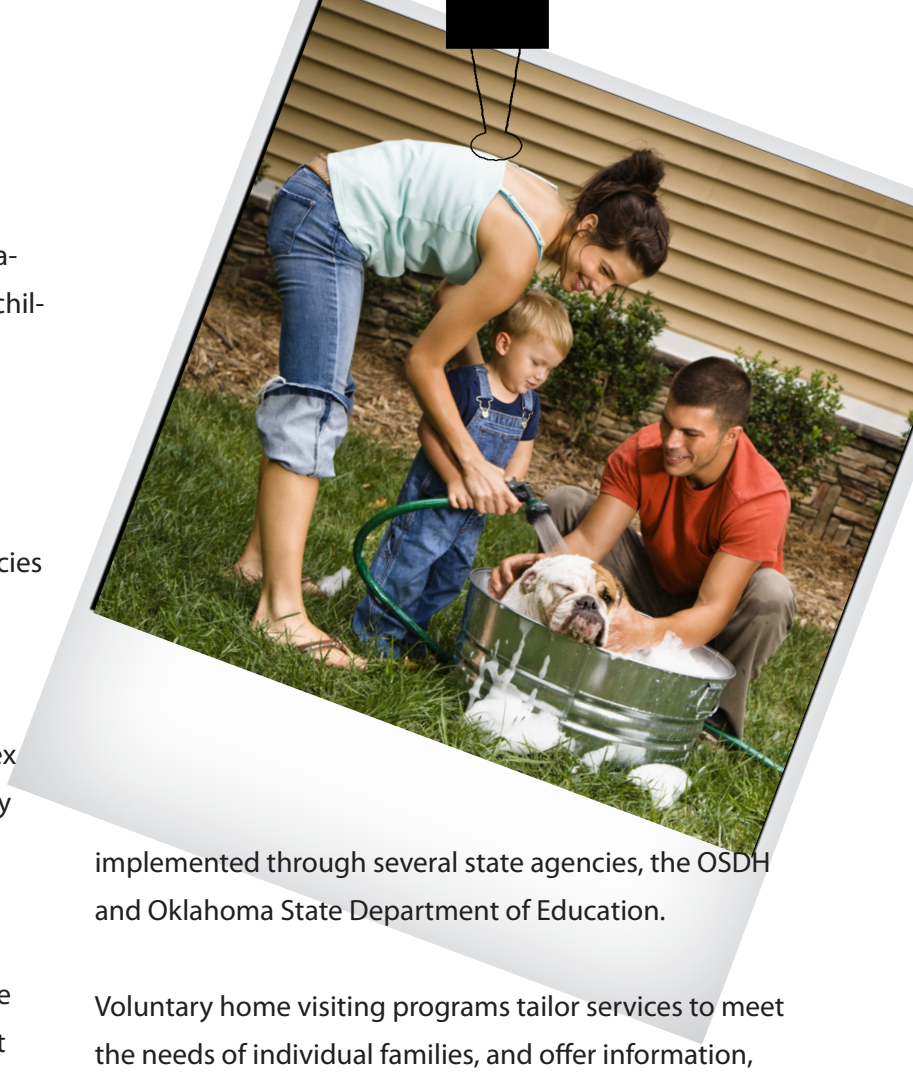
Comprehensive System

Prevention is a long–term investment in the well-being of children and families. Various public agencies have responsibilities for prevention programs with different funding streams, policies and procedures and populations served. We know that piecemeal, single focused solutions do not address the complex issues that families face. A coordinated, interagency approach is needed to provide the supports that families need.

Coordination and collaboration strategies can range from those that are easy to implement to those that are multi-faceted. Interagency coordination can lead to efficient use of resources and a coordinated response to family needs.

Oklahoma has a broad array of public and private services focused on the needs of families. We are recognized for the evidence-based programs implemented and our history of helping our neighbors in need. In order to develop a five year comprehensive plan, it is first necessary to identify all of our current resources, gaps in resources, needed resources, assess the best strategies to support families and develop a clear plan with identified actions and measurable results to prevent abuse and neglect among our families.

One key component of supporting parents and child development is through statewide home visiting



implemented through several state agencies, the OSDH and Oklahoma State Department of Education.

Voluntary home visiting programs tailor services to meet the needs of individual families, and offer information, guidance and support directly in the home environment. While home visiting programs, such as Healthy Families America, the Nurse-Family Partnership, the Parent-Child Home Program and Parents as Teachers, share similar overall goals of enhancing child well-being and family health, they vary in their program structure, specific intended outcomes, content of services and target populations.

A growing body of research demonstrates home visiting programs that serve infants and toddlers, can be an effective method of delivering family support and child development services, particularly when services are part of a comprehensive and coordinated system of high quality, affordable early care and education, health and mental health, and family support services for families prenatally through pre-kindergarten.[6]

6 Statement of Mathew Melmed, Executive Director, Zero to Three, submitted to the subcommittee on income security and family support of the House Committee on Ways and Means hearing on Early Childhood Home Visitation, June, 2009

Goal 8: Work towards the establishment of a comprehensive system of prevention programs available across the state to families with risk factors for child abuse and neglect.

Strategy 1: The OSDH and the ITF will work with partners across the state to increase the number and quality of center-based parent support groups and parent education programs.

Strategy 2: The OSDH and the ITF will work with partners across the state to increase the number and quality of home visitation services.

Measurable Outcomes:

1. Oklahoma implements programs with measurable outcomes that meet the needs of children and families.
2. ITF coordinates and integrates program activities and funds for the prevention of child abuse and neglect with regard to primary and secondary prevention.
3. Home visitation services are available and funded statewide.

Tertiary Prevention

Tertiary prevention activities focus on families where maltreatment or identified challenges have already occurred, seek to reduce the negative consequences of the maltreatment and to prevent its recurrence.

Goal 9: Include in the comprehensive system, prevention programs focused on serving families identified by the child welfare, mental health, substance abuse, and/or domestic violence systems.

Strategy 1: The OSDH and the ITF will support the Oklahoma Department of Human Services, Child Welfare as they continue to implement the new Practice Model and Standards emphasizing child safety.

Strategy 2: The OSDH and the ITF will provide support in increasing the number and quality of mental health services available to both adults and children.

Strategy 3: The OSDH and the ITF will provide support in increasing the number and quality of substance abuse treatment services for both adults and children.

Strategy 4: The OSDH and the ITF will provide support in increasing the number and quality of domestic violence services.

Strategy 5: The OSDH and the ITF will continue to explore the overlap between child abuse and domestic violence incidents, investigations, as well as best practices for prevention and intervention.

Measurable Outcomes:

1. Implement Practice Model and standards leading to reduction of number of children entering the child welfare system and improvement of care for those that do.
2. Mental health and domestic violence services available to meet the needs of all children and families.
3. Integrate child abuse prevention strategies into mental health and domestic violence programs.

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.[7]

There are five essential elements that contribute to a system's ability to become more culturally competent. The system should (1) value diversity, (2) have the capacity for cultural self–assessment, (3) be conscious of the "dynamics" inherent when cultures interact, (4) institutionalize cultural knowledge, and (5) develop adaptations to service delivery reflecting an understanding of diversity between and within cultures.[8] Furthermore, these five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies and services.

Valuing diversity means accepting and respecting differences. People come from very different backgrounds and their customs, thoughts, ways of communicating, values, traditions, and institutions vary accordingly. The choices that individuals make are powerfully affected by culture. Cultural experiences influence choices that range

7(Davis, 1997 referring to health outcomes)

8 Isaacs, M. and Benjamin, M. (1991). Towards a culturally competent system of care, volume II, programs which utilize culturally competent principles. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

from recreational activities to subjects of study. Even how one chooses to define family is determined by culture.

As we further define a comprehensive approach for the prevention of child abuse and neglect, we must attend to the unique culture of Oklahoma, recognizing our strengths and weaknesses.[9]

Goal 10: Promote and/or provide culturally appropriate services that maximize the participation of various cultural and ethnic populations.

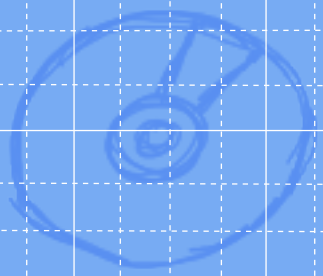
9Knitzer, J. (1982). Unclaimed Children: The failure of public responsibility to children and adolescents in need of mental health services. Washington, D.C.: U.S. Government Printing Office.

Strategy 1: The OSDH and the ITF will seek and provide to interested partners best practice and evidence-based/ evidence informed models on a continual basis to assure appropriate services are available to culturally diverse populations.

Strategy 2: The OSDH and the ITF will continue to redefine the components needed for the comprehensive system as child abuse prevention programs' populations evolve.

Measurable Outcomes:

1. Families are able to access needed services.
2. Workforce reflects diversity of families served.



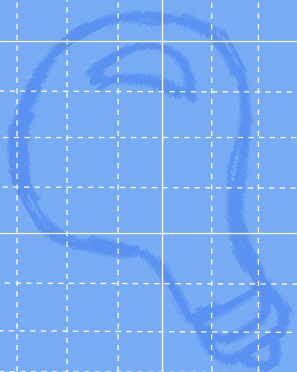
41 cm

20 cm

UPDATED activities

20 cm

38 cm



State Plan: Updated Activities, 2009

LEADERSHIP

Leadership is needed to engage the broad array of partners, state and local, including traditional partners such as social services, substance abuse/mental health, health and education as well as non-traditional partners such as housing, finance and the private sector.

Strategy 1: Interagency Task Force provides leadership and direction for state efforts to prevent child abuse and neglect

Activities:

- Fund and implement evidence–based community programs using the Health Families America model.
- Evaluate local Start Right projects on a yearly basis.
- Review current use of resources and allocate based on recommendations received regarding the comprehensive system of services focused on prevention.
- Provide leadership for establishing topical task forces, when necessary.
- Provide updates and training to ITF board members in order to increase capacity and knowledge of board members and representing agencies on the critical issues related to prevention throughout the year.
- Finalize a five-year comprehensive plan by 2010.
- Participate in Prevent Institute.

Measurable Outcomes:

1. Start Right programs funded for FY10.
2. Leadership provided by the ITF for development of comprehensive plan.

<u>Activities Completed as of September 2009:</u>

- Start Right model funded in communities; budgets reduced; evaluation model implemented.
- Topical task forces developing recommendations; due January 2010.
- Presentation given monthly on different programs and/or research for the ITF.
- Team participating in PREVENT.

Strategy 2: Office of Child Abuse Prevention will continue support of ITF and prevention programs.

Activities:

- Continue efforts to facilitate collaboration between the Oklahoma Child Death Review Board and the Oklahoma Domestic Violence Fatality Review Board.

- Continue efforts related to the Home Visitation Leadership Advisory Committee.
- Participate on national boards/coalitions/work groups related to prevention of child abuse and neglect.
- Determine how linkages with other community-based organizations (i.e., Smart Start Oklahoma, OCCY's community partnership boards) can enhance services for families.
- Explore the feasibility of implementing existing evidenced-based programs such as:
    - Children First (utilizing the Nurse-Family Partnership model);
    - Project Safe Care;
    - Parents as Teachers;
    - Strengthening Families;
    - The Incredible Years ;
    - Circle of Parents; and
    - Front Porch Project.

Measurable Outcomes

1. OCAP provides staff support to family support programs within the division.

Activities completed as of September 2009:

- Participate on Home Visitation Leadership Advisory Committee.
- Presentations are made to Smart Start and various other coalitions regarding focus on primary prevention.
- Front Porch is initiated in Tulsa; at least 12 trainers are certified.
- Five communities selected and had participants willing to become trainers for the Front Porch Project:
    1. Woodward;
    2. Ardmore;
    3. McAlester;
    4. Lawton; and
    5. Shawnee.

    Other trainers participants were to come from OKC agencies that were willing to go to any community.

    Implementation of Front Porch delayed due to contract issues.
- Strengthening Families model in 7 communities; funding cut.
- Children First services provided in 73 number of sites; budgets reduced.

Strategy 3: Enhance professional development of existing workforce on prevention of and early intervening in abuse and neglect by 2010 and cross train staff from various agencies where appropriate.

Activities:

- Enhance existing and/or develop new training on identifying and intervening with families exhibiting stress factors for professionals.
- Implement enhanced training across agencies and programs beginning in 2011.
- Provide training to professionals working with families so that they may assist in reducing the family's stress factors and strengthen protective factors.
- Support Child Abuse Prevention Programs that serve special populations:
    1. Contract with Indian Tribes in order to assure their population is provided child abuse prevention services;
    2. Contract with agencies that serve special populations, such as teen parents, physically and mentally challenged parents and racial and ethnic minority parents; and
    3. Allow OCAP Contractors to incorporate culturally-specific curricula if supported by research.

Measurable Outcomes:

1. Cross-training on recognizing high risk, high stress families is provided for those frontline staff delivering home visitation programs.
2. Fund prevention programs with measurable outcomes that serve special populations.

Activities completed as September 2009:

- OSDH provided a limited number of scholarships to individuals for the Annual CCAN Conference.
- OSDH staff provided suggestions for presenters at the CCAN and also served as presenters.
- OSDH made numerous copies of the Home Visitor Safety Guidelines training video and it is now available upon request.
- OSDH attempting to place video trainings on website for all to view.
- Meeting set with OU Trauma to further discuss training of delivery nurses and implementation of an Abusive Head Trauma program for mothers at delivery; in the past have distributed "The Period of Purple Crying".

COMPREHENSIVE SYSTEM

Prevention is a long–term investment in the well-being of children and families. Various public agencies have responsibilities for prevention programs with different funding streams, policies and procedures and populations served. We know that piecemeal, single focused solutions do not address the complex issues that families face. A coordinated, interagency approach is necessary to provide the supports families need.

Coordination and collaboration strategies can range from those that are easy to implement to those that are multi-faceted. Interagency coordination can lead to efficient use of resources and a coordinated response to family needs.

Oklahoma has a broad array of public and private services focused on the needs of families. We are recognized for the evidence-based programs implemented and our history of helping our neighbors in need. In order to develop a five year comprehensive plan, it is first necessary to identify all of our current resources, gaps in resources, needed resources and assess the best strategies to support families and develop a clear, plan with identified actions and measurable results to prevent abuse and neglect among our families.

Strategy 4: Develop a framework for a comprehensive system that focused on prevention of and early intervening in abuse and neglect by 2010.

Activities:

- Task forces will be established or existing groups tapped to address specific topics: child welfare, substance abuse, mental health, domestic violence, economic stability, family support, special needs and comprehensive system development for the purpose of identifying short and long term strategies that address prevention and early intervention; identifying existing resources and gaps in local and state systems by 2010.
- Identify existing primary, secondary and tertiary prevention programs; populations served, geographic availability, resources allocated and program outcomes and evaluation by November 2009.
- Review other state systems to identify strategies, programs and policies that support prevention efforts.
- Coordinate and integrate program activities and funds for the prevention of child abuse and neglect with regard to primary and secondary prevention.
- Establish workgroup to review existing evidence-based programs addressing prevention of sexual abuse. Make recommendation to ITF based on review by December 2009.

Measurable Outcomes:

1. Comprehensive Plan for the Prevention of Child Abuse and Neglect is completed by 2010.
2. System "map" of primary, secondary and tertiary prevention programs available statewide completed by 2010.
3. Recommendations regarding how prevention of sexual abuse will be address by program approved and implementation is in progress by 2010.

Activities completed as of September 2009:

- Task forces established to develop recommendations for Comprehensive Plan.
- Initial listing of existing prevention programs developed.
- Literature pulled relating to various prevention programs.
- Draft assessment of child abuse and neglect and other factors contributing to abuse and neglect completed.

Strategy 5: Enhance Professional development of existing workforce on prevention of and early intervening in abuse and neglect by 2010.

Activities:

- Enhance existing and/or develop new training for professionals working in the field on identifying and intervening with families exhibiting stress factors.
- Implement training across agencies and programs beginning in 2011.
- Provide professional working families with interventions aimed at reducing stress factors and strengthening protective factors.
- Support child abuse prevention programs that serve special populations:
    i. Contract with Tribal Nations in order to assure their population is provided child abuse prevention services;
    ii. Contract with agencies that serve special populations such as teen parents, physically and mentally challenged parents and racial and ethnic minority parents; and
    iii. Allow OCAP Contractors to incorporate culturally-specific curriculums if supported by research.

Measurable Outcomes:

1. Annual reports for OCAP/Start Right , Children First and CBCAP completed
2. Specific plan for SFY 2011 developed
3. County-by-county assessment of resources completed

Activities completed up to September 2010:

- Research on cross training for professionals, review other state models, initiate discussions with training entities about implementation of training; no funding at this time
- Presentation on protective factors at various conferences such as the Family Child Care Conference

PUBLIC WILL

Strategy 6: Strengthen the public will and community capacity to prevent abuse and neglect and raise awareness of the impact of abuse and neglect on children, families and communities

Activities:

- Based on recommendations for the five year plan, develop a policy agenda that supports the goals of the plan.
- Develop a statewide campaign that promotes specific child abuse prevention programs (as family support programs).

- Develop a statewide campaign that celebrates the diversity of families in Oklahoma and provides tips on supporting families in your community.
- Develop a statewide campaign that promotes positive parenting practices utilizing television, radio, billboard and/or other print mediums and reframing principles.
- Provide the following educational materials upon request when funding is available, e.g., Identification and Reporting of Child Abuse and Neglect Brochures and Child Abuse Hotline Cards.
- Promotion and Community Involvement of Child Abuse Prevention Month (every April) through coordination of Child Abuse Prevention Day at the Capitol and other planned community events.

Measurable Outcomes:

1. Policy agenda that defines needed resources for a comprehensive system focused on prevention of abuse and neglect.
2. Statewide media campaign implemented.
3. Education materials provided when requested by programs.
4. Annual Child Abuse Prevention Day at the Capitol.

<u>Activities completed as of September</u>:

- Funding for educational materials cut due to budget reduction.
- Invitation to Bid developed for a free-standing Parent Website; not accomplished because against agency policy; will pursue developing pieces of it on the OSDH website.
- Have conducted four or more interviews with the media including Telemundo; focused on budget cuts and the need of citizens to become involved in child abuse prevention.
- Pursued utilization of social media (Facebook, Twitter); not allowed at this time.
- Created art work to be used in child abuse awareness items.
- Annual Child Abuse Prevention month activities are being planned.
- Poll information regarding community awareness and perceptions of child abuse gathered by Prevent Child Abuse Oklahoma; will be used for public awareness, funds permitting, and included in the next iteration of the State Plan.
- Upcoming Institute for Child Advocacy Fall Forum will identify key policy issues for upcoming legislative session.
- OCAP/Start Right Program Consultant developed a postcard individuals can send to compliment a business for being family-friendly as her OICA Kids Count Leadership project.

During the past year, the Interagency Child Abuse Prevention Task Force listed the many activities, services and programs they believed to be necessary to support children and families. The idea of developing a "County Grid" that included such items was accepted by the ITF.

Between February 2010 and June 2010, a variety of programs and services were asked to provide information for the State Plan.

The submitted information is included in this document. However, the ITF recognizes that many state agencies will be reworking their budgets for State Fiscal Year 2011. Unfortunately, many agencies have been asked to "make do" with less state appropriations. It is assumed that this exercise involving the Grid, as well as the programmatic detail, will have to be repeated in order to learn about Oklahoma's current state of social services.

94 cm

47 cm

child abuse & neglect: ACTIVITIES, SERVICES & PROGRAMS

12 cm

12 cm

126 cm

Child Abuse Prevention in Oklahoma
Continuum of Care

COUNTY	Primary Prevention													Secondary Prevention					Tertiary Prevention								
	Concrete Supports	Community Engagement	Local Task Forces	Oklahoma Parent Website	Parent Warmline	AHT Education in Hospital	Health Care Pediatrics, Etc.	Child Guidance General Services	Parent Education Groups	Sex Abuse Prevention Education for Parents or Adults	Sex Abuse Prevention Education For Children	Quality Early Childhood Education	Child Care Centers	Child Guidance The Incredible Years	Home Visitation for First Time Mothers	Home Visitation for Parents of Young Children	RESPITE	Alternative Schools for Pregnant & Parenting Teens	Home Visitation for High Risk Parents	SoonerStart	Trauma Services for Children	Parent Child Interaction Therapy	Mental Health Services	Substance Abuse Services	Domestic Violence Services	Systems of Care	Child Advocacy Centers / MDTs
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Adair									X			X				X			X	X							X
Alfalfa																X			X	X							
Atoka															X				X	X							X
Beaver															X				X	X							X
Beckham															X	X			X	X				X		X	X
Blaine															X	X			X	X						X	X
Bryan															X	X			X	X				X	X		X
Caddo															X	X			X	X				X			
Canadian															X	X			X	X			X			X	X
Carter															X	X			X	X			X		X	X	X
Cherokee									X			X			X	X			X	X			X	X	X	X	X
Choctaw												X			X	X			X	X				X		X	
Cimarron																			X	X							X
Cleveland									X			X			X				X	X			X		X	X	X
Coal															X	X			X	X							X
Comanche												X			X	X			X	X			X	X	X	X	X
Cotton															X	X			X	X							
Craig												X			X				X	X				X		X	X
Creek												X			X	X			X	X						X	X
Custer															X	X			X	X			X		X	X	X
Delaware								X							X	X			X	X				X		X	
Dewey																			X	X							

Child Abuse Prevention in Oklahoma
Continuum of Care

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	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
	Primary Prevention													Secondary Prevention					Tertiary Prevention								
Ellis															X				X	X							
Garfield		x													X	X			X	X			X	X	X	X	X
Garvin															X	X			X	X							
Grady															X	X			X	X				X		X	X
Grant															X	X			X	X							
Greer															X	X			X	X							
Harmon															X				X	X							
Harper															X				X	X							
Haskell															X				X	X				X	X		X
Hughes															X	X			X	X							
Jackson															X	X			X	X					X		
Jefferson															X	X			X	X							
Johnston															X				X	X							X
Kay		x							X						X	X			X	X				X	X	X	X
Kingfisher															X	X			X	X						X	
Kiowa															X	X			X	X				X			
Latimer															X				X	X				X			X
LeFlore															X	X			X	X					X	X	X
Lincoln												X			X				X	X				X	X	X	
Logan		x										X			X	X			X	X				X		X	X
Love															X	X			X							X	X
Major															X	X			X	X							

Child Abuse Prevention in Oklahoma Continuum of Care

COUNTY	Primary Prevention													Secondary Prevention					Tertiary Prevention								
	Concrete Supports	Community Engagement	Local Task Forces	Oklahoma Parent Website	Parent Warmline	AHT Education in Hospital	Health Care Pediatrics, Etc.	Child Guidance General Services	Parent Education Groups	Sex Abuse Prevention Education for Parents or Adults	Sex Abuse Prevention Education For Children	Quality Early Childhood Education	Child Care Centers	Child Guidance The Incredible Years	Home Visitation for First Time Mothers	Home Visitation for Parents of Young Children	RESPITE	Alternative Schools for Pregnant & Parenting Teens	Home Visitation for High Risk Parents	SoonerStart	Trauma Services for Children	Parent Child Interaction Therapy	Mental Health Services	Substance Abuse Services	Domestic Violence Services	Systems of Care	Child Advocacy Centers/ MDTs
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Marshall															X				X	X							X
Mayes												X				X			X	X				X		X	X
McClain															X	X			X	X				X		X	X
McCurtain									X			X			X	X			X	X				X	X	X	X
McIntosh									X						X				X	X						X	X
Murray															X	X			X	X							
Muskogee												X			X	X			X	X			X	X	X	X	X
Noble															X	X			X	X				X	X	X	
Nowata															X	X			X	X			X	X		X	
Okfuskee															X				X	X						X	
Oklahoma		X										X			X	X			X	X			X	X	X	X	X
Okmulgee												X			X	X			X	X			X		X	X	
Osage												X			X	X			X	X				X		X	
Ottawa															X				X	X				X	X	X	
Pawnee															X				X	X				X		X	
Payne		X										X			X	X			X	X				X		X	X
Pittsburg															X	X			X	X			X	X	X	X	X
Pontotoc		X													X	X			X	X				X	X	X	X
Pottawatomie												X			X	X			X	X				X	X	X	X
Pushmataha												X			X	X			X	X				X		X	X
Roger Mills																X			X	X						X	X
Rogers															X	X			X	X				X	X	X	X

Child Abuse Prevention in Oklahoma Continuum of Care

COUNTY	PRIMARY PREVENTION													SECONDARY PREVENTION					TERTIARY PREVENTION								
	Concrete Supports	Community Engagement	Local Task Forces	Oklahoma Parent Website	Parent Warmline	AHT Education in Hospital	Health Care Pediatrics, Etc.	Child Guidance General Services	Parent Education Groups	Sex Abuse Prevention Education for Parents or Adults	Sex Abuse Prevention Education For Children	Quality Early Childhood Education	Child Care Centers	Child Guidance The Incredible Years	Home Visitation for First Time Mothers	Home Visitation for Parents of Young Children	RESPITE	Alternative Schools for Pregnant & Parenting Teens	Home Visitation for High Risk Parents	SoonerStart	Trauma Services for Children	Parent Child Interaction Therapy	Mental Health Services	Substance Abuse Services	Domestic Violence Services	Systems of Care	Child Advocacy Centers/ MDTs
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
	PRIMARY PREVENTION													SECONDARY PREVENTION					TERTIARY PREVENTION								
Seminole												X				X			X	X				X	X	X	
Sequoyah															X	X			X	X				X			X
Stephens															X	X			X	X							X
Texas															X	X			X	X					X	X	X
Tillman															X	X			X	X							
Tulsa		X										X			X	X			X	X			X		X	X	X
Wagoner									X			X			X	X			X	X							
Washington															X	X			X	X				X	X	X	X
Washita																X			X	X						X	X
Woods															X	X			X	X				X			
Woodward															X				X	X			X	X	X	X	X

Index Examples of what each County might have in a given area.

(1) Concrete Supports - Food pantries, Diapers, etc.
(2) Community Engagement - Front Porch, Strengthening Families, Smart Start, etc.
(3) Local Task Forces – Turning Point Initiatives, Special Project Groups, Task Forces.
(4) Oklahoma Parent Website -
(5) Oklahoma Parent Warmline -
(6) AHT Education in the Hospital – Potential Models Utilized: Period of Purple Crying.
(7) HealthCare Pediatrics - Maternity, Family/General Practice
(8) Child Guidance Services (OSDH) – Parent Consultations, Child Development Screenings, Parenting Workshops, Parent Talk Sessions, Child Care Trainings.
(9) Parent Education Groups - Parent Workshops, Parent Education Groups (i.e. Circle of Parents, S.T.E.P., etc), Parent Support Groups, etc.
(10) Sexual Abuse Prevention Education for Parents/Adults -
(11) Sexual Abuse Prevention Education for Children -
(12) Quality Early Childhood Education - Preschools, Pre-kindergarten Programs, Early Head Start, Head Start, Educare, etc. [*Pre-Kindergarten Program → Everywhere]
(13) Child Care Centers.
(14) The Incredible Years through Child Guidance General Services -
(15) Home Visitation for First Time Mothers – Children First.
(16) **Home Visitation for Parents of Young Children** – Oklahoma Parents as Teachers, Start Right Programs (formerly OCAP), Healthy Start.
(17) RESPITE -

(18) Alternative School for Pregnant & Parenting Teens.
(19) Home Visitation for High-Risk Parents – Comprehensive Home-Based Services, Project SafeCare.
(20) SoonerStart.
(21) Trauma Services for Children.
(22) Parent Child Interaction Therapy.
(23) Mental Health Services.
(24) Substance Abuse Services.
(25) Domestic Violence Services.
(26) Systems of Care.
(27) Child Advocacy Centers/MDTs.

Strengthening Families

Agency	Description & Target Population
Oklahoma State Department of Health SmartStart Oklahoma	Eligibility: Who is served? Children in child care settings involved in the Strengthening Families Sites. Duration of Participation Children and families are served while participating in child care program or through various community events. Description of Services Research shows that the protective factors of parent resiliency, social connections, knowledge of parenting and child development, concrete support in times of need and child social and emotional development reduce the incidence of child abuse and neglect by providing parents with what they need to parent effectively, even under stress. By building relationships with families, programs can recognize signs of stress and build families' Protective Factors with timely, effective help. Programs and communities implement activities that build the Protective Factors t into programs and systems that already exist such as early childhood education and child welfare, at little cost
Funding Source	
Public and Private Funding	
Counties Served	
Garfield, Logan, Kay, Pontotoc, Payne, Stephens and Tulsa	

Program Model

Strengthening Families - this initiative works with child care, child welfare, and early childhood programs to infuse evidence-based Protective Factors around young children and to build supportive relationships between professionals and parents as a way to strengthening parent-child interactions and reduce the potential for harmful parenting behaviors.

Numbers Served

The 3 sites participating in the initial evaluation report serving 22 child care facilities, 1273 parents, 3044 children and 209 child care providers.

Evaluation

During the FY 2008, an evaluation protocol was developed to concretely measure the Strengthening Families Initiative for child care. First year narrative reports and Strengthening Families Initiative description provided background to develop an evaluation plan for the SF child care component. SF stake holders' such as Smart Start staff and pilot sites were involved in identifying program needs and shaping the evaluation plan. Evaluation drafts were presented at the Strengthening Families Strategic Planning meeting in September 2008. Feedback from the meeting was incorporated to finalize the evaluation plan and data collection tools. Seven sites participating in second year of SF Initiative were provided with evaluation materials and an evaluation manual during evaluation training held in October 2008.

Outcomes

1. Prevention of child abuse and neglect through increased knowledge and understanding of child development and parenting strategies.
2. All child and family serving agencies will build in the protective factors throughout their programs.
3. Strong partnerships between early childhood programs, child care and child welfare to prevent abuse and neglect and strengthen families.

Contact Information	Grace Kelley 1000 NE 10th Street Oklahoma City, OK 73117 405-271-7611 GraceK@health.ok.gov
Website	www.strengtheningfamiliesprogram.org

Smart Start Oklahoma

Agency	Description & Target Population
Smart Start Oklahoma	The charge for Smart Start Oklahoma (SSO) is to develop a local community network, engaging the public in school readiness, analyzing and developing public policy for children ages 0-6 and their caregivers. The Smart Start Oklahoma Board has been designated by Governor Henry as the state's early childhood advisory council, increasing the board's existing role to serve as an advisory body to the Governor's office for early childhood system's development. We also contract with 18 SSO communities who assist in this work on a local level.
Funding Source	
State and Foundation Funds	
Counties Served	
52	

Program Model
Smart Start Oklahoma works through a Coalitions/Boards model on a local level and through topical workgroups and committees on a state level.
Numbers Served
Rather than direct service, most work is in planning, data gathering and making recommendations and community mobilization.
Evaluation
SSO communities' work plans are evaluated locally.
Outcomes
1. 100% of SSO communities will have current strategic plans in place to facilitate school readiness for children 0-6. 2. 100% of SSO communities will have a current needs assessment in place. 3. 100% of SSO communities will support the State Early Childhood Advisory Council annually by soliciting and reporting local recommendations.

Contact Information	Executive Director 421 N.W. 13th Street, suite 270 Oklahoma City, OK 73103 (405) 278-6978
Website	www.smartstartok.org

Multidisciplinary Child Abuse Teams (MDT)

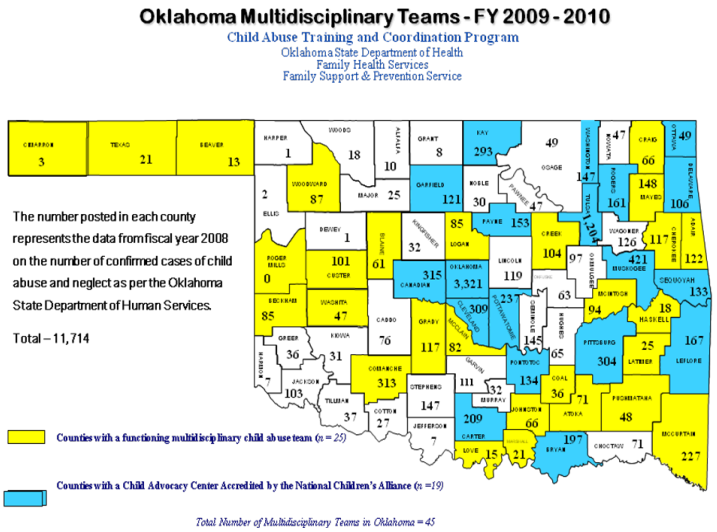
Agency	Description & Target Population
Oklahoma State Department of Human Services (funds) Oklahoma State Department of Health (training, standards, development, and assessment) District Attorney Offices (county level development)	A multidisciplinary team is a group of professionals from various organizations and agencies that work toward providing a more coordinated, effective child protection system within a community. MDTs work to minimize the number of interviews necessary for a child victim of sexual abuse, physical abuse, or neglect and coordinate the response to child maltreatment. Oklahoma legislation calls for the establishment of teams in every county and the funding of functional MDTs. As of SFY 2009, there are 45 functioning multidisciplinary teams.
Funding Source	
Child Abuse Multidisciplinary Account (CAMA). Only functioning teams receive CAMA funds. $606,873.54 for teams in FY 2009; $2,864,443.12 for centers; totalling $3,471,316.67.	

Program Model

Minimum standards are set by the Child Abuse Training and Coordination Council (CATCC), Family Support and Prevention Service at the Oklahoma State Department of Health. MDTs submit annual, numerical, and membership reports to the Child Abuse Training and Coordination Program.

Numbers Served

In SFY 2009, common data on cases reviewed was provided by 45 MDT's. During this period, 5,074 cases of child abuse and neglect were reviewed. A case was usually reviewed once (77%) while 15% were reviewed twice and 8% were reviewed more than twice.



Conntact Information	Pat Damron, CATC Program Coordinator; Patriciaad@health.ok.gov Shelagh Hadden, Program Manager; shelaghh@health.ok.gov Lisa Slater, Administrative Assistant; lisaj@health.ok.gov
Website	http://catcp.health.ok.gov

Reaching for the Stars Child Care Rating System

Department of Human Services

Agency	Description & Target Population
Oklahoma Child Care Services	Research has demonstrated that the quality of childcare impacts the cognitive, emotional, and physical development of a child. The Oklahoma Department of Human Services/Child Care Services implemented a child care rating and improvement system in 1998 to provide an easily understandable guide to licensed child care facilities, including centers, homes, and head start. The goals of the Stars program are to provide a system to help parents evaluate child care; improve the quality of child care by increasing the competence of teachers; and raise the Department's subsidy reimbursement rate, resulting in more slots for children whose families are receiving child care assistance._ The criteria encourages facilities to exceed the minimum standards for the care they provide. One Star facilities meet minimum licensing requirements that focus on health and safety. One Star Plus programs meet the minimum requirements plus additional quality criteria that includes: additional training, daily reading to children, parent involvement and some program evaluation. Two Star programs meet further quality criteria including master teacher/home provider qualifications and program assessment or accredited by a national accreditation body. Three Star programs meet all additional quality criteria AND are nationally accredited.
Funding Source	
(Spreadsheet available with specific funding information): Feb 2010 TANF CCDF	
Counties Served	
Statewide	

Program Model
Licensing and Quality Rating and Improvement System

Numbers Served
Total licensed child care capacity 135,560 FY-09 subsidy cumulative unduplicated child count 69,295 Average monthly number of subsidy children per month 38,500

Evaluation
Child Care Facilities are monitored 3 times a year, star criteria is monitored annually and an Environment Rating Scale is completed every 3 years.

Outcomes
1. Licensed and affordable child care. 2. Quality care for children with the opportunity to develop to their fullest potential in a safe, healthy and nurturing environment. 3. Improved competency level of child care providers.

Contact Information	Lesli Blazer, Director of Child Care Services PO BOX 25352 Oklahoma City, OK 73125 (405) 521-3561
Website	http://www.okdhs.org/programsandservices/cc/

Oklahoma Parents As Teachers (OPAT)

Agency	Description & Target Population
Oklahoma State Department of Education Administered at the School District level through competitive grants.	OPAT is a parent education program based on the philosophy that parents are their children's first and most important teachers. It is a voluntary monthly home visitation program for parents with children birth to age three. OPAT is affiliated with the nationally validated Parents As Teachers Program. Through home visits and monthly group meetings, OPAT is designed to strengthen the capacity of parents to be effective first teachers and to foster an early partnership between home and school so that parents take a far more active role during their children's formal years of schooling. Target Population: All families with children, birth to 36 months of age, who reside in participating school districts.
Funding Source	
State Appropriations ($1.9 million in grant funds for school year 08-09)	

Program Model

Parents as Teachers

Numbers Served

In the 2008-2009 school year, Parent Educators made 33,775 personal visits with 4,388 families and 5,027 children, for the average cost per child at $384.

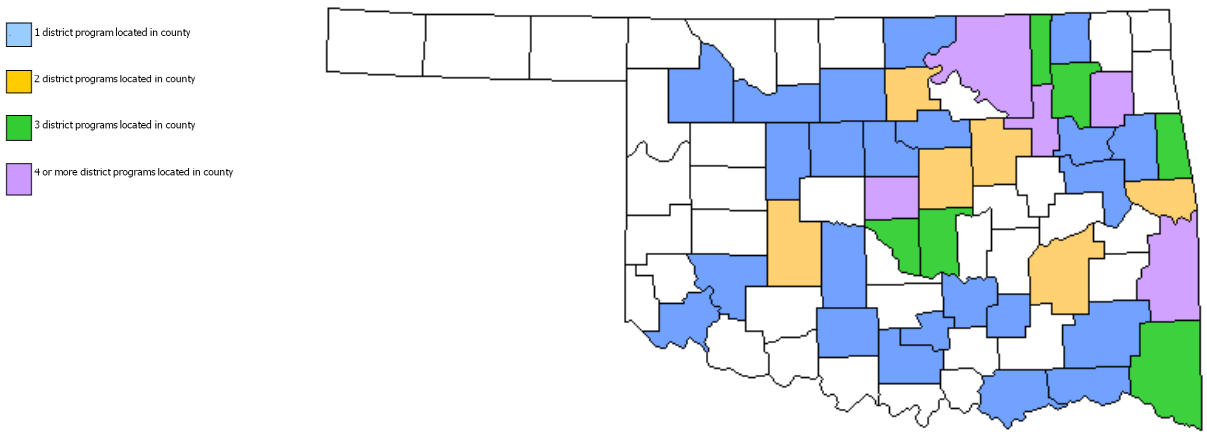
Evaluation

National evaluation showed that PAT children were significantly more advanced at three years in language, social development, problem solving, and other intellectual activities and at first grade in reading and math. Other positive results were demonstrated.

Outcomes

1. Reduced risk levels for participating children (Oklahoma Technical Assistance Center, 2010)
2. Increased parental knowledge of child development (Parents as Teachers National Center)
3. Participating parents are more likely to read to their children and enroll them in a pre-school program (Parents as Teachers National Center)

Map



Oklahoma Parents as Teachers Grant Program Locations

County	District	Funded Amount (in dollars)
Adair	Maryetta	$ 13,500
Adair	Watts, Peavine	$ 13,500
Adair	Westville	$ 21,000
Blaine	Geary, Maple	$ 13,500
Bryan	Durant	$ 21,000
Caddo	Anadarko	$ 21,000
Caddo	Binger-Oney, Gracemont	$ 13,500
Canadian	El Reno*	$ 21,000
Carter	Ardmore	$ 35,000
Cherokee	Hulbert*	$ 13,500
Cherokee	Tahlequah	$ 21,000
Choctaw	Hugo City	$ 21,000
Cleveland	Little Axe	$ 13,500
Cleveland	Noble	$ 21,000
Cleveland	Norman	$ 48,500
Coal	Coalgate	$ 13,500
Creek	Bristow	$ 21,000
Creek	Sapulpa	$ 21,000
Garfield	Enid	$ 35,000
Garfield	Pioneer-Pleasant Vale*	$ 13,500
Grady	Minco	$ 13,500
Jackson	Altus	$ 21,000
Kingfisher	Kingfisher	$ 21,000
Kiowa	Hobart	$ 13,500
Leflore	Heavener	$ 13,500
Leflore	Pocola, Arkoma	$ 21,000
Leflore	Poteau	$ 21,000
Lincoln	Meeker	$ 13,500
Logan	Guthrie	$ 35,000
Major	Fairview	$ 13,500
Mayes	Chouteau-Mazie	$ 21,000
Mayes	Locust Grove	$ 21,000
Mayes	Pryor	$ 21,000
Mayes	Salina	$ 13,500
McCurtain	Haworth	$ 13,500
McCurtain	Idabel	$ 21,000
McCurtain	Swink,* Fort Towson, Forest Grove	$ 13,500
McCurtain	Wright City, Glover	$ 13,500
Murray	Sulphur	$ 21,000
Muskogee	Porum	$ 13,500
Noble	Morrison	$ 13,500
Noble	Perry	$ 21,000
Oklahoma	Bethany	$ 21,000
Oklahoma	Midwest City-Del City	$ 42,500
Oklahoma	Oklahoma City	$ 84,000
Oklahoma	Putnam City	$ 63,000
Osage	Avant, Bowring, Osage Hills, South Coffeyville	$ 13,500
Osage	Newkirk	$ 13,500
Osage	Pawhuska	$ 13,500
Osage	Shidler, Frontier	$ 13,500
Osage	Wellston	$ 13,500
Osage	Woodland, Kaw City, Wynona	$ 13,500
Osage	Hominy	$ 13,500
Payne	Perkins-Tryon	$ 21,000
Pittsburg	McAlester	$ 21,000
Pittsburg	Quinton	$ 13,500
Pontotoc	Ada	$ 21,000
Pottawatomie	Grove, South Rock Creek	$ 13,500
Pottawatomie	Shawnee	$ 35,000
Pottawatomie	Tecumseh	$ 21,000
Rogers	Claremore	$ 21,000
Rogers	Verdigris	$ 21,000
Sequoyah	Muldrow	$ 21,000
Sequoyah	Vian	$ 13,500
Stephens	Comanche	$ 13,500
Tulsa	Bixby*	$ 35,000
Tulsa	Broken Arrow	$ 48,500
Tulsa	Glenpool	$ 21,000
Tulsa	Jenks	$ 35,000
Tulsa	Sand Springs	$ 21,000
Tulsa	Skiatook	$ 21,000
Tulsa	Tulsa	$ 84,000
Tulsa	Union	$ 48,500
Wagoner	Okay	$ 13,500
Washington	Bartlesville	$ 35,000
Washington	Caney Valley, Copan	$ 21,000
Contact Information	Erin Nation <Erin_Nation@sde.state.ok.us> Oklahoma State Department of Education (405) 521-3346	
Website	http://www.sde.state.ok.us	

Early Head Start Program

Agency	Description & Target Population
Early Head Start is administered by the Head Start Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Local community-based organizations and American Indian Tribes are local program providers through grant funds issued directly from the federal government.	Early Head Start is a federal program established in 1994 for low-income families with infants and toddlers and pregnant women. At least 90 percent of enrolled children must be from families at or below the poverty line, and at least 10 percent of program enrollment must be children with disabilities. The mission is to promote healthy prenatal outcomes for pregnant women, enhance the development of eligible very young children, and promote healthy family functioning. Services provided by Early Head Start include: • Quality early education both in and out of the home • Parent education • Comprehensive health and mental health services, including services to women before, during, and after pregnancy • Nutrition education • Family support services Early Head Start offers income-eligible children (ages 0-3) and their families comprehensive child development services through center-based, home-based, and combination program options. Target Population: Low income (100% of Federal Poverty Level) pregnant women and families with infants and toddlers less than 3 years of age.
Funding Source	
The Early Head Start grantees received $9,187,267 in federal funds in FFY 2009.	

Program Model

Early Head Start

Numbers Served

A total of 1,856 children and 58 pregnant women were served by Early Head Start in Oklahoma in FFY-09.

Outcomes

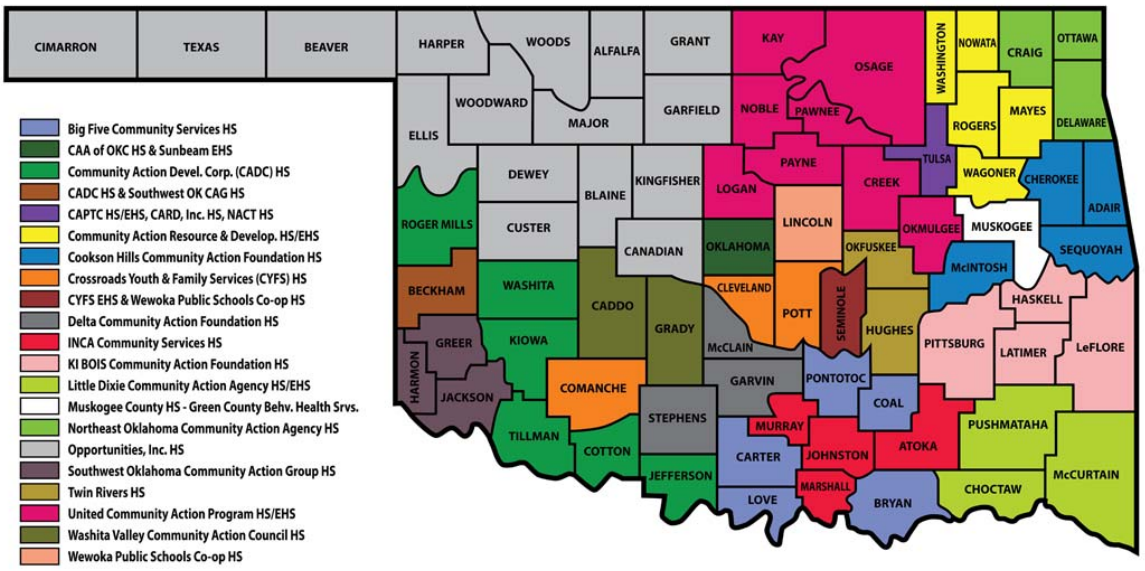
1. Parents/families learn how to ensure infant/toddler medical screenings are performed at appropriate ages.
2. Assistance is provided in accessing mental health services for both mothers and children.
3. Counseling and assistance in obtaining adult education (GED, college) is provided.

Grantees and Counties Served

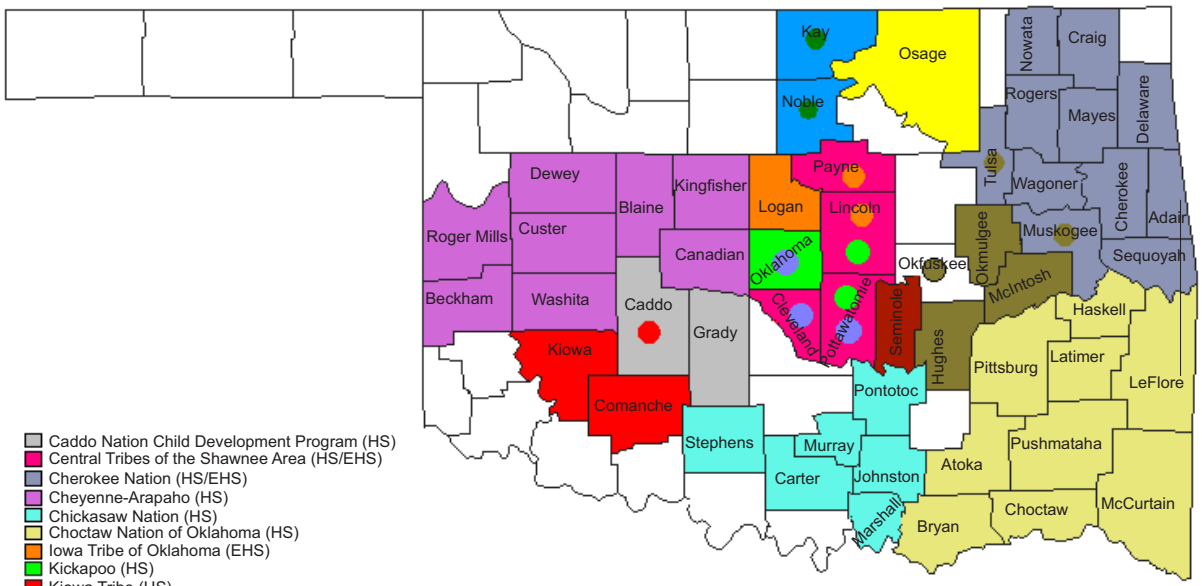
Oklahoma Early Head Start Grantee and Counties Served:
Community Action Resource & Development -Mayes, Rogers, Tulsa, and Wagoner
Community Action Project of Tulsa County - Tulsa
Crossroads Youth & Family Services - Cleveland, Comanche, Pottawatomie and Seminole
Green Country Behavioral Services - Muskogee
Little Dixie Community Action Agency - Choctaw, McCurtain and Pushmataha
Sunbeam Early Head Start - Oklahoma
United Community Action Program - Creek, Logan, Okmulgee, Osage, Payne, and West Tulsa

American Indian Early Head Start Grantees and Counties Served:
Central Tribe of the Shawnee Area - Pottawatomie
Cherokee Nation Early Head Start -Cherokee, Adair, Craig, Mayes
Iowa Tribe of Oklahoma - Payne, Lincoln, Logan
Seminole Nation of Oklahoma - Seminole
University of Oklahoma (American Indian Institute) - Pottawatomie, Cleveland, Oklahoma

Head Start Grantees



Tribal Head Start Grantees



Contact Information	Kay C. Floyd, State Director of Head Start Collaboration Oklahoma Association of Community Action Agencies 2800 NW 36th Street, Suite 221 Oklahoma City, OK 73112 Telephone: (405) 949-1495 Fax: (405) 949-0955 kfloyd@okacaa.org
Website	www.okacaa.org

Pre-Kindergarten Programs

Agency	Description & Target Population
Oklahoma State Department of Education	Children, who are age four on or before September 1, are eligible for the voluntary public school pre-kindergarten program. Currently, nearly 75% of Oklahoma's four-year-olds attend public school and have access to: • an Early Childhood Certified Teacher, • a 10:1 child to teacher ratio, • comprehensive school services, and • full-day or half-day programs, • state adopted curriculum standards, • school readiness program.
Funding Source	
State funding through the school funding formula.	
Counties Served	
All school districts have the option of having a Pre-Kindergarten program. In 2008-2009, 97% of school districts offered a Pre-Kindergarten program.	

Program Model

Half-day/full-day option

Voluntary participation

A bachelor-degreed, early childhood certified teacher

Adult/child ratio of 1:10

Priority Academic Student Skills (PASS) desiged to be appropriate to age development

Numbers Served

In 2008-2009, a total of 36,042 children were enrolled in a public school Pre-Kindergarten program. 16,166 in a half-day program and 19,522 in a full-day program.

Evaluation

The Effects of Universal Pre-Kindergarten on Cognitive Development, Georgetown University (2003)

http://www.crocus.georgetown.edu/publications.html

Outcomes

1. Increased readiness for reading and academic learning (Georgetown study, 2003-2004)
2. Easy transition to Kindergarten
3. 52% increase in Letter-word identification; 27% increase in Spelling; and 21% increase in Applied Problems (Georgetown University, 2004)

Contact Information	Dr. Ramona Paul, <Ramona_Paul@sde.state.ok.us> Oklahoma State Department of Education (405) 521-4311 Erin Nation, <Erin_Nation@sde.state.ok.us> Oklahoma State Department of Education (405) 521-3346
Website	http://www.sde.state.ok.us

Educare

Oklahoma City

Agency	Description & Target Population
Sunbeam Family Services – OKC Educare	Educare is a comprehensive early education service for children and families. OKC Educare serves 200 children in a full-day, year round program. Services are provided at no cost to the family. Target Population: Educare (Okc) serves Oklahoma County children birth to five years and their families (must qualify under federal poverty line). Can be in the program from birth to five, or can enroll based on availability at any time before the child turns 5 years old.
Funding Source	
Federal Head Start/Early Head Start Grant, OKCPS Funding for Pre-K classes, private funds, United Way	
Counties Served	
Oklahoma	

Program Model
Head Start/Early Head Start, OKCPS Pre-K. Full-year, full-day program model. High teacher-child ratio, intensive family support, strong mental health componet.
Numbers Served
200 is the current enrollment of children and the capacity for the program. During FY-09, 264 children were served at the Oklahoma City Educare Center (an approximate count of parents and enrolled children would be 650).
Evaluation
Extensive evaluation component. Several different methods utilized, part of a national research project.
Outcomes
1. In 2009, 87% of enrolled children demonstrated growth in all areas of development, such as social-emotional, cognitive, and gross motor skills. 2. In 2009, 98% of children enrolled in the program were completely up-to-date on all required immunizations. 3. In 2009, 85% of enrolled parents participated in parenting classes or other adult education classes (like GED and ESL classes). 4. In 2009, 100% of enrolled pregnant mothers received prenatal and postpartum care, including breastfeeding education and postpartum depression screeners.

Contact Information	Paula Gates, Program Director 500 SE Grand. Blvd OKC, Ok 73129- (405) 605-8232
Website	www.okceducare.org

Educare

Tulsa

Agency	Description & Target Population
Tulsa Educare I Tulsa Educare II	Educare is a comprehensive early education service for children and families. In Tulsa, Educare 1 opened in 2006; Educare 2 opened in 2010. Services are provided at no cost to the family. State of the art early childhood centers that provide education and care of 364 children (from birth to age five) and their families with full day, year round early childhood education, family support services and ongoing medical care. Target Population: Educare (Tulsa) serves Tulsa County children birth to five years and their families (must qualify under federal poverty line). Can be in the program from birth to five, or can enroll based on availability at any time before the child turns 5 years old.
Funding Source	
George Kaiser Family Foundation, Dept. of Education, State Pilot Project, Early Head Start, Head Start, Department of Human Services, Private Pay	
Counties Served	
Tulsa County	

Program Model
Bounce Learning Network, Early Head Start, Head Start
Numbers Served
200 children at Educare 1; 164 children at Educare 2.
Evaluation
Bayley Cognitive and Language Scores, Peabody Picture Vocabulary Test, and Bracken School Readiness.
Outcomes
1. Early entry into the program results in more positive outcomes. In 2007 – 2009, two year old children at Educare sites scored 96.0 on the Bayley Congnitive and Language test compared to 89.9 for the control group children 2. Scores on vocabulary for three year olds at Educare in 2007 - 2009 indicated 93.0 compared to 81.1 for the control group. 3. 2007- 2009 scores for school readiness of Kindergarten bound children again indicated that the earlier entry into the program, the better outcome for children. Children who entered the program at 2 yrs. of age or less scored 105.1 (English speaking) and 104.4. for non-English speaking children compared to children who entered the Educare program at age 4 plus years with scores of 95.5 (English speaking) and 88.7 (non-English speaking), respectively.

Contact Information	Caren Calhoun, Executive Director 3420 N. Peoria Tulsa, Ok 74106 (918) 508-2255
Website	Educaretulsa.org

Child Guidance Services

General Services

Agency	Description & Target Population
Oklahoma State Department of Health Administered at the County and City-County Health Department levels	Child Guidance services focus on strengthening families by promoting positive parent-child relationships and optimal child development. Child development specialists, speech language pathologists, psychologists, social workers, and audiologists provide screening, assessment and intervention for developmental, communication, hearing, and behavioral concerns and assist families in accessing resources. Target Population: Families with children birth to 13 years.
Funding Source	
Child Guidance State Appropriations and Local Millage ($6.1 million in SFY 09); CBCAP Funds ($80,000 in FFY 09)	

Program Models ~ Two Specialized Programs within Child Guidance

The Incredible Years: Parents, Teachers, and Children Training Series is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 4 to 8 years). The interventions that make up this series - parent training, teacher training, and child training programs are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family and school) in the development of conduct problems.

Parent-Child Interaction Therapy (PCIT): PCIT is an empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.

Child Care Mental Health Consultation: The Child Care Mental Health Consultation Network provides onsite child care consultation to address issues surrounding behavioral challenges in the classroom. The Network is staffed by behavioral health and child development specialists in Child Guidance, Community Mental Health Centers and private consultants through the Center for Early Childhood Professional Development. Requests for referrals are obtained through the Oklahoma Child Care Warmline. This initiative is provided in collaboration with the Oklahoma Department of Human Services and the Oklahoma Department of Mental Health and Substance Abuse Services.

Child Care Warmline: The Warmline for Oklahoma Child Care Providers offers free telephone consultation to child care providers on numerous topics of concern. Consultants can also refer providers to appropriate services and resources within their communities. In addition to a personalized phone consultation, an automated topic library with 1,500 topics on pre-recorded messages (including topics on child care, health, behavior and guidance, and development)) are available on the Warmline 24 hours per day. Child Care Mental Health consultation is coordinated through this project. This initiative is provided in collaboration with the Oklahoma Department of Human Services.

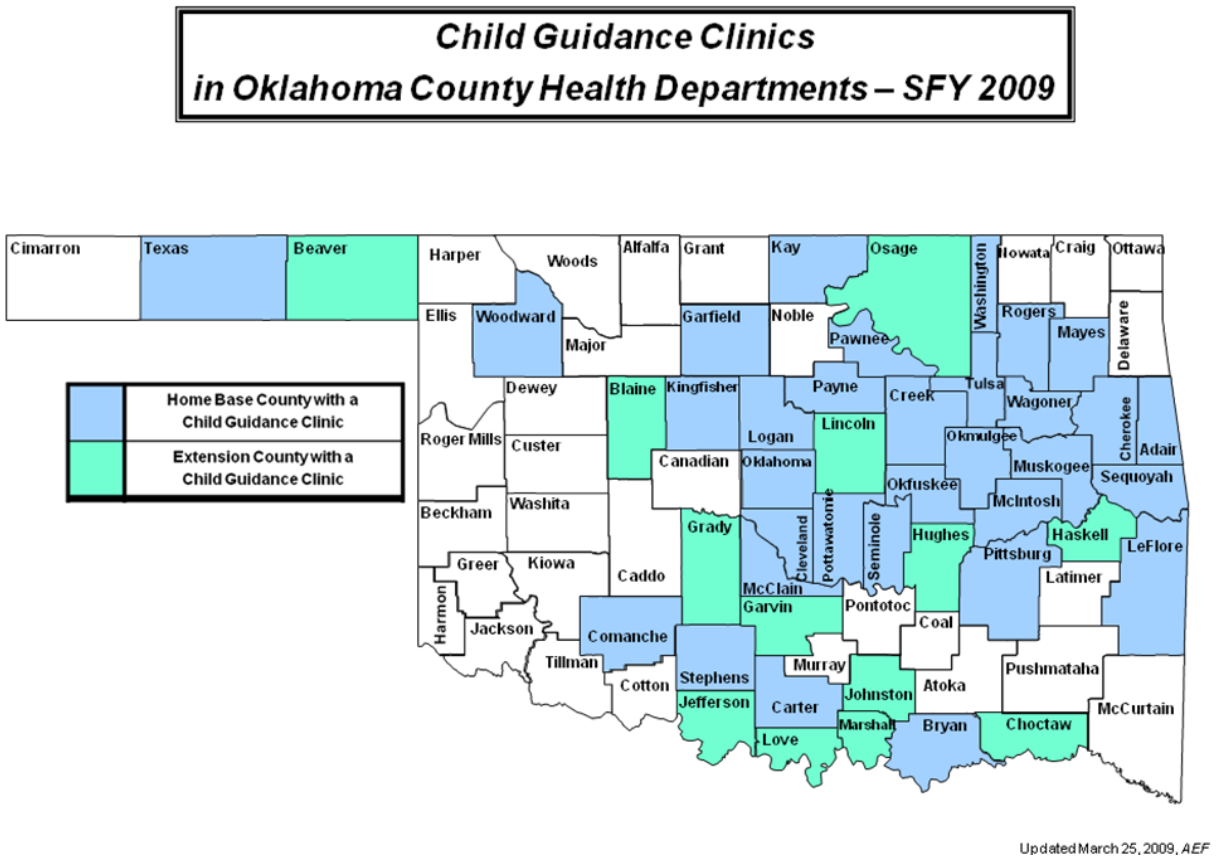
Numbers Served

In SFY 2009, approximately 52,402 individual sessions were conducted for screening, assessment, evaluation, or treatment services. Guidance clinicians provided workshops, training, consultations, or community outreach activities to approximately 42,759 individuals. There were 828 mental health consultation visits provided to childcare providers.

Outcomes

1. For SFY 2009, 36.2% of children being seen for services due to concerns about communication showed good or very good progress toward reaching treatment goals.
2. For SFY 2009, 45.7% of children being seen for services for behavior problems showed good or very good progress toward reaching treatment goals.
3. For SFT 2009, 44.7% of children being seen for services due to concerns about development showed good or very good progress toward reaching treatment goals.

Map



Child Guidance Services

The Incredible Years

Agency	Description & Target Population
Oklahoma State Department of Health Administered at the County and City-County Health Department levels	The Incredible Years Program serves parents and children 4-8 years of age. • Parent Group – consists of a 12 week, 2 hour program which teaches parents interactive play & reinforcement techniques, nonviolent discipline techniques, logical & natural consequences, and problem solving strategies • Classroom Group - consists of between 45 and 60 sessions offered in circle time 2-3 times per week for 30 minutes in a classroom setting. Material taught is followed with practice activities and skill promotion throughout the day. The program also includes letters sent home to parents with home activity suggestions to promotion material learned. • Treatment Group - consists of 18-20 weekly 2 hour sessions and is designed for a small group of children with behavior problems. It can be used to address attention problems, social isolation, internalizing problems and peer rejection; and promotes children's positive self-esteem and social & emotional competence.
Funding Source	
Child Guidance State Appropriations and Local Millage ($5.1 million in SFY 08); CBCAP Funds ($80,000 in FFY 07) Funding for the Incredible Years programs is included in the Child Guidance overall appropriation.	

Program Model

The Incredible Years: Parents, Teachers, and Children Training Series is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 4 to 8 years). The interventions that make up this series – parent training, teacher training, and child training programs are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family and school) in the development of conduct problems.

Numbers Served

The Incredible Years Program served 63 parents in parenting groups, 24 children in classroom groups, and 12 children in treatment groups.

Outcomes

1. For 2005-2008, of the parents participating in the Incredible Years Parent Program, 89% reported feeling confident in handling their child's current and future behavior problems.

Child Guidance Map (see next page)

Incredible Years (Offered by Child Guidance Services) Sites

The Incredible Years Programs were offered in the following areas:
Parent group – Oklahoma County, Tulsa County
Classroom group – Cleveland County, Tulsa County
Treatment group – Cleveland County, Tulsa County

Contact Information	Debra Andersen, Chief Child Guidance Service Oklahoma State Department of Health 1000 NE 10th Street Oklahoma City, OK 73117-1299 (405) 271-4477
Website	www.ok.gov/health/Child_and_Family_Health/Child_Guidance_Service

Start Right Programs (OCAP)

Agency	Description & Target Population
Oklahoma State Department of Health Office of Child Abuse Prevention	Start Right provides 4 basic individual and community services: home visitation, center-based services, assessments and referrals, 2 annual community awareness events. The Office of Child Abuse Prevention programs teach positive parenting skills, and connect families with resources helping reduce the risk of child abuse and neglect by providing home visitation and center-based services. Target Population: First-time mothers after the 29th week of pregnancy, pregnant women expecting a subsequent child, and parents who have a baby less than one year of age. Families are served up to the child's 6th birthday. The Kemp Family Stress Checklist is used to determine the appropriateness of the program for the family.
Funding Source	
State Appropriations ($3,336,482 in SFY09); Local Match Funds (approximately 11% match in SFY 09); CBCAP Funds ($115,000 in FFY 09); and the Child Abuse Prevention License Plate Fund (nominal amount)	
Counties Served	
• Adair, Alfalfa, Beckham, Canadian, Carter, Cherokee, Cleveland, Comanche, Cotton, Creek, Custer, Delaware, Garvin, Grant, Greer, Hughes, Jackson, Jefferson, Kay, Kiowa, Love, Major, McClain, McCurtain, Murray, Nowata, Oklahoma, Okmulgee, Pittsburg, Pontotoc, Roger Mills, Seminole, Stephens, Texas, Tillman, Tulsa, Wagoner, Washington, Washita, Woods (40 total, 39 with state appropriated funding)	

Program Model

Structure based on the Healthy Families America® model; utilizes the Parents as Teachers® and other nationally recognized, evidence-based curricula for delivering services; includes a center-based component.

Numbers Served

During SFY 2009, 2,910 adults were contacted and screened for program participation. 2,671 families screened positive and were potential candidates for the Start Right program. 1,858 individuals were referred for further assessment, and 878 individuals were offered home visitation services in addition to those already participating. A total of 17,317 home visits were completed during SFY 2009. 720 center-based parent education or support activites were completed, and 123 Circle of Parents® meetings were held.

Evaluation

OCAP is authorized by Oklahoma Statute (Title 63, Section 1-227.2) to monitor, review and evaluate child abuse prevention programs. Evaluation activities consist of OCAP programs collecting data from families during home visits. On a weekly basis, the data is entered at programmatic level into the OCAPPA database. OCAP program evaluator provides day-to-day technical assistance, consultation and training to OCAP programs for database and evaluation. Program performance reports are provided on a monthly and quarterly basis along with an annual program outcomes report produced at the end of each SFY. Performance reports are reviewed by OCAP program consultants (central office staff) along with conducting on-site visits to ensure contractors' compliance.

In SFY 2008, evaluation activities focused on refining the program theory through development of the OCAP logic model and defined new measures for program outcomes. Revisions to the standardized evaluation forms and the statewide database (OCAPPA) were implemented in February 2008.

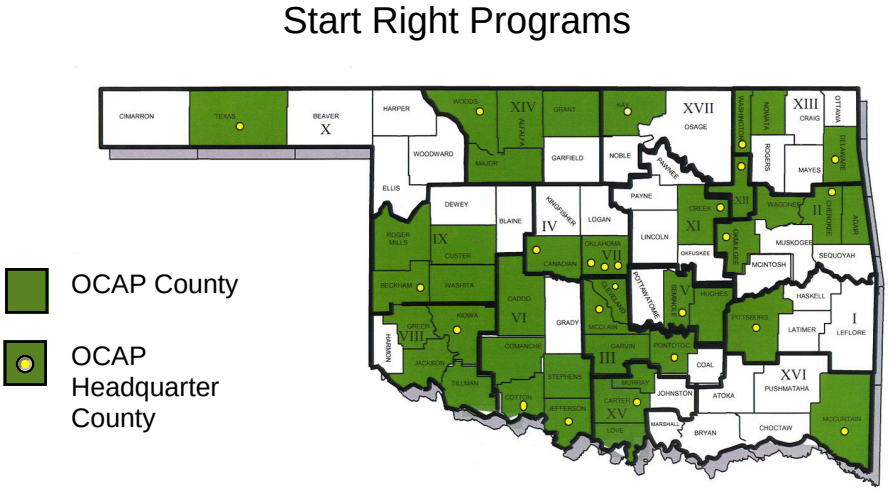
Outcomes

1. During SFY 2009, 30% of newly enrolled primary caregivers smoked. Six months post-enrollment, 57% quit or reduced smoking.
2. During SFY 2009, 90 mothers were assessed for post-partum depression, 7% of which were referred for more intense treatment.
3. During SFY 2009, 91.5% of Start Right children were current with their immunizations. The state rate is 78.5%.
4. Of the 78% of children participating in Start Right that assessed for lead poisoning in high risk areas, 92% were referred to their health care provider for actual lead testing.

OCAP Home Visit Logic Model

The OCAP logic model defines OCAP home visitation programs, related activities and outcomes (see attachment: OCAP Home Visitation Program Logic Model for details). In SFY 2008, the OCAP logic model was introduced. Throughout 2009, the model was presented at multiple events to provide an opportunity for program staff and the Interagency Task Force (performance review and oversight entity) to become familiar with tracking program outcomes and successfully adopting activities that would help to achieve the defined targets. The OCAP will, by year's end 2010, assess in greater detail short and long-term outcomes (i.e. changes in tobacco use, providing for adequate prenatal care, stable housing and transportation, linking families to health care, educational and economic resources, and monitoring program integrity). Further, the new evaluation components will measure changes in frequency of hospital care and emergency room use, families becoming involved with the child welfare system, exercise and nutritional habits, utilization of quality child care, and improved home safety conditions.

OCAP Map



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Start Right Programs (OCAP)

Center-Based Services - Structured Parent Groups

Agency	Description & Target Population
Oklahoma State Department of Health Administered through local Start Right Contractors	The Office of Child Abuse Prevention Start Right Programs provide 4 core services: • Home Visitation • Center-Based Services - Structured Parent Education Services • Assessments and Referrals • Annual Community Awareness Events The Start Right objectives is to teach positive parenting skills, and connect families with resources helping reduce the risk of child abuse and neglect by providing intensive home visitation and center-based services. Target Population: First-time mothers after the 29th week of pregnancy, women expecting a subsequent child, and parents who have a baby less than one year of age. Participants do not have to be enrolled in home visitation services to benefit from center-based services.
Funding Source	
State Appropriations CBCAP Funds and CAP funds $3,246,246 for total contract amounts. Center-based services is a subset of contract requirements of all subrecipient contractors.	
Counties Served	
Alfalfa, Beckham, Canadian, Carter, Comanche, Cotton, Creek, Custer, Delaware, Garvin, Grant, Greer, Hughes, Jackson,Jefferson, Kay, Kiowa, Love, Major, McClain, McCurtain, Murray,Okfuskee,Oklahoma, Okmulgee, Pittsburg, Pontotoc, Stephens, Comanche, Texas, Tulsa, Roger Mills, Seminole, Tillman, Washita, Woods	

Program Model

The Structured Parent Education Group is one of two options required by contract for providing information to parents who may or may not be involved in home visitation services. Structured Parent Ed. groups are intended to supplement home visitation information or simply enhance a parent's ability to effectively deal with the issues of raising children and stabilizing the family. Participants are not necessarily identified as at risk but volunteer to be included in a series of classes on a number of topics. Classes utilize a formal curriculum that are conducted in 4 to 12-week sessions on a weekly, bi-weekly, or monthly basis. Each session runs for 1 to 2 ½ hours in length. The final 10 minutes of each class includes a structured, interactive session with the parents' children. Topic include a variety of relevant family-stabilizing issues including but not limited to: budgeting, discipline, preparing for returning to school or the work force, child development, domestic violence, nutrition, breastfeeding, child abuse identifying and reporting.

Numbers Served

720 parent sessions were conducted during SFY 2009.

Evaluation

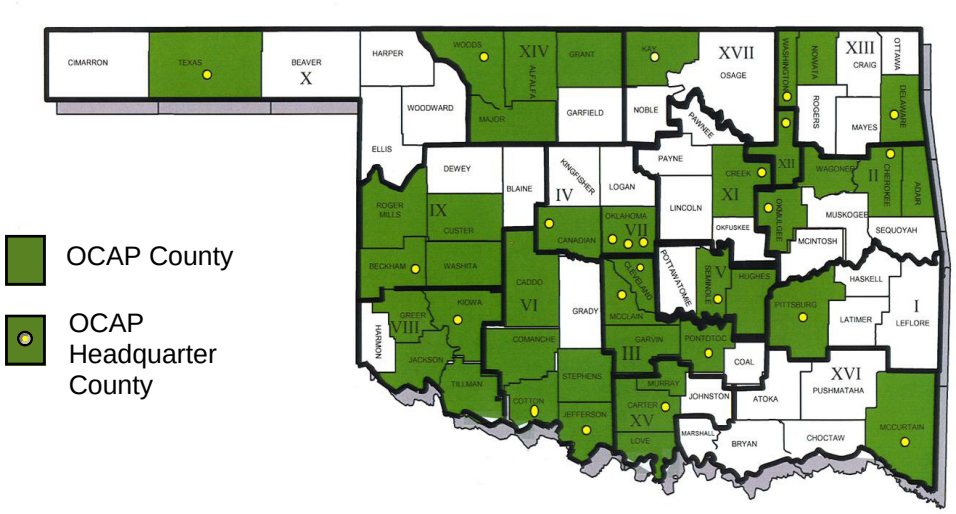
Evaluation currently consists of process information including demographics, meeting content, and participation.

Outcomes

Outcome evaluation from Center-based services is currently being developed in a separate reporting subset based on the home visitation logic model. There is no quantifiable data to report in terms of other than process outcomes.

OCAP Map

Start Right Center-Based Services



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Start Right Programs (OCAP)

Circle of Parents

Agency	Description & Target Population
Oklahoma State Department of Health Administered through local Start Right contractors	The Office of Child Abuse Prevention Start Right Programs provide 4 core services: • Home Visitation • Center-Based Services • Assessments and Referrals • Annual Community Awareness Events The Start Right objectives is to teach positive parenting skills, and connect families with resources helping reduce the risk of child abuse and neglect by providing intensive home visitation and center-based services. Target Population: First-time mothers after the 29th week of pregnancy, women expecting a subsequent child, and parents who have a baby less than one year of age. Participants do not have to be enrolled in home visitation services.
Funding Source	
State Appropriations CBCAP Funds ($1,500); this is a subsection of the Start Right Program.	
Counties Served	
Adair, Cleveland, Cherokee, Delaware, Kay, McCurtain, Wagoner.	

Program Model

Circle of Parents® is a national network of parent support groups. The groups are parent led with a professional co-facilitator. Groups may operate weekly, bi-weekly or monthly. The meeting format may last from 1-2 hours and will focus on topics that may include information provided to parents involved in home visitation or center-based services. Circle of Parents® groups are generally located on site at the professional agency with whom it is affiliated, but may also be at a civic center, library, church, or public meeting facility. The model is structured to focus on a variety of topics or may have a special emphasis such as grandparents raising children, families with special needs children, parents of abused or adopted children, single parents, etc.

Numbers Served

123 parent sessions were conducted during SFY 2009.

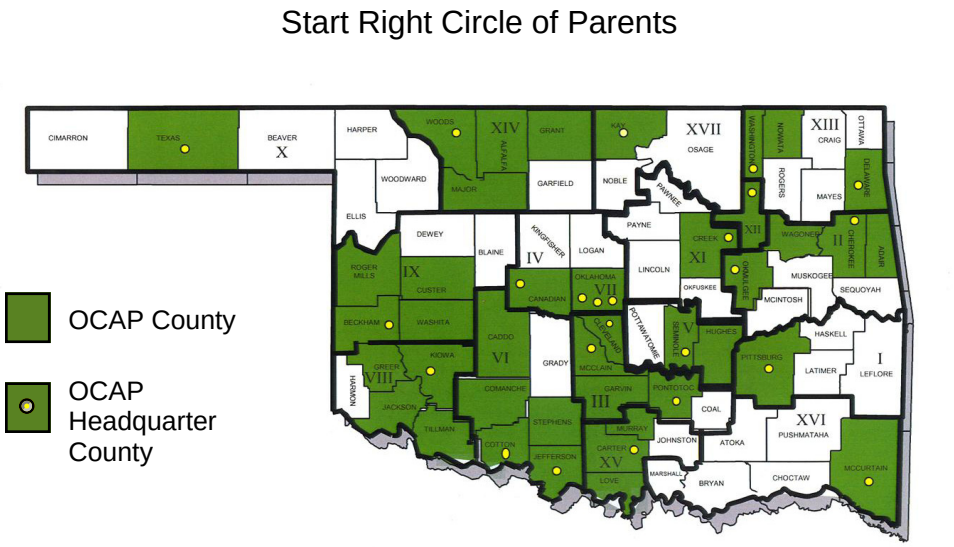
Evaluation

Evaluation currently consists of process information including demographics, meeting content, and participation. Circle of Parents® is currently developing national, standardized outcomes that should produce better trend in behavior information in the coming years. Note that OCAP helps establish Circle of Parents® groups in cooperation with established service agencies local to the area. As the groups are led by a parent volunteer under the oversight and consultation of an outside agency facilitator, OCAP expends no state or federal dollars for this program.

Outcomes

1. A partnership was created at the McCurtain County Memorial Hospital. Those involved included parent participants and local community members focused on child abuse/neglect and staff working in the domestic violence prevention and intervention efforts.
2. In Ponca City, a community partnership was formed with the Circle of Parents® group. Two, biannual meetings were held that brought together local stakeholders with interests in parent support and community leadership.
3. In Bartlesville, Civitan Park Day, a community maternity fair, and annual service summit were held, bringing community members together for information sharing and involvement in discussions centering on parent support and child abuse and neglect.
4. In Norman, a partnership was formed between Succes by Six and the Home Visitation Program Coalition and Circle of Parents®, future events during the SFY 2010 were planned for providing community awareness of the need for parent involvement in local resource programs.

OCAP Map



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OKLAHOMA CHILD ABUSE PREVENTION NETWORK

Secondary Prevention — Office of Child Abuse Prevention Home Visitation Program - Logic Model

ASSUMPTIONS

1. Program services are guided by literature on primary prevention programs and risk & protective factors of child abuse and neglect that show positive results such as:

Prevention programs are most effective when they are tailored to the specific needs of the target population.

The timing of the intervention matters.

Intensity and duration of the intervention matters.

Programs using modeling, role-playing are nearly twice as effective as programs using non-directive strategies such as counseling and group discussions.

Enhancement of protective factors and minimization of risk factors reduces the occurrence of child abuse and neglect amongst children and families.

2. OCAP Home Visitation program will utilize the Healthy Families America model and Parents as Teachers curriculum to deliver services.

i. The program will follow the critical elements of the HFA model i.e. service initiation, service content, and staff characteristics to ensure model fidelity.

ii. Program benefits from the research-based PAT curriculum will depend on the core values and assumptions of the PAT model.

INPUTS

OCAP contracting agencies.

HFA & PAT trained agency staff including program supervisors, FAWs, FSWs, data entry support.

Transportation for conducting home visits.

Social services / resources.

Partnerships to provide referrals.

Stable OCAP funding.

OCAP central office staff.

Program Evaluation.

Program monitoring and contract compliance to ensure program fidelity.

POPULATION SERVED

Identified families from 40 out of 77 counties within Oklahoma, regardless of race/ethnicity, gender, or socio-economic status.

Enrollment Criteria –
Any woman pregnant for first time and beyond 29th week of pregnancy; **or**
Any woman pregnant with a child regardless of gestational age; **or**
Any family with a child less than 1 year of age, **and**
Identified as being at-risk for suspected child abuse and neglect based upon screening and assessment.
Family is served till the child is 6 years of age.

OUTPUTS-Activities

- Link to health care.
- Link to prenatal care.
- Educate on consequences of smoking, alcohol and drugs.
- Educate on personal care.
- Identify depression and make referrals.
- Promote healthy nutrition and exercise.

- Link to health care.
- Conduct developmental screenings and make referrals.
- Promote prenatal care.
- Promote breast-feeding.
- Educate about nurturing home environments.
- Educate about proper nutrition.
- Promote play and exercise.
- Educate about the effects of smoking around the child.
- Promote positive parenting practices.
- Link parents to licensed and star-rated day care facilities.

- Enroll in education, employment and housing services.
- Set FSP goals.
- Build skills for problem solving.
- Build skills in finding and linking to appropriate community resources.
- Educate on family planning, contraceptive use.
- Link to community services, as needed.

- Utilize Parents as Teachers curriculum.
- Set FSP goals.
- Provide positive role model for parent-child interaction.
- Promote and increase father involvement.

- Educate on safe practices and safe home environment such as water, fire, vehicle and wheeled toys safety; poisons, child-proofing home,abusive head trauma and safe sleeping practice.
- Educate on domestic violence.
- Assess risk of child maltreatment.

SHORT-TERM OUTCOMES-Objectives

- Connect 90% of PCGs without health insurance, but eligible, to a health insurance plan within 6 months of enrollment.
- Seek to have 80% of insured mothers, who enrolled during 1st trimester, complete at least 10 prenatal visits by birth.
- Reduce the use of smoking, alcohol and drugs.
- PCG's score above 14 on the 'personal care' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- PCG's score above 23 on the 'depression' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- Screen and refer all postpartum mothers that score 23 or less on the 'depression' section of the Healthy Families Parenting Inventory, with the Edinburgh Postnatal Depression Scale.
- Increase in consumption of fruits and vegetables servings per day.
- Increase exercise/physical activity among PCGs.

- Connect 90% of identified children without health insurance but eligible to a health insurance plan within 6 months of enrollment.
- Seek to have 90% of identified children up to date with immunizations by 2nd year and 95% of identified children by 6th year.
- Screen 90% of identified children for appropriate development with the ASQ / ASQ: SE and refer for services, if needed.
- Conduct lead assessments for at least 90% of identified children with the LERAQ according to the recommended schedule and refer for services, if needed.
- Seek to have at least 85% of those mothers enrolled prenatally, deliver a child with normal birth weight (5 lbs 8 oz or more).
- Seek to have at least 75% of mothers enrolled prenatally to initiate breast-feeding.
- PCG's score above 29 on the 'home environment' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- Increase in intake of healthy nutrition.
- Increase exercise and physical activity.
- Reduction in smoking around children.
- Seek to have at least 95% of children needing child care in a licensed day care facility.
- Seek to have at least 50% of the children needing child care in a day care facility with a DHS rating of 2 star and above.

- Refer all families for public assistance programs, if needed.
- Increase in family stability as measured by education, income level, employment status or housing stability.
- Increase in number of PCGs who have stayed in a safe residence for at least 6 months.
- PCG's score above 17 on the 'problem-solving' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- PCG's score above 14 on the 'social support' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- PCG's score above 17 on the 'mobilizing resources' section of the Healthy Families Parenting Inventory showing no area of concern or an improvement in score.
- Seek to have no more than 30% of mothers have a subsequent pregnancy within 2 years of the birth of the identified child.
- Seek to strengthen parental relationships regardless of marital status by making appropriate referrals.

-PCG's score for 'parenting efficacy' section of the Healthy Families Parenting Inventory will show no area of concern (score above 17) or show an improvement in score.
-PCG's score for 'role satisfaction' section of the Healthy Families Parenting Inventory will show no area of concern (score above 17) or show an improvement in score.
-PCG's score for 'parent/child behavior' section of the Healthy Families Parenting Inventory will show no area of concern (score above 29) or show an improvement in score.
-Increase in father involvement as measured by financial contribution, engagement in home visits and playing/taking care of child.

- Improvement in scores of parent's self-reported safety practices as measured by the Home Safety Checklist.
- Decrease in use of ER or hospitalizations due to injuries, ingestion or poisonings.
- Identify and refer families for domestic violence.
- Seek to have no more than 5% of the families enrolled, confirmed as a child abuse and neglect case by the child protective service, while participating in program.
- Decrease the percentage of identified children removed from their homes.

LONG-TERM OUTCOMES-Goals

Primary Caregiver Health

To systematically assess primary caregiver prenatally or at birth for strengths and needs and provide appropriate information and referrals

Child Health & Development

To enhance healthy child growth and development

Family Stability

To enhance family functioning by establishing a trusting, nurturing relationship, improving the family's support system, and teaching problem-solving skills

Positive Parenting & Parent-Child Interaction

To promote positive parent-child relationships

Family Safety

To promote safe practices and reduce the risk of deaths

OCAP GOALS COLOR GUIDE

Yellow: PCG health | Purple: Child health & Development | Blue: Family Stability | Pink: Positive Parenting & Parent-Child Interaction | Gold: Family Safety

Rev: Dec/08

Children First

Agency	Description & Target Population
Oklahoma State Department of Health Administered through local county health departments	Children First Program, Oklahoma's Nurse-Family Partnership, is a statewide public health nurse home visitation service offered through local health departments. Services are provided at no cost to families expecting to deliver and/or to parent their first child and include brief health assessments, child growth and developmental evaluations, nutrition education, parenting and relationship information and links to other community resources. The program encourages early and continuous prenatal care, personal development, and promotes the involvement of fathers, grandparents and other supporting persons in parenting. Target Population: Low income pregnant women who are expecting to parent for the first time and enroll prior to the 29th week of pregnancy. The family's income must be at or below 185% of the federal poverty level. Services continue until the child is two years of age.
Funding Source	
State Appropriations ($11,550,000 in SFY 09 & 10) Federal Medicaid Reimbursement ($2,357,027 in SFY 09); and CBCAP Funds ($337,746 in SFY 09)	
Counties Served	
Services were available in 69 Oklahoma counties in SFY 2009; Counties not receiving C1 services include: Adair, Alfalfa, Cimarron, Dewey, Mayes, Nowata, Osage and Washita.	

Program Model

Nurse-Family Partnership

Numbers Served

During SFY 2009, the Children First Program served 4,590 Oklahoma families.

Evaluation

Children First (C1) program evaluation is multi-faceted, and consists of activities on the county and state level, as well as monitoring by the National Nurse-Family Partnership Service Office (www.nursefamilypartnership.org). On the county level, data are collected on forms and entered into the Public Health Oklahoma Client Information System (PHOCIS). Day-to-day monitoring and feedback is provided to counties from central office staff, which includes an epidemiologist. Nurse caseload data are disseminated in report format on a monthly basis. Annually, the national Nurse-Family Partnership Service Office provides an Evaluation Study which examines 1) characteristics of participants at the time of entry into C1, 2) the extent to which C1 is implemented with fidelity to the Nurse-Family Partnership (NFP) model, 3) information on program outcomes, and 4) comparisons of the C1 program to selected other dissemination sites and to the Denver clinical trial. In addition, C1 Nurse Program Consultants conduct biannual site audits to ensure quality program delivery.

Outcomes

- Recent program evaluation findings indicated the infant mortality rate among C1 infants between 2001 and 2004 is half that of other first-time births in the state.
- Of children born into C1 in SFY 2009, 96% were normal birth weight and 92% were normal gestational age.
- During SFY 2009, nearly 82% of C1 mothers initiated breastfeeding.
- A recent study of parents participating in the program between 2002 and 2006 found that while C1 babies are at higher risk for abuse and neglect and are reported more often, fewer confirmations of maltreatment are found among participating families.

County Health Department and Satellite Clinic Locations	
Adair County Health Department - Stilwell Atoka County Health Department – Atoka Beaver County Health Department – Beaver Beckham County Health Department – Sayre & Elk City Blaine County Health Department – Watonga Bryan County Health Department – Durant Caddo County Health Department – Anadarko Canadian County Health Department - El Reno & Yukon Carter County Health Department – Ardmore & Healdton Cherokee County Health Department – Tahlequah Choctaw County Health Department – Hugo Cleveland County Health Department – Norman & Moore Coal County Health Department – Coalgate Comanche County Health Department – Lawton Cotton County Health Department – Walters Craig County Health Department – Vinita Creek County Health Department – Sapulpa, Drumright & Bristow Custer County Health Department – Clinton & Weatherford Delaware County Health Department – Jay Garfield County Health Department - Enid Garvin County Health Department – Pauls Valley & Lindsey Grady County Health Department - Chickasha Grant County Health Department – Medford & Pond Creek Greer County Health Department - Mangum Harmon County Health Department - Hollis Harper County Health Department – Laverne & Buffalo Haskell County Health Department - Stigler Hughes County Health Department – Holdenville Jackson County Health Department - Altus Jefferson County Health Department - Waurika Johnston County Health Department - Tishomingo Kay County Health Department - Ponca City & Blackwell Kingfisher County Health Department - Kingfisher Kiowa County Health Department - Hobart Latimer County Health Department - Wilburton	LeFlore County Health Department – Poteau & Talihina Lincoln County Health Department - Chandler Logan County Health Department - Guthrie Love County Health Department - Marietta McClain County Health Department – Purcell & Blanchard McCurtain County Health Department - Idabel McIntosh County Health Department – Eufaula & Checotah Major County Health Department - Fairview Marshall County Health Department - Madill Mayes County Health Department - Pryor Murray County Health Department - Sulphur Muskogee County Health Department - Muskogee Noble County Health Department - Perry Okfuskee County Health Department - Okemah Oklahoma City-County Health Department - Oklahoma City Okmulgee County Health Department – Okmulgee, Henryetta & Beggs Ottawa County Health Department – Miami Pawnee County Health Department – Pawnee & Cleveland Payne County Health Department – Stillwater & Cushing Pittsburg County Health Department - McAlester Pontotoc County Health Department – Ada Pottawatomie County Health Department - Shawnee Pushmataha County Health Department – Antlers & Clayton Rogers County Health Department - Claremore Seminole County Health Department – Wewoka & Seminole Sequoyah County Health Department - Sallisaw Stephens County Health Department - Duncan Texas County Health Department - Guymon Tillman County Health Department - Frederick Tulsa City-County Health Department - Tulsa Wagoner County Health Department - Wagoner & Coweta Washington County Health Department - Bartlesville Woods County Health Department - Alva Woodward County Health Department – Woodward
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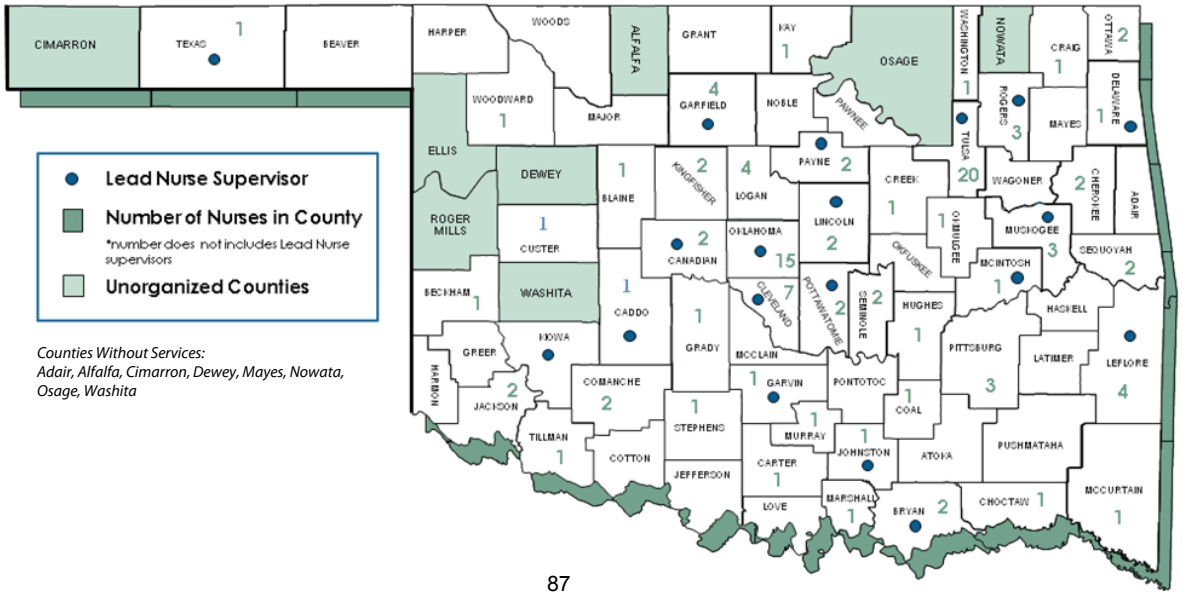
Children First Program



OKLAHOMA CHILD ABUSE PREVENTION NETWORK
Secondary Prevention

Children First - Logic Model

ASSUMPTIONS

1. Program services are guided by literature on primary prevention programs and risk & protective factors of child abuse and neglect that show positive results such as:

- Prevention programs are most effective when they are tailored to the specific needs of the target population.
- The timing of the intervention matters.
- Intensity, duration and regularity of the intervention matters.
- Programs using modeling, role-playing are nearly twice as effective as programs using non-directive strategies such as counseling and group discussions.
- Enhancement of protective factors and minimization of risk factors reduces the occurrence of child abuse and neglect amongst children and families.

2. Children First Home Visitation program will utilize the Nurse Family Partnership model to deliver services.

•Home visitation programs have been proven to decrease incidence of abuse and neglect of children.

INPUTS

•Registered Nurses with valid Oklahoma licenses with training in the NFP model of home visitation services

•Transportation for conducting home visits.

•Social services / resources.

•Partnerships to provide referrals.

•Stable C1 funding.

•Clinical and administrative support of county health departments

•C1 central office staff.

•Program Evaluation.

•Program monitoring and contract compliance to ensure program fidelity.

•NFP Dr. Old's Model of Home Visitation

POPULATION SERVED

Women from all 77 Oklahoma counties who are:

•At or below 185% of the Federal Poverty Level

•Less than 29 weeks gestation

•First time mothers

•Voluntary Participants

OUTPUTS-Activities

-Assess maternal health
- Link to health care.
- Link to prenatal care.
- Educate on consequences of smoking, alcohol and drugs during pregnancy
- Identify depression and make referrals.

- Assess child health
- Link to health care.
- Conduct developmental screenings and make referrals.
- Promote breast-feeding.
- Educate about nurturing home environments.
- Educate about the effects of smoking around the child.
•Educate about the effects of domestic violence around the child.
- Demonstrate positive parenting techniques

- Assist in building skills for problem solving.
- Assist in building skills for finding and linking to appropriate community resources.
•Link to community services, as needed.
•Encourage appropriate stress –coping mechanisms.
•Promote and increase father involvement.

-Refer to employment or education resources.
• Educate on family planning and contraceptive use
- Provide positive role model for parent-child interaction.
- Provide referrals to public assistance programs when appropriate.

- Educate on safe practices and safe home environment such as water, fire, vehicle and wheeled toys safety; poisons, child-proofing home,abusive head trauma and safe sleeping practice.
- Educate on domestic violence.
- Assess risk of child maltreatment.

SHORT-TERM OUTCOMES-Objectives

Perinatal Health
- Decreased incidence of STD and UTI among clients during pregnancy
- Decreased emergency room usage
- Appropriate weight gain
- Early recognition and referral for Post Partum Depression

Health Behaviors
- Smoking Cessation
- No alcohol usage
- No substance usage

Appropriate prenatal obstetrical care
- Increase in clients receiving 10+ prenatal visits

Infant Health
- Increased breastfeeding initiation and duration
- Decreased time spent in NICU, if necessary
- Increased gestational age at delivery
- Decrease in preterm births

Toddler Health
- Immunizations up-to-date
- Well Child Checks up-to-date
- Decreased emergency room visits due to illness
- Appropriate growth patterns

Paternal Involvement
•Increase paternal involvement during pregnancy, infancy and toddlerhood
•Increased communication between mother and father
•More Positive Parent-Child Interaction

Child and Maternal Living Arrangement
•Increased stability of living arrangement for mother and child

-**Subsequent Pregnancy Spacing and Family Planning**
•Increased interval between pregnancies, increased use of contraception
-**Workforce Participation**
•Increased participation in workforce by clients over 18
-**Continuing Education**
•Increased enrollment and attendance of educational or technical program
-**Appropriate use of Public Assistance programs**
Increased use of services available as appropriate

Decreased usage of emergency room due to injuries
Home Safety Checklist

Safe Sleep Practices
•Increase in safe sleep practices

Car Seat Safety
•Increased car seat usage

Decreased confirmations of abuse or neglect to OKDHS

Decreased exposure to home violence

LONG-TERM OUTCOMES-Goals

Maternal Health

To enhance mother's health throughout pregnancy and after delivery to ensure adequate care and referrals if necessary.

Infant/Toddler Health & Development

To enhance healthy growth and development.

Family Stability

To enhance family functioning by establishing a trusting, nurturing relationship, improving family support systems and teach problem solving skills.

Maternal Life Course Development

To promote achievement of personal goals in employment, education and personal health.

Family Safety

To promote safe practices and reduce the risk of injury, illness, abuse and neglect.

Children First GOALS COLOR GUIDE

Yellow: Maternal health | Purple: Child Health & Development | Blue: Family Stability | Pink: Maternal Life Course Development | Gold: Family Safety

Nurse-Family Partnership (NFP) Implementation Logic Model

Developed by Maurene Flory, Ph.D.

ASSUMPTIONS - Implementing Nurse-Family Partnership with fidelity to the model requires implementing agencies, nurse supervisors, and nurse home visitors to make program decisions guided by the theories of self-efficacy, attachment and human ecology. Nursing practice is central to all aspects of the nurse-client relationship.

Inputs - Resources What Implementing Agency Invests

Team of registered nurses with BSN, educated in the Nurse-Family Partnership model

Team supervisor who is a registered nurse with BSN/MS, educated in the Nurse-Family Partnership model

Clerical support trained for Nurse-Family Partnership

Implementing agency (IA) supports team in implementing and sustaining Nurse-Family Partnership services

IA works with National Service Office to ensure implementation is in fidelity with Nurse-Family Partnership model

Long-term, stable funding

Builds and maintains community partnerships that support implementation and provide resources

Output - Participation Who NFP Implementing Agency reaches

Client Household

Voluntary, low-income, first-time mother, up through 28 weeks pregnant

Their first infant (birth-age 2)

Individuals in client's social network

Community and institution

Implementing Agency

Sponsor agencies of Implementing Agency

Community partners

Experts

Champions

Social Structures, Policies and/or Practices

Representatives of federal, state and local government

Federal, state and local government; corporations; and non-profit funding streams

Formal and informal community service networks and advisory boards

Output - Activities What NFP Implementing Agency does

Nurse home visitors (NHV) and nurse supervisor (NS) network with community service providers so that potential clients can be referred to, recruited into and enrolled into the program early in pregnancy.

NS provides administrative & clinical supervision using reflective practice, demonstrating integration of the theories and facilitating professional development of NHV.

NHV engages in a therapeutic nurse-client relationship focused on promoting the client's abilities and behavior change to protect and promote her own health and well-being and that of her child.

NHV provides service coordination based on each client's identified needs, referring to available community services, as needed.

NHV follows *Nurse-Family Partnership Visit Guidelines* individualizing them to the strengths and challenges of each family and apportioning time across the NFP domains.

NHV works with client in supporting a healthy pregnancy, by recognizing and reducing risk factors and by promoting prenatal health care, healthy diet, exercise, stress management, and ongoing well-woman care.

NHV helps client envision how she would like life to be for herself and her child, promoting pregnancy planning, education, and employment as a means of accomplishing client's goals.

NHV works with client to envision how she wants to care for her child using the guidelines and program materials to promote her ability to accurately read and respond to her infant's cues; to promote infant's trust and attachment, child's language skills, behavioral regulation and emotional, physical and cognitive development.

In collaboration with her client, the NHV promotes engaging other appropriate individuals in the client's family and social networks, promoting healthy relationships and nurturance of the child.

NHV assesses and promotes positive infant and toddler health, screens development, and works with parents and community providers to obtain supportive services.

NFP team gathers data on program implementation, and maternal and child health; enters data into the national database; and utilizes reports for quality assurance.

Short-Term Outcomes Learning

Personal Health
Client increases knowledge of and confidence in her ability to engage in positive prenatal health related behavior

Maternal Role
Client increases knowledge of and confidence in her ability to provide sensitive and competent child care

Life Course Development
Client increases knowledge of and hope for her future options; and her confidence and ability to identify and accomplish her goals, including planning for subsequent pregnancies, educational attainment and employment

Family & Friends; Health & Human Services
Client increases knowledge of other supportive individuals and services for herself and her family, and her confidence in her ability to access them

Environmental Health
Client increases awareness of her and her child's environments, and her confidence in her ability to improve those environments and avoid dangerous situations

Medium-Term Outcomes Action

Client demonstrates positive behaviors related to personal health

Client assumes the role of sensitive and competent parent

Client increases planning, goal setting and engagement in pregnancy planning, education and employment

Client demonstrates initiative in identifying and engaging additional, supportive individuals and/or services

Long-Term Outcomes Conditions

Good pregnancy outcomes

Healthy infant/ toddler growth and develop-ment

Self-sufficient, healthy families

Nurse-Family Partnership®
Helping First-Time Parents Succeed

EXTERNAL FACTORS - The following factors can affect funding, sustainability and the degree to which an agency is able to implement Nurse-Family Partnership with fidelity to model: national, state and local political climates; issues within professional communities of practice; structures of IAs and their systems; physical and cultural environments of individual families.

Early Intervention Makes the Difference

Nurse-Family Partnership (NFP) is an evidence-based, nurse home visiting program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. From pregnancy through the child's second birthday, registered nurses thoroughly educated in the NFP model work with their clients to achieve three important goals:

- Good pregnancy outcomes;
- Healthy infant/toddler growth and development; and
- Self-sufficient, healthy families.

Research, Evidence, and Integrity

Nurse-Family Partnership is the most rigorously tested program of its kind. Three decades of research have proven that the program, when implemented with fidelity, reduces child abuse and neglect, reduces juvenile delinquency and criminal activity, improves prenatal health, improves maternal employment and improves school readiness.

These outcomes produce enduring benefits for program participants, and they also benefit society economically and reduce longer-term social services expenditures that extend across multiple generations. Several independent studies have substantiated that the Nurse-Family Partnership program reduces health care, criminal justice, and welfare costs, and increases tax revenues.

For the higher-risk families now served by the program, a 2005 RAND Corporation analysis found a net benefit (benefits minus costs) to society of $34,148 (in 2003 dollars) per family served, with the bulk of the savings accruing to government which equates to a $5.70 return per dollar invested in Nurse-Family Partnership.*

* Karoly, L., Kilburn, M., Cannon, J. (2005). *Early Childhood Interventions: Proven Results, Future Promise.* Santa Monica, CA: RAND Corporation.

Nurses are the Cornerstone

Experienced, registered nurses are critical to the successful delivery of the Nurse-Family Partnership model. Pregnant women have many questions and concerns about their health and the baby's health, and highly value the expertise that nurses can bring to them during this critical life transition.

NFP's "Implementation Logic Model"

This logic model is a systematic and visual way to present and share our understanding of the relationships among the resources an Implementing Agency needs to have to operate the Nurse-Family Partnership program, the activities the Implementing Agency and the Nurse-Family Partnership team will engage in, and the outcomes participants are likely to achieve based on the randomized clinical trial research of Dr. David Olds.

In general, this logic model reads from left to right, showing how a community's investment in a Nurse-Family Partnership team and the Nurse-Family Partnership model translates into client services, which lead to families and communities achieving the desired outcomes.

The major elements of the logic model include the Inputs (what an Implementing Agency Invests), Outputs (who the Implementing Agency reaches and what the Implementing Agency does), and Outcomes (what learning and actions happen to create the desired results). Though they take up little space in the logic model, the Assumptions and External Factors influence every aspect of program implementation from Inputs to Outputs to Outcomes.

This logic model is a working draft that will be refined as the model is enhanced and refined through continuing research.

NFP's "Theory of Change Logic Model"

There is an additional logic model developed by Dr. Ruth O'Brien that provides a visual depiction of a program's theory of change - the way in which services to NFP clients are linked to expected program outcomes. The articulation of a program's theory of change can help communities, agencies, program staff and families stay focused on the outcome goals. The "Theory of Change Logic Model" can be downloaded from the NFP website > Research Evidence > NFP Logic Model.

Replication Services

The National Service Office of Nurse-Family Partnership provides service to communities in implementing and sustaining this program. These services include:

- Program implementation support;
- Education of nurse home visitors and nurse supervisors and ongoing clinical support;
- Agency management and operations support;
- Evaluation, reporting and quality improvement systems and support designed to ensure quality services and progress toward program goals;
- Federal policy and program financing support; and
- Marketing and community outreach resources.

If you would like more information, please visit our website at www.nursefamilypartnership.org

Nurse-Family Partnership National Service Office
1900 Grant Street, Suite 400, Denver, CO 80203-4304
Direct 303.327.4240 Fax 303.327.4260 Toll Free 866.864.5226

Nurse-Family Partnership®
Helping First-Time Parents Succeed

Oklahoma Respite Resource Network (ORRN)

Agency	Description & Target Population
Oklahoma State Department of Human Services Oklahoma State Department of Health (as well as a host of other state agencies depending on the population served)	Respite, a temporary relief for families and caregivers, is recognized as a method to reduce the stress in families and to reduce child abuse and neglect. Target Population: For OSDH purposes, Children First and OCAP are the families targeted to receive these services. Expansion of Target Population: All of the OCAP and Children First Program sites received respite program training and fund allocations in FFY 07, with three sites receiving refresher training. The respite care program at the health department is coordinated within the Office of Child Abuse Prevention using funds from the Federal Community-Based Child Abuse Prevention Grant.
Funding Source	
CBCAP Funds ($30,000 in FFY 09)	

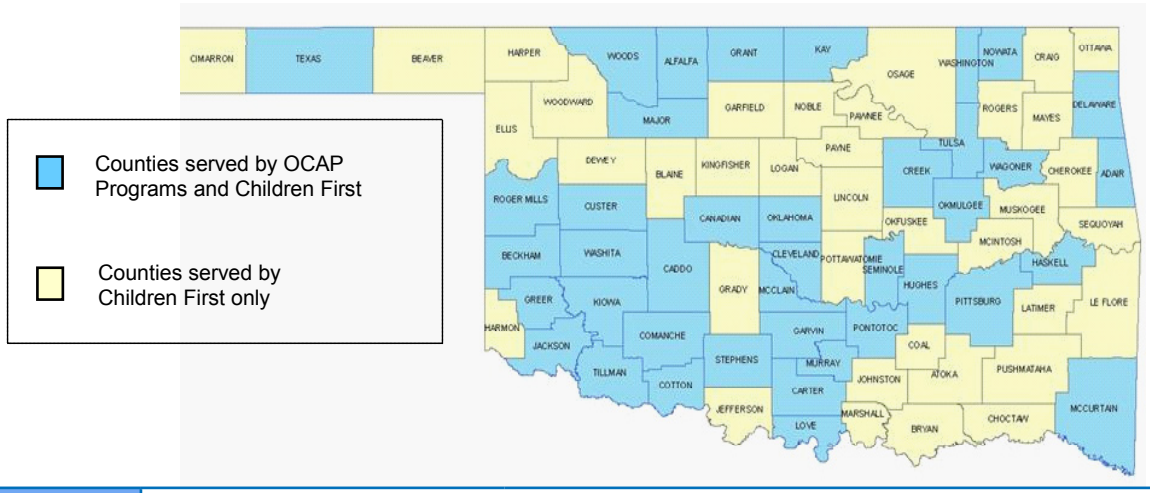
Numbers Served

For the Oklahoma State Department of Health, 364 families have received respite services in FFY - 2009.

Outcomes

1. In SFY 2009 42% of the OCAP Start Right and Children First caregivers used Respite vouchers to provide stress relief from parental duties; 20% of them used the vouchers for seeking or sustaining employment and 15% used them for obtaining a GED, furthering their education, or job training.
2. Respite vouchers were also used by caregivers in SFY 2009 for finding housing for the family (3%), rehabilitation, therapy, family and parenting counseling (8%), medical appointments (8%), and mental health appointments (4%).
3. In SFY 2009 the use of Respite vouchers gave OCAP Start Right and Children First caregivers the direct responsibility of hiring and paying childcare services, thereby learning skills that increase their self-confidence and give them a sense of empowerment.

Oklahoma State Department if Health Programs with Respite Care



Contact Information	Lori Owen Family Support & Prevention Service, Office of Child Abuse Prevention 1000 NE 10th Street Oklahoma City, Oklahoma 73117 (405) 271.7611
Website	http://ocap.health.ok.gov

Family Expectations

Agency	Description & Target Population
Public Strategies Inc. Family Expectations	Family Expectations is a comprehensive, couple-based intervention for lower-income expectant or new parents. The overarching goal of the program is to increase family well-being by helping expectant couples strengthen their relationships and/or marriages during and immediately following the birth of a child. Family Expectations is uniquely designed to help young parents be well-equipped to handle the stressors that will likely accompany their growing family. Target Population: • Couples in a committed relationship, married or unmarried • Couples expecting a baby or recently had a baby, enrollment anytime during pregnancy up to 3 months post-birth, • Both individuals are over 18 years of age. Service Period: Couples are eligible to participate in the Family Expectations Program until their baby turns 1 year of age regardless of enrollment in the program. Description of Services: There are two primary components of the FE program, workshops and individualized family support services. 1) The workshop component is comprised of an initial 30 hour workshop that couples participates in together that address healthy communication, anger and stress management, baby care, and the importance of couple time. Other workshops or expended activities are offered to the couple on topics that support and provide the couple with additional information on healthy relationship skills, child development, good communication, and family issues. 2) Each couple has a Family Support Coordinator that works with them to identify strengths and needs, provide information and referrals, and help the couple integrate the workshop tools and concepts into their daily life.
Funding Source • Administration of Children and Families Building Strong Families (BSF) project and Supporting Healthy Marriages (SHM) project • OKDHS • Office of Family Assistance (OFA)	
Counties Served Oklahoma County	

Program Model
Family Expectations Program Model
Numbers Served
FY 2009 - 670 families served.
Evaluation
The dissolution of the couple's relationship is twice as likely to occur after the birth of a child. This is a time which the stress related to raising an infant can break down a couple's relationship, especially for couples that are not married. The Family Expectation's program goal is to strengthen these fragile families and bring stability to their child's life. This preventative intervention is meant to be provided at this pivotal transitional point in the couple's relationship, thus creating a "teachable moment."
Outcomes
1. Decrease the number of children born to unmarried parents which places families at greater risk for poverty and family dissolution. 2. Increase the number of children who are raised by their biological parents. 3. Increase child well-being.

Contact Information	David Kimmel, Ph.D., Program Director 301 N.W. 63rd, Suite 140, Oklahoma City, OK 73116 (405) 639-2054 david.kimmel@familiesok.org
Website	www.familiesok.org

Healthy Start Initiative

Agency	Description & Target Population
Private and Public Organizations	Healthy Start programs are focused on reducing infant mortality and related pregnancy and women's health problems in communities with high infant mortality. Services are provided for the expectant mothers through the time that their infants are two years of age or through the next pregnancy. The infants are also served. The services include case management, client advocacy, referrals to health care and other services, direct outreach from trained community members, health education to address risk factors, and plan development. The plan describes how the community-based organizations and local, state, public and private providers identify and address barriers to quality, family-centered services. Target Population: Medically/socially high-risk pregnant women.
Funding Source	
Federal ($700,000 for Oklahoma City and $1,075,000 for Tulsa) for SFY 10.	
Counties Served	
Tulsa and Oklahoma Counties	

Program Model

Healthy Start Initiative using the Life Continuum Model (Lu)

Numbers Served

In SFY 2009:
Healthy Start (Tulsa) served 702 clients as well as 700 program and community.
Healthy Start (Oklahoma City) served 252 program participants and 4041 community participants.

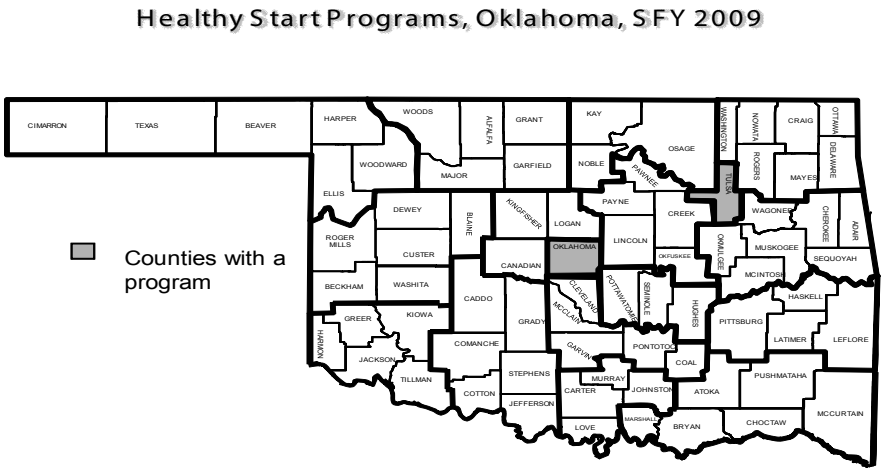
Tulsa Outcomes

1. Reduction in infant mortality in the target areas of service. In 2009, the IMR for Tulsa Healthy Start was 5.6 the county rate was 8.2 in 2008.
2. Reduction of low birth weight and premature infants. In 2009, the LBW was 7.6% for Tulsa Healthy Start; the county rate was the same.
3. Increase in entry into prenatal care. In 2009, the number of high risk women getting into prenatal care in the first trimester improved 50% over 2008 for Tulsa Healthy Start women.

Oklahoma City General Outcomes

1. Reduction in infant mortality in the target areas of service.
2. Reduction of low birth weight and premature infants.
3. Increase in entry into prenatal care.

Healthy Start Map



Source: United States Department of Health and Human Services

Contact Information	TULSA Corrina Jackson, Tulsa Health Department Tulsa Healthy Start cjackson@tulsa-health.org Telephone: (918) 595-4220	OKLAHOMA CITY LaWanna Porter, Community Health Centers, Inc. Central Oklahoma Healthy Start Initiative lporter@okh4b.org Telephone: (405) 427-3208
Website	http://www.csctulsa.org/family%20health.htm#Tulsa_Healthy_Start_Initiative	http://www.chciokc.org/

Child Maltreatment Prevention
High Risk Urban Pilot Project (SafeCare +)

Oklahoma County

Agency	Description & Target Population
Oklahoma State Department of Human Services	SAFECARE - An echobehavioral program model developed by John Lutzker, PH.D, that addresses parent-child bonding, home safety and cleanliness and child health. SAFECARE+ an enhanced version of SAFECARE which includes problem solving, motivational interviewing, conflict resolution skills, violence prevention and safety planning to address risk factors. Target Population: Families with children 0-18 years of age, with at least one child under the age of six years and who do not have a history or more than two prior child abuse or neglect referrals or have an open child welfare case. Client families have at least one of the following conditions: an active substance abuse disorder; a history of domestic violence; a mental health diagnosis; a physical or developmental disability resulting in impaired parenting; or a combination of any of the above mentioned conditions. A recent five year grant awarded by the Chidren's Bureau is designed to improve the SafeCare+ model by enhancing the service model to address conflict resolution skills and violence prevention more broadly; and expands the program to include the Oklahoma Latino Community.
Funding Source	
State appropriation of $250,000 annually.	

Program Model

Project SafeCare, a program developed by Dr. John Lutzker and his colleagues, replicating an Ecobehavioral Model of Child Maltreatment Prevention.

Numbers Served

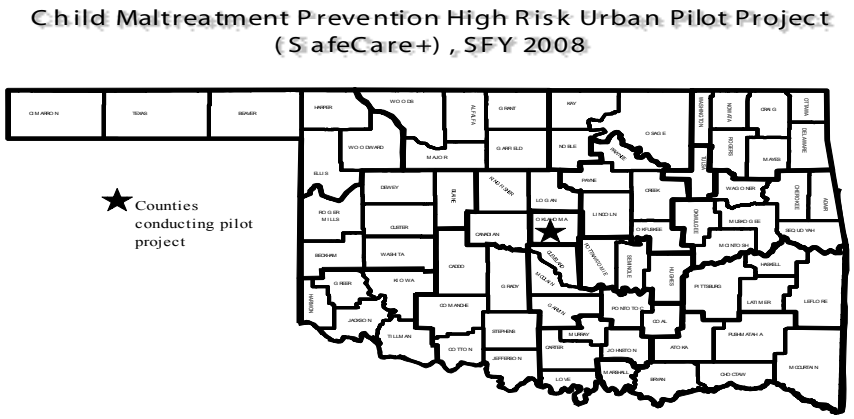
As of January 31, 2010, 1044 families have been referred to the Oklahoma County project. Payne County served 105 families but the trial ended in 2009.

Evaluation

A pilot randomized controlled study of traditional home-based services and the SafeCare+ is on-going. The evaluation is being conducted by researchers from the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center.

Outcomes

1. Between 2007-2009, families randomized to SafeCare were much more likely to enroll in services and remain engaged through to completion than the Services as Usual group (e.g., service enrollment: 83% vs. 33% for SC vs. SAU, repectively).
2. Between 2007-2009, SafeCare participants reported improved competence (Satisfaction survey) in (a) meeting children's basic health needs (99%), (b) managing behavioral problems (99%), (c) parent -child interaction (96%), (d) increased knowledge of home safety hazards (97%) and (e) problem solving (90%).
3. Between 2007-2009, improvements were observed in participants in the Safecare program specific targets areas of: a) Parent-child interaction (88%), b) Infant-child health (90%), and c) Home safety (69%).

Map
   Counties Served Oklahoma County

Contact Information	Nelda Ramsey, M.Ed. Programs Manager, OKDHS, Children & Families Services Division, PO Box 25352, Oklahoma City, OK 73125 (405) 521.4266
Website	www.oumedicine.com/highriskprevention

Child Maltreatment Prevention
High Risk Rural Pilot Project (SafeCare +)

Payne County

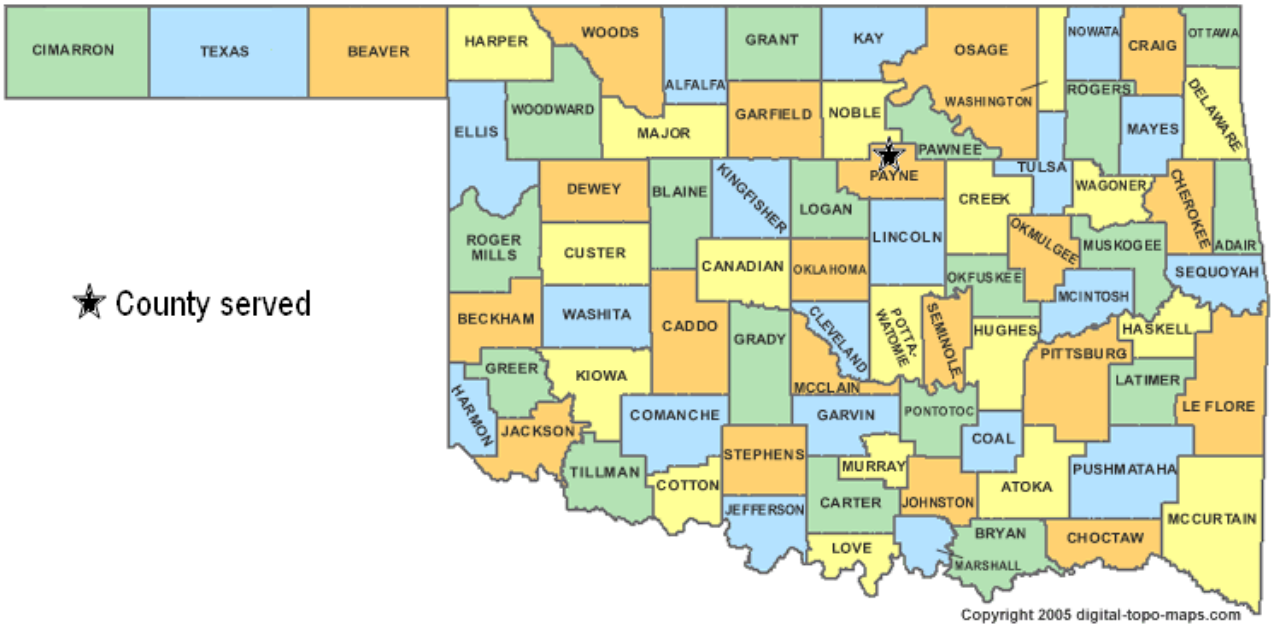
Agency	Description & Target Population
Center on Child Abuse and Neglect (CCAN) Section of Behavioral and Developmental Pediatrics Department of Pediatrics Oklahoma University Health Sciences Center	Safe Care (SC) is an in-home eco-behavioral model emphasizing the importance of the socio-cultural context in which child abuse occurs. Services. One on one service within a family's natural environment. Safe Care provides direct skill training to parents in child behavior management using planned activities training, home safety training, and teaching child health care skills to prevent child maltreatment. The service model for this project is an enhancement of SafeCare (SafeCare+) that includes problem solving, motivational interviewing, conflict resolution skills, violence prevention and safety planning to address risk factors with in a Rural community setting. Target Population. Highest-risk populations, such as families with parental substance use disorders, intimate partner violence (IPV), parental depression and/or other multiple risk factors with children from birth to five years.
Funding Source	
State appropriation of $300,000 annually. Oklahoma State Department of Human Services Office of Juvenile Justice and Delinquency Prevention	

Program Model
Safe Care+ (Safe Care developed by Dr. Lutzker, chhs.gsu.edu/safecare) Adapted to fit Rural Communities and augmented to address risk factors of Family Violence, Substance Abuse and Mental Health Issues.
Numbers Served
As of September 1, 2009, 105 families had been enrolled and served in the Payne County area. The project has ended prematurely due to funding cuts.
Evaluation
Process/Implementation and Program Fidelity. The process/implementation evaluation has examined the feasibility and acceptability of the SafeCare+ curriculum (augmented to address Healthy Relationships/Violence Prevention within a Rural community setting). Family and Child Outcomes. For the family and child outcomes evaluation, OUHSC has examined future reports to child maltreatment and foster care placement, and changes on protective factors and risk factors proximal to child maltreatment. SafeCare+ adapted model was evaluated utilizing a randomized clinical trial design. Two service models were provided through NorthCare Center: (a) community mental health services (Services as Usual: SAU) and SafeCare+ (SC: based on an eco-behavioral model). Cost Evaluation. The cost evaluation examined the time, effort, and resources used to deliver program services, including fixed and variable service costs. Cost analysis was facilitated by closely tracking all categorical funding streams for the varying population risk groups served at both program and participant levels.

Outcomes

1. Between 2007-2009, families randomized to SafeCare were much more likely to enroll in services and remain engaged through to completion than the Services as Usual group (e.g., service enrollment: 83% vs. 33% for SC vs. SAU, respectively).
2. Between 2007-2009, SafeCare participants reported improved competence (Satisfaction survey) in (a) meeting children's basic health needs (99%), (b) managing behavioral problems (99%), (c) parent -child interaction (96%), (d) increased knowledge of home safety hazards (97%) and (e) problem solving (90%).
3. Between 2007-2009, improvements were observed in participants in the Safecare program specific targets areas of: a) Parent-child interaction (88%), b) Infant-child health (90%), and c) Home safety (69%).

Site Map



Counties Served
Payne County

Contact Information	Jane F. Silovsky Project Director University of Oklahoma Health Sciences Center 940 NE 13th Street OUCPB 3B3406, Oklahoma City, OK 73104 TEL: (405) 271-8858 FAX: (405) 271-2931 Email: jane-silovsky@ouhsc.edu
Website	www.oumedicine.com/highriskprevention

Evidence-Based Home Visitation Federal Grant

Agency	Description & Target Population
Center on Child Abuse and Neglect (CCAN) Section of Behavioral and Developmental Pediatrics Department of Pediatrics Oklahoma University Health Sciences Center	Evidence-Based Child Maltreatment Prevention for High Risk Families: Expanding to Latino Communities, Enhancing Family Violence Prevention, and Sustaining Prevention Programs. Safe Care (SC) is an in-home eco-behavioral model emphasizing the importance of the socio-cultural context in which child abuse and neglect occurs. Services. One on one service within a family's natural environment. Safe Care is designed to prevent child maltreatment in high risk families by providing direct skill training to parents in parent child bonding and parenting skills using planned activities training, home safety training, and teaching child health care skills to prevent child maltreatment. The service model for this project is an adaption of SafeCare (SafeCare+) augmented to address risk factors (through problem solving, motivational interviewing, conflict resolution skills, violence prevention, and safety planning) and adapted for our Latino communites. Target Population. Highest-risk populations, such as families with parental substance use disorders, intimate partner violence (IPV), parental depression and/or other multiple risk factors with children birth to five years.
Funding Source	
Children's Bureau Administration on Children, Youth and Families Administration for Children and Families U.S Department of Health and Human Services	
Counties Served	
Oklahoma County (specific to Latino Communities)	

Program Model

Safe Care+ (Safe Care developed by Dr. Lutzker, chhs.gsu.edu/safecare) Adapted for Latino Communities and Augmented to address risk factors of Family Violence, Substance Abuse and Mental Health Issues

Numbers Served

We anticipate serving 360 families from 2010 through to 2013 as part of the outcomes evaluation.

Evaluation

Process/Implementation and Program Fidelity. The process/implementation evaluation will examine the feasibility and acceptability of the modified SafeCare curriculum (augmented to address Healthy Relationships/Violence Prevention and adapted for Latino communities). Trainings in SafeCare+ curriculum will be evaluated by OUHSC through service providers report. Implementation of services will be directly observed to evaluate fidelity. The local evaluation team will collect data on fidelity, as well as data on participants and service providers, including written evaluations and assessments, direct observation, interviews, and monthly reports.

Family and Child Outcomes. For the family and child outcomes evaluation, OUHSC will examine future reports to child maltreatment and foster care placement, and changes on protective factors and risk factors proximal to child maltreatment. SafeCare+ adapted model will be evaluated utilizing a hybrid design which merges aspects of the simple regression discontinuity (RD) design with aspects of the simple randomized clinical trial design. Two prevention service models will be provided through the LCDA: (a) El Programa de Familias Seguras which is SafeCare+ adapted for the Latino community and designed for highest risk families and (b) Nuestras Familias, funded through the Department of Health's Oklahoma Child Abuse Prevention (OCAP) programs, utilizes Parents as Teachers as well as other curricula and is designed for low to moderate risk families. Using a risk classification tree, families will be screened for risk with the highest risk group being assigned to SafeCare+, the lowest risk group to OCAP, and the moderate risk group being randomized to SafeCare+ or OCAP. OUHSC will collect data on demographics, child maltreatment, risk factors, protective factors, and services. Self-report and home observational data will be collected prior to randomization, at 6 months, and at 12 months.

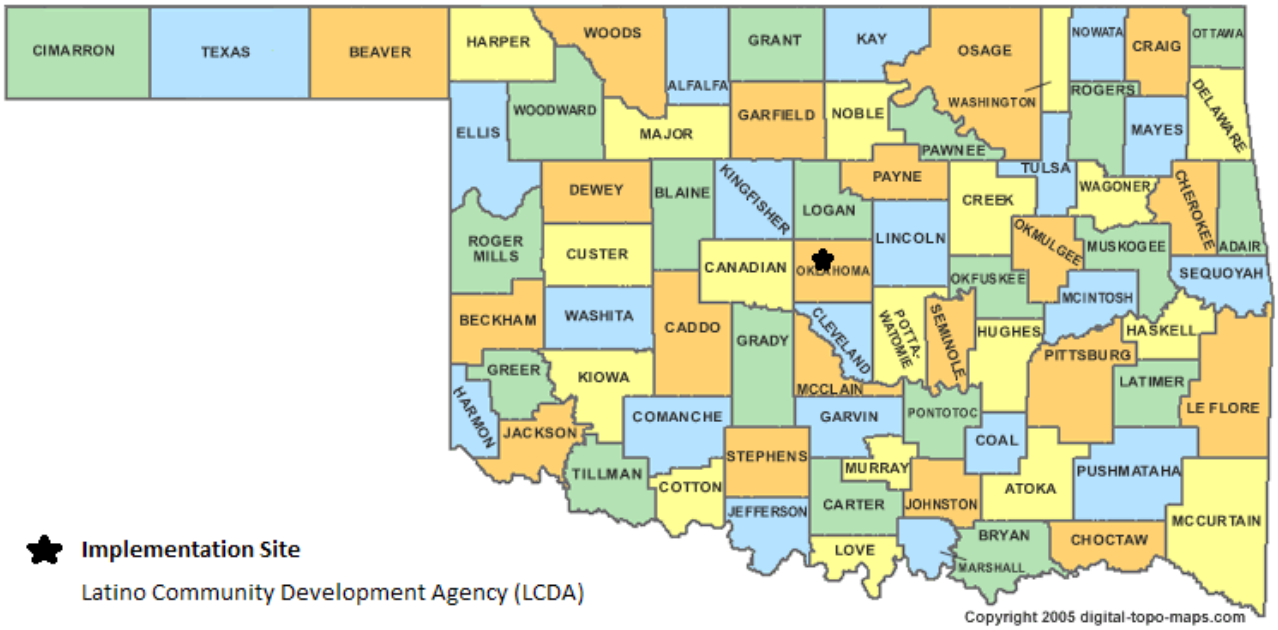
Cost Evaluation. The cost evaluation will examine the time, effort, and resources used to deliver program services, including fixed and variable service costs. Cost analysis will be facilitated by closely tracking all categorical funding streams for the varying population risk groups served at both program and participant levels.

Outcomes

Outcomes to be evaluated:

1. Decreased likelihood of child maltreatment (e.g., future child welfare report, out of home placements).
2. Increased protective factors (e.g., family resources, knowledge of parenting and child development).
3. Reduced risk factors (e.g., depression, substance abuse, family violence).

Site Map



Counties Served
Oklahoma County

Contact Information	Jane F. Silovsky Project Director University of Oklahoma Health Sciences Center 940 NE 13th Street OUCPB 3B3406, Oklahoma City, OK 73104 TEL: (405) 271-8858 FAX: (405) 271-2931 Email: jane-silovsky@ouhsc.edu
Website	www.supportingebhv.org/grantees www.oumedicine.com/highriskprevention

Comprehensive Home-Based Services & Parent Aide Services

Agency	Description & Target Population
Oklahoma State Department of Human Services	Comprehensive Home-Based Services (CHBS) offers specific services to help ensure and enhance, or ameliorate obstacles that impede, the safety, well being and social functioning of children and their families. CHBS incorporates existing community services and resources with needs-driven, family-focused treatment through a partnership of contract case management and child welfare staff. CHBS is the primary component of the Oklahoma Children's Services (OCS); a contracted community based service delivery system. The standard service period of CHBS is six months. Target Population: Families with children 0-18 years of age who are at risk of being removed due to child abuse and neglect and/or exposure to parental drug/alcohol abuse. Approximately 56% of the families served were court ordered with the remaining families being voluntary (44%). Families served have reported histories of alcohol and drug problems, medical conditions, and mental health issues. The single point of entry for this service is from an active Child Welfare case wherein children have been determined unsafe. Parent Aide Services (PAS) are in-home, non-therapeutic services to encourage parenting skill development for families affected by or at risk for child abuse and neglect. PAS are designed to deal with very basic issues, such as: housekeeping, child development, budgeting, transportation and modeling appropriate parenting skills. PAS is a secondary component of the Oklahoma Children's Services (OCS); a contracted community based service delivery system. The standard service period is six months. Target Population: Typical parent aide clients are families at risk for child/abuse/ neglect due to lack of knowledge and experience in parenting and housekeeping skills. They are often young and unfamiliar with how to access available resources. Most have had a recent referral of abuse or neglect, not considered serious enough to warrant court intervention.
Funding Source	
* CHBS: $9,801,076 - Total State - $4,000,000; PSSF - $930,608; TANF - $4,870,468 PAS: State $7,000, PSSF - $522,392, TANF - $340,000 Total State and federal: ($869,392 in SFY 09) * Best information provided. Complete and exact breakdown of funding not available.	

Program Model
Traditional CHBS service model and SafeCare/ECO Behavioral Model continued during SFY 09.

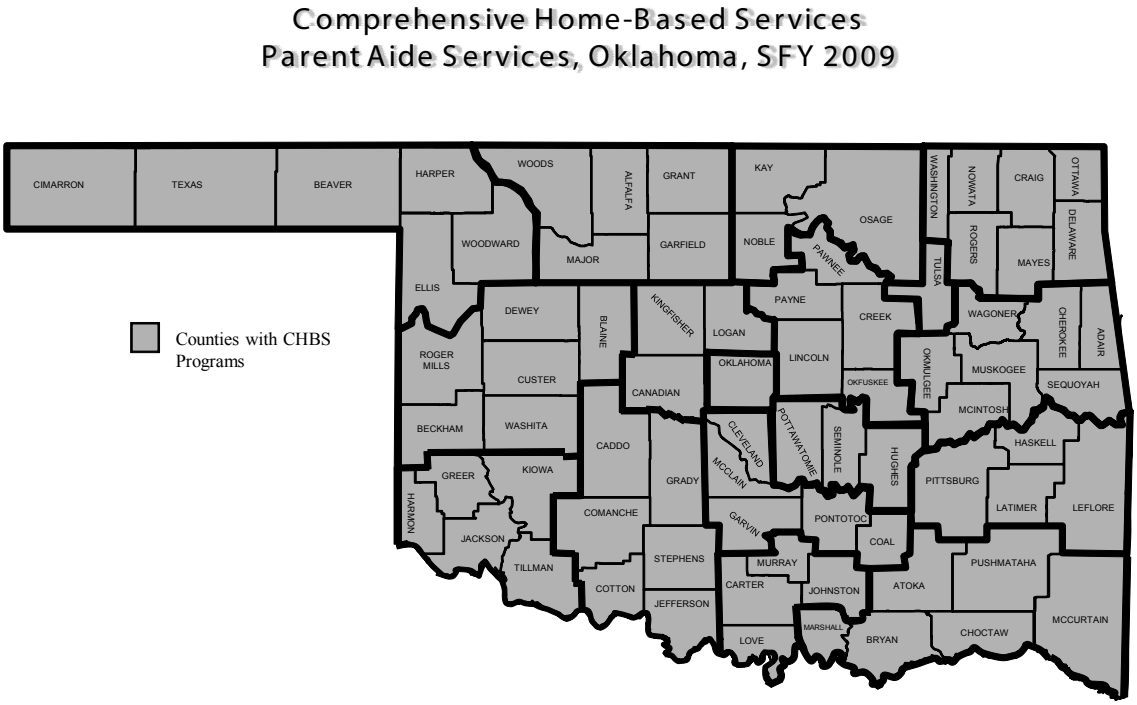
Numbers Served
CHBS: Over 3,125 families were served by CHBS during SFY 2009. PAS: 448 families were served by PAS during SFY 2009.

Evaluation
A pilot comparison study of the traditional CHBS service model and the SafeCare ecobehavioral model by Dr. John Lutzker finalized data collection during 2008 and started analysis of the data. The evaluation is being conducted by researchers from the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center. The reseachers were awarded a 5-year grant from the National Institute of Mental Health to support the comparative study. In SFY '09, the Eco-Behavioral model was expanded statewide.

Outcomes

1. Families who participate in Oklahoma Children's Services, both CHBS and PAS, respond at a rate of 15% to Client Satisfaction Surveys provided at the conclusion of services. Anonymity is ensured. For SFY 2009, 98% of responders reported they were highly satisfied with the services they received.
2. Comprehensive Home Based Services (CHBS), is provided to families of children at the highest levels of risk for maltreatment. Those served during SFY 2009, where the mean rate of prior referrals to Child Welfare was 3.45, showed a 40% recidivism rate at the end of their follow-up period at approximately 500 days.
3. Families who met all of the risk-related service goals as rated by their service providers, were much less likely to have a subsequent referral to child welfare than families who met some or none of their risk-related goals, translating to approximately a 20% difference each year (SFYs 2006 - 2009) in survival rates (without subsequent reports of abuse or neglect).
4. Reunification outcomes for CHBS focus on safely maintaining children in their homes after having been in state custody for an average of 12 to 15 months. In SFY 2008, 541 families received reunification services, 291 of whom or 53.8% were fully reunified. In SFY 2009, 474 families received reunification services and 295 (62.2%) were fully reunified.

Map



Source: Oklahoma Department of Human Services

Contact Information	B.K. Kubiak, Programs Manager for Oklahoma Children's Services Oklahoma Department of Human Services, Children and Family Services Division P.O. Box 25352, Oklahoma City, OK 73125 (405) 521-2859
Website	www.okdhs.org

SoonerStart Program

Agency	Description & Target Population
Oklahoma State Department of Education Administered out of 28 sites based in county health departments with the exception of Grady, Oklahoma, and Tulsa County.	SoonerStart is Oklahoma's early intervention program. The program provides services to infants and toddlers (birth to 36 months) with developmental delays and their families under PL 99-457Part C of the Individuals with Disabilities Education Act (IDEA) as amended by PL 108-446, Part C of the Individual with Disabilities Education Improvement Act (IDEIA) of 2004, and the Oklahoma Early Intervention Act of 1989. SoonerStart is a collaborative interagency effort of the Oklahoma Departments of Education, Health, Human Services, Mental Health and Substance Abuse Services and the Oklahoma Health Care Authority and the Oklahoma Commission on Children and Youth. Target Population: Infants and toddlers, age birth to 36 months, who are developmentally delayed. Developmentally delayed means children of the chronological age group (birth through two) who exhibit a delay in their developmental age compared to their chronological age of fifty-percent or score two standard deviations below the mean in one of the following domains/sub-domains: cognitive, physical, communication, social/emotional, or adaptive development; or exhibit a delay in their developmental age compared to their chronological age of twenty-five percent or score 1.5 standard deviations below the mean in two or more of the above reported domains/sub-domains; or have a diagnosed physical or mental condition that has a high probability of resulting in delays.
Funding Source	
State Appropriations and Federal Funds ($25,215,241.03 in SFY 09)	
Counties Served	
SoonerStart services are available statewide across all 77 Oklahoma counties.	

Services

Depending on individual needs, SoonerStart offers one or a combination of the following services:

- Assistive technology services
- Occupational therapy
- Child development
- Family training, counseling and home visits
- Special instruction
- Speech-language pathology
- Service coordination for toddlers and their families
- Vision services
- Nutrition services
- Audiology- hearing
- Early Identification with screening, evaluation and assessment services
- Physical therapy
- Psychological services
- Medical services (only for diagnostic or evaluation purposes)
- Social work services
- Nursing services

Program Model

Services are provided in the family's home or other natural environments through an Individualized Family Service Plan (IFSP) based on the child's delay, family priorities, resources and concerns.

Numbers Served

In State Fiscal Year 2009, SoonerStart provided screening, evaluation, and services to 13,534 infants and toddlers.

Evaluation

In accordance with Part C of the Individuals with Disabilities Education Act, Oklahoma has in place a state performance plan that evaluates the state's efforts to implement the requirements and purposes of Part C and describes how the state will improve such implementation.

The SoonerStart Early Intervention Program uses a quality assurance process to monitor federal and state compliance. The Oklahoma State Department of Education must report annually to the public on the performance of each SoonerStart site located in the state on the 14 federal indicators, such as timely services, child find, child and family outcomes and transition.

Outcomes

1. In FFY2008, SoonerStart services were provided to 1.79% of infants and toddlers (0-3).
2. In FFY2008, 78.53% of eligible infants and toddlers with IFSPs had an evaluation, assessment, and initial IFSP meeting within Part C's 45-day timeline.
3. In FFY2008, 94.41% of records reviewed indicated that SoonerStart services were provided within 15 working days from the date of parent consent for services (i.e., the date on the initial IFSP).

Locations

SoonerStart Region 1:

Garfield County Health Department, Enid
Payne County Health Department, Stillwater
Texas County Health Department, Guymon
Woodward County Health Department, Woodward

SoonerStart Region 2:

Canadian County Health Department, El Reno
Custer County Health Department, Clinton
Kingfisher County Health Department, Kingfisher
Logan County Health Department, Guthrie

SoonerStart Region 3:

Oklahoma County SoonerStart, Oklahoma City

SoonerStart Region 4:

Carter County Health Department, Ardmore
Comanche County Health Department, Lawton
Grady County Health Department, Chickasha
Jackson County Health Department, Altus

SoonerStart Region 5:

Cleveland County Health Department, Norman
Pontotoc County Health Department, Ada
Pottawatomie County Health Department, Shawnee

SoonerStart Region 6:

Creek County Health Department, Sapulpa
Tulsa County SoonerStart, Tulsa

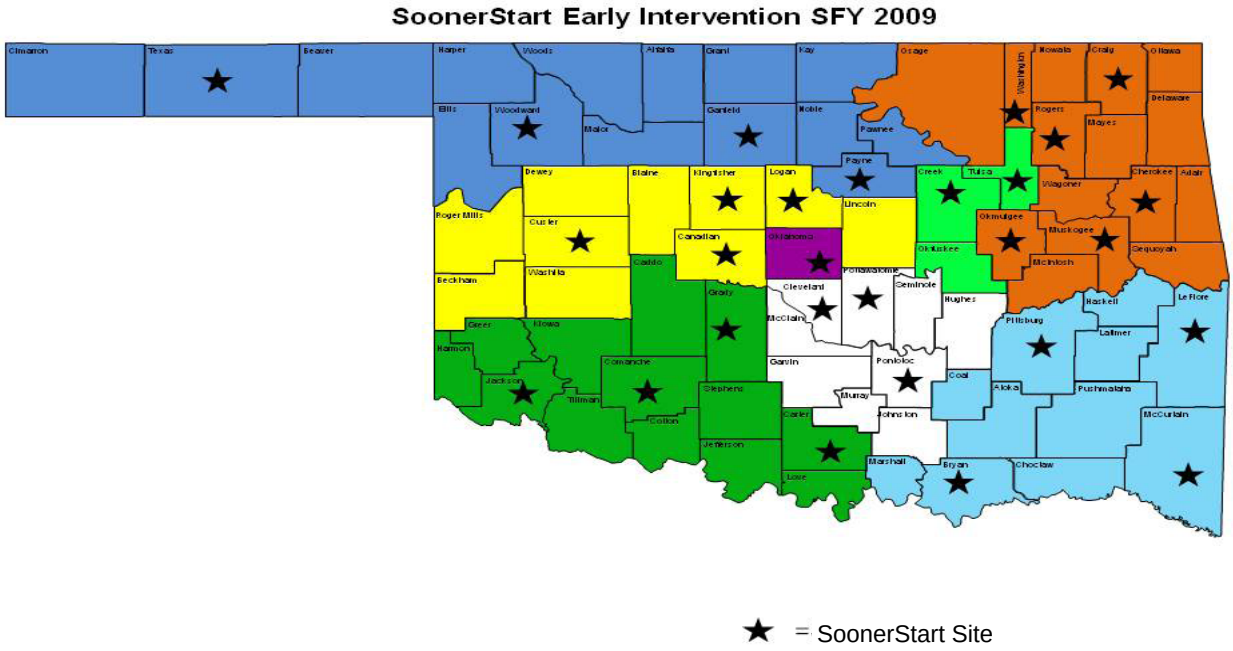
SoonerStart Region 7:

Cherokee County Health Department, Tahlequah
Craig County Health Department, Vinita
Muskogee County Health Department, Muskogee
Okmulgee County Health Department, Okmulgee
Rogers County Health Department, Claremore
Washington County Health Department, Bartlesville

SoonerStart Region 8:

Bryan County Health Department, Durant
LeFlore County Health Department, Poteau
McCurtain County Health Department, Idabel
Pittsburg County Health Department, McAlester

SoonerStart Map



Contact Information	Oklahoma State Department of Education Special Education Services Division (405) 521-4155
Website	Oklahoma State Department of Education, Lead Agency www.sde.state.ok.us

Child Guidance Services

Parent Child Interaction Therapy (PCIT)

Agency	Description & Target Population
Oklahoma State Department of Health Administered at the County and City-County Health Department levels	Child Guidance provides Parent-Child Interaction Therapy (PCIT) for children ages 3 to 12 with disruptive behavior disorders and their parents. Therapy is provided until the parent achieves self confidence in their parenting. Parents receive parenting assessment and instruction, and then receive coaching, in which parents are provided instruction through a "bug-in-the-ear" receiver while playing with the child in a playroom.
Funding Source	
Child Guidance State Appropriations and Local Millage ($5.1 million in SFY 08); CBCAP Funds ($80,000 in FFY 07) Funding for PCIT programs is included in the Child Guidance overall appropriation.	

Program Model

Parent-Child Interaction Therapy (PCIT): PCIT is an empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.

Numbers Served

For SFY 2008, 82 children and families entered PCIT, and completed a majority of the program while 49 families completed both the Child Directed and Parent Directed portions of the program.

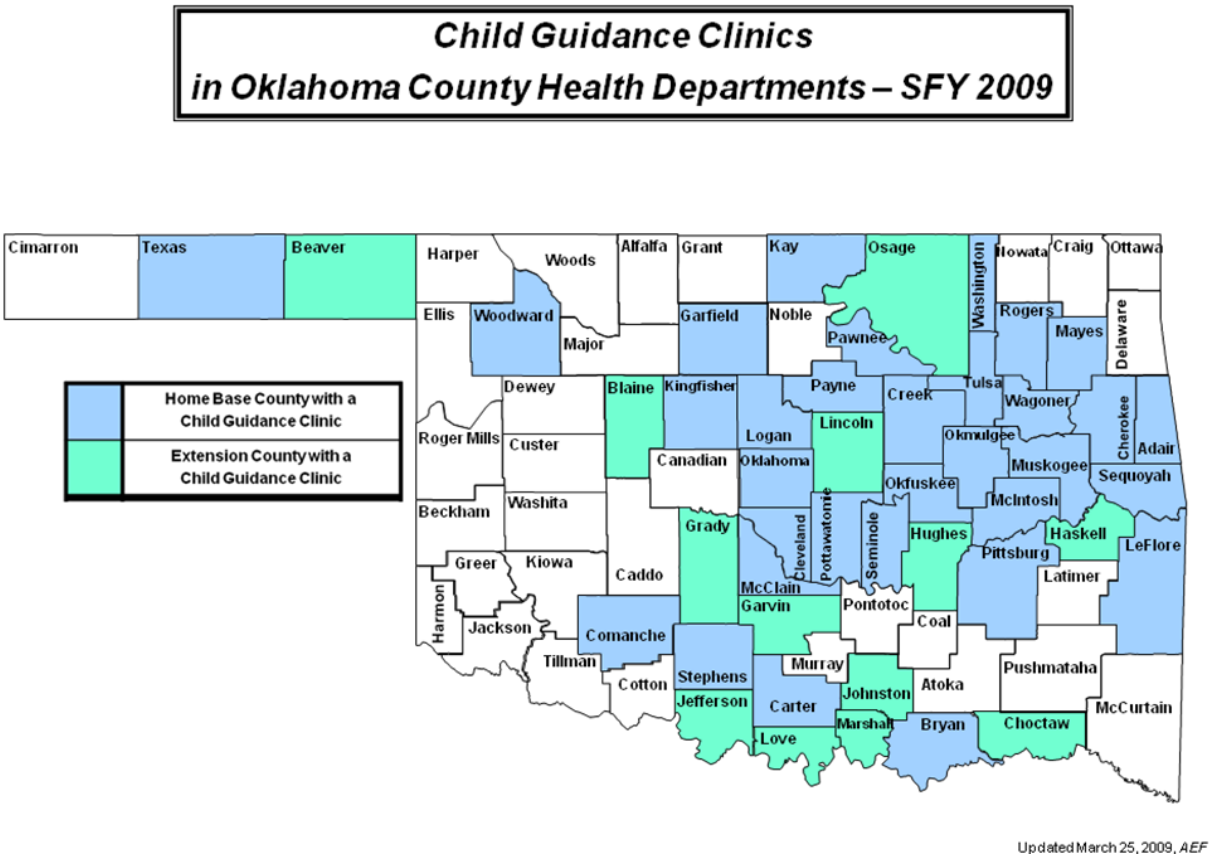
Outcomes

For SFY 2009, of families completing PCIT, 65% showed good or very good progress toward reaching treatment goals.

Child Guidance Map (see next page)

PCIT (Offered by Child Guidance Services)

Map



Contact Information	Debra Andersen, Chief Child Guidance Service Oklahoma State Department of Health 1000 NE 10th Street Oklahoma City, OK 73117-1299 (405) 271-4477
Website	www.ok.gov/health/Child_and_Family_Health/Child_Guidance_Service

Systems of Care

Agency	Description & Target Population
Oklahoma Department of Mental Health and Substance Abuse Services	Eligibility: kids 0-21 and their families, with a serious emotional disturbance and involved in two or more child serving systems and at risk for out of home placement. Systems of Care • How communities come together to provide a system of behavioral health services and supports for children, youth and families • Families as partners and therapeutic allies • Multi-disciplinary teams and blended resources • Individualized "Wraparound" approach • Strengths-based assessments • Community-based ownership • Coordination with informal and natural supports • Comprehensive service array Wraparound Wraparound is a process which helps a family develop and carry out their own individualized treatment plan. The treatment plan focuses on meeting the needs of the child, youth and the family. Wraparound improves the lives of families by building on their strengths and encouraging them to make helpful, caring connections in their communities. Wraparound is different because it gives the family a choice about the services they receive and a voice in the manner in which they receive them. A trained and credentialed Wraparound facilitator works with the family to identify natural supports and service providers to form a family team. The team then works together to achieve the goals chosen by the family. A Family Support Specialist is provided for every family and helps monitor "family voice and choice" on the family team.
Funding Source	
State Appropriation and Federal SAMHSA Systems of Care Federal Funding	
Counties Served	
46	

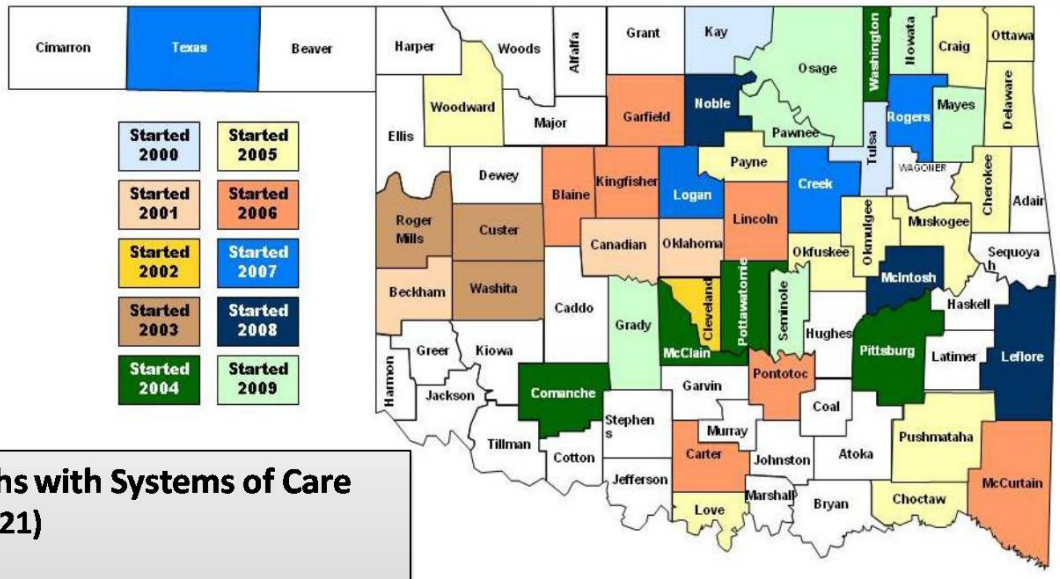
Program Model
Wraparound
Numbers Served
1,500 families per year
Evaluation
Conducted by the University of Oklahoma, John Vetter, contact, 325-3275
Outcomes

After 6 months with Systems of Care; FY 2008 (n=1,021)

1. Reduced Days of Out-of-Home Placement: 26%
2. Reduced School Detentions: 54%
3. Reduced Suicide Attempts: 56%
4. Reduced Arrests: 42%
5. Reduced School Absences: 20%
6. Reduced School Suspensions: 16%

Systems of Care Site Map

ODMHSAS Systems of Care (SOC) and Outcomes



After 6 months with Systems of Care
FY 2008 (n=1,021)

Reduced Days of Out-of-Home Placement	26%
Reduced School Detentions	54%
Reduced Suicide Attempts	56%
Reduced Arrests	42%
Reduced School Absences	20%
Reduced School Suspensions	16%

Contact Information	Darlene Bricky, (405) 522-4151
Website	http://www.ok.gov/odmhsas/Consumer_Services/Children,_Youth_and_Family_Services/Systems_of_Care/

Mental Health Services

Agency	Description & Target Population
Oklahoma Department of Mental Health and Substance Abuse Services	ODMHSAS mental health services encompass a broad range of needs. The department operates a psychiatric hospital for adults, a facility with specific services for children and adolescents, along with a specialty center devoted to forensic services. In addition, ODMHSAS provides a variety of community mental health services through a statewide network of Community Mental Health Centers (CMHCs). Residential care services, housing and access to benefits are just some of the other related support services available. For individuals in crisis, the department provides emergency assessment, mobile crisis, community-based crisis stabilization and inpatient hospitalization. Specialized programs in partnership with law enforcement (CIT) and the criminal justice system (Mental Health Court) have been highly successful, as have other targeted programs related to children and family services (SOC) and community response (Project Heartland). ODMHSAS also provides funding for social and recreational services for individuals with mental illness who live in residential care facilities, as well as support for certain other community-based services such as assistance for mentally ill individuals who are homeless. State-funded services are available for adult Oklahomans in need of mental health and substance abuse treatment who are 200% of poverty or below and have no other means of pay. However, because of limited resources, there are illness severity criteria that must be met for adults to receive services. Eligibility requirements for children include those with no other means of payment. Individuals are free to seek services in any locale they prefer, regardless of service area of residence.
Funding Source	
ODMHSAS receives funding from a variety of sources. For FY 2009, mental health funding totaled $208,992,628. Sources: 74% state, 6% federal government, and 20% other.	

Program Model

ODMHSAS is dedicated to funding best practice models such as Programs of Assertive Community Treatment (PACT), Illness Management and Recovery, Systems of Care for children and support other nationally recognized supportive programs such as case management, jail diversion programs, psychiatric rehabilitation services and services provided by persons in recovery.

Services

While the majority of services delivered by ODMHSAS are center based, there are some home based services provided. Services are provided at state-operated and/or contracted service facilities, however, specialized community-based services for targeted at-risk populations are utilized (such as with PACT, children/family centered wrap around services, targeted outreach, etc.) and have become an integral part of the department's service delivery network .

Numbers Served

In State Fiscal Year 2009, there were 52,226 individuals served with mental health services from DMHSAS-funded agencies.

Outcomes

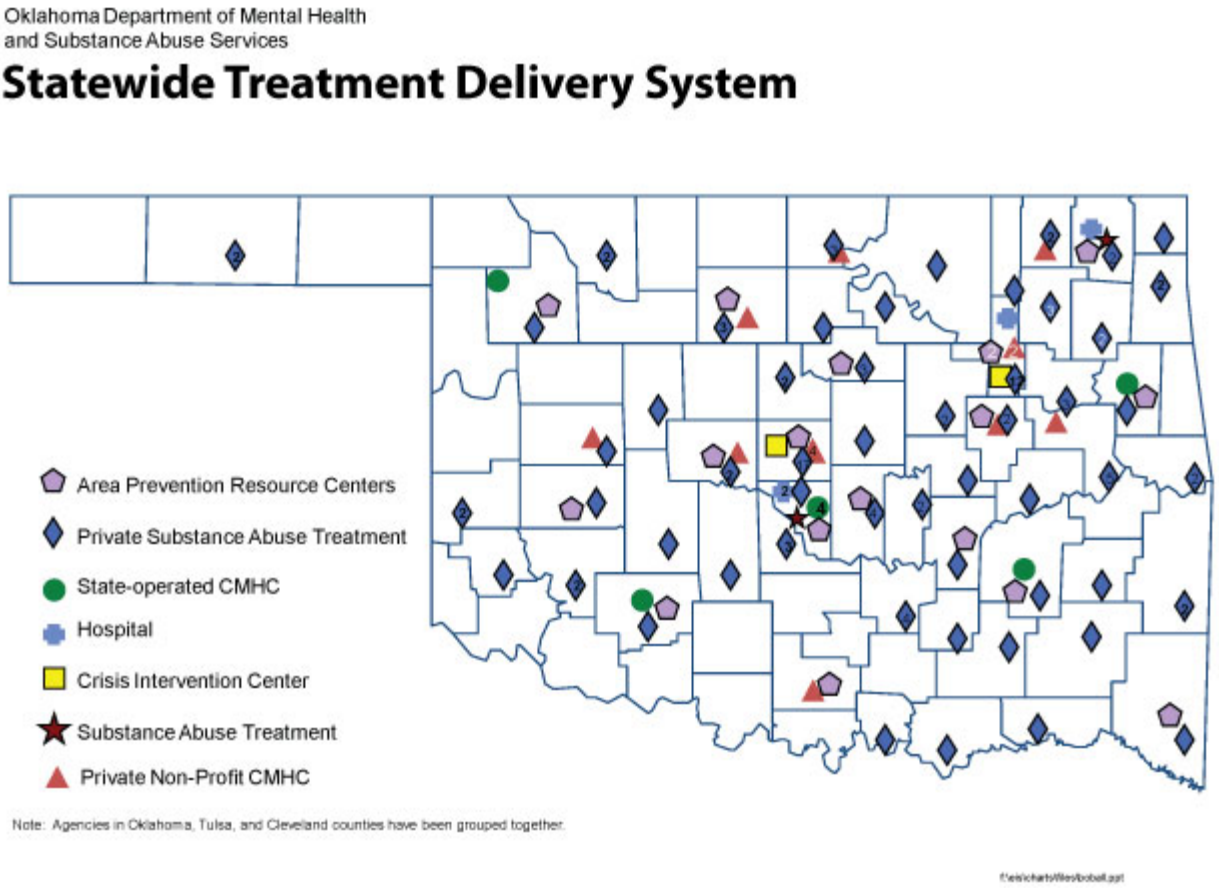
ODMHSAS monitors program effectiveness based on a variety of outcome measures. Specifically, the department collects information related to changes in at-risk behavior, wellness status and recovery progression of individuals who have received treatment services. Comparisons are made between pre-admission and post-admission history. Significant outcomes related to ODMHSAS mental health treatment services include:

1. Percent of customers receiving a medication visit within 14 days of admission: 60%
2. Percent of customers receiving a follow up service within 7 days after an inpatient discharge: 70%
3. Percent of customers who receive four services within 45 days of admission: 58%

Evaluation

ODMHSAS maintains a comprehensive evaluation system of all processes and programs, involving a variety of data collection methods and statistical reports. Access to this information is available through the ODMHSAS website at www.odmhsas.org, or by calling the department's decision support services division at 405-522-3908.

Map



Contact Information	Jeffrey Dismukes, Director ODMHSAS Public Information 405-522-3907 jdismukes@odmhsas.org
Website	http://www.odmhsas.org

Substance Abuse Services (Prevention)

Agency	Description & Target Population
Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS)	The DMHSAS supports prevention initiatives such as: the Oklahoma Prevention Resource Center, 17 Area Prevention Resource Centers (APRCs) Youth Suicide Prevention Contracts, Methamphetamine Prevention, Substance Abuse Prevention for Children in Substance Abusing Families, Enforcing Underage Drinking Laws (EUDL)/2Much2Lose (2M2L), Strategic Prevention Framework State Incentive Grant (SPF-SIG), State Epidemiological Outcomes Workgroup (SEOW), Justice Assistance Grant (JAG) and Safe and Drug Free Schools and Communities – Governor's Discretionary Portion to name a few. Substance Abuse Prevention initiatives focus on successful implementation of evidence-based strategies - with a focus on environmental strategies - that are proven to be effective in alcohol, tobacco and other drug (ATOD) prevention. Providers create and sustain partnerships with community stakeholders to develop and implement environmental prevention strategies for their Oklahoma communities. Programs are based on an environmental prevention approach and may also offer education and assistance to schools, parents, agencies and community groups. Target Population: Oklahomans across the lifespan.
Funding Source	
Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Prevention and Treatment (SAPT) Block Grant, Administration on Children and Families (ACF), Office of Juvenile Justice and Delinquency Prevention (OJJDP), District Attorneys Council, Tobacco Settlement Endowment Trust (TSET) and U.S. Department of Education Office of Safe and Drug Free Schools	

Program Model

The Strategic Prevention Framework (SPF) model is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, State/tribal and community levels.

The SPF requires States and communities to systematically:

1. Assess their prevention needs based on epidemiological data,
2. Build their prevention capacity,
3. Develop a strategic plan,
4. Implement effective community prevention programs, policies and practices, and
5. Evaluate their efforts for outcomes.

Services

Community based services which aim to enhance the ability of the community to provide more effective prevention services such as organizing, planning, interagency collaboration, coalition building and networking.

Numbers Served

Not Provided

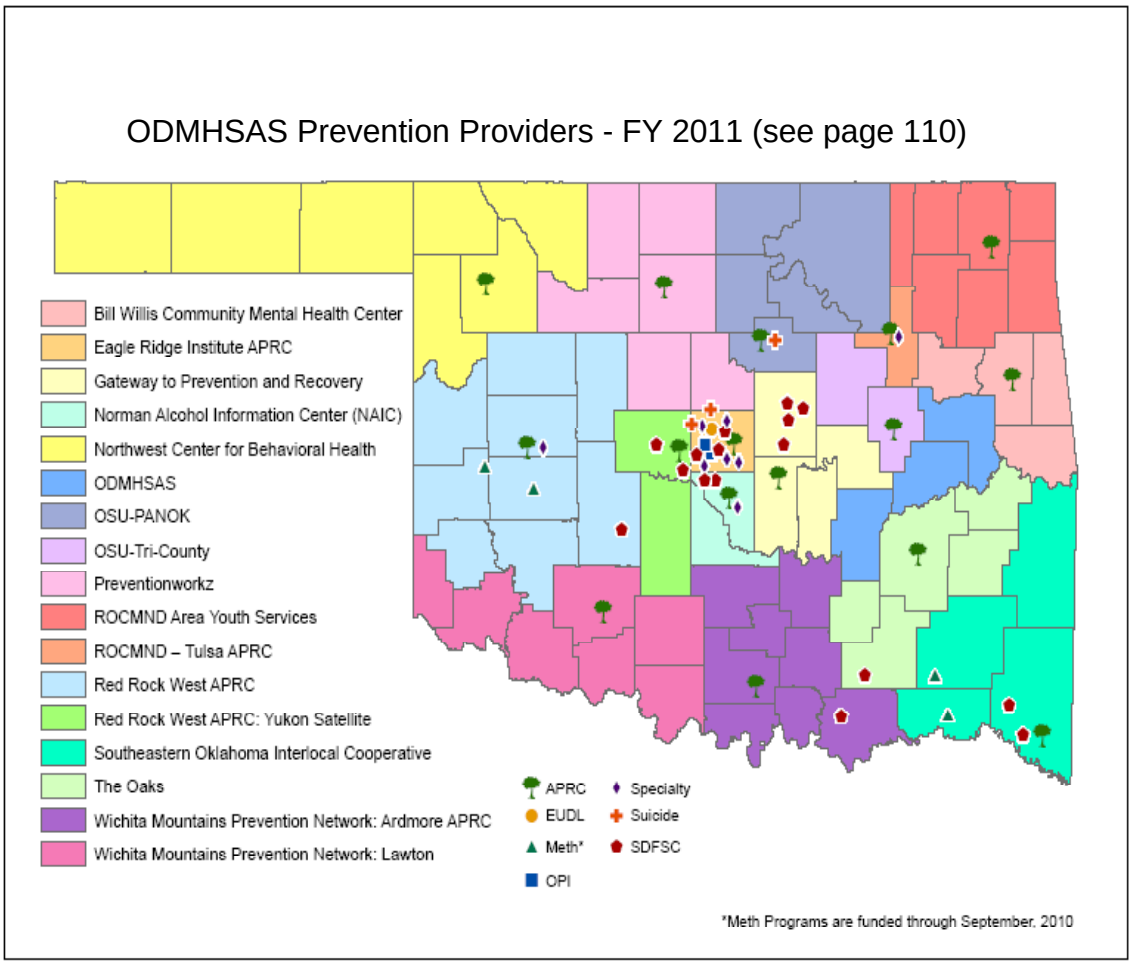
Outcomes

1. There was a 13% decrease in methamphetamine treatment admissions between FY2006 to FY2008.
2. Over 40% of Oklahoma Partnership Initiative's Strengthening Families Program Graduates reported "NO" current use of alcohol or drugs at time of post-testing.
3. Through an innovative collaboration with Mercy Hospital and ODMHSAS, over 4,000 medical staff were trained in suicide prevention and how to refer a patient for follow-up care. The referrals to mental health centers has more than doubled since the implementation of trainings.

Evaluation

All of the Substance Abuse Prevention initiatives focus on the implementation of evidenced-based environmental strategies that are proven to be effective in ATOD prevention.

Map



Contact Information	Jessica Hawkins Director, Prevention Services 405.522.3619/jhawkins@odmhsas.org
Website	www.odmhsas.org

Substance Abuse Services (Treatment)

Agency	Description & Target Population
Oklahoma Department of Mental Health and Substance Abuse Services	ODMHSAS operates or contracts with substance abuse treatment centers across Oklahoma, many with satellite offices, to provide services for individuals in need. Facilities are located statewide, and offer a variety of services including: assessment and referral, detoxification, outpatient counseling, residential treatment, substance abuse education, transitional living, and aftercare services. Some programs are designed to meet the needs of specific populations, such as criminal justice, women with children, adolescents, Hispanics and Native Americans.
Funding Source	State-funded services are available for adult Oklahomans in need of mental health and substance abuse treatment who are 200% of poverty or below and have no other means of pay. However, because of limited resources, there are illness severity criteria that must be met for adults to receive services. Eligibility requirements for children include those with no other means of payment. Individuals are free to seek services in any locale they prefer, regardless of service area of residence.
ODMHSAS receives funding from a variety of sources. For FY 2009, substance abuse funding totaled $85,296,372. Sources: 45% state, 43% federal government, and 12% other.	

Program Model

ODMHSAS provides a comprehensive, therapeutic approach to the delivery of substance abuse services targeting individual need and focused on the use of evidence based practices to offer an appropriate continuum of care. Individuals are actively engaged in all processes, with attention also given to behavior modification and development of healthy life skills.

Services

While the majority of services delivered by ODMHSAS are center based, there are some home based services provided. Services are provided at state-operated and/or contracted service facilities, however, specialized community-based services for targeted at-risk populations are utilized (such as with PACT, children/family centered wrap around services, targeted outreach, etc.) and have become an integral part of the department's service delivery network .

Numbers Served

In State Fiscal Year 2009, there were 22,226 persons served by ODMHSAS funded substance abuse services.

Outcomes

ODMHSAS monitors program effectiveness based on a variety of outcome measures. Specifically, the department collects information related to changes in at-risk behavior, wellness status and recovery progression of individuals who have received treatment services. Comparisons are made between pre-admission and post-admission history. Significant outcomes related to ODMHSAS substance abuse treatment services include:

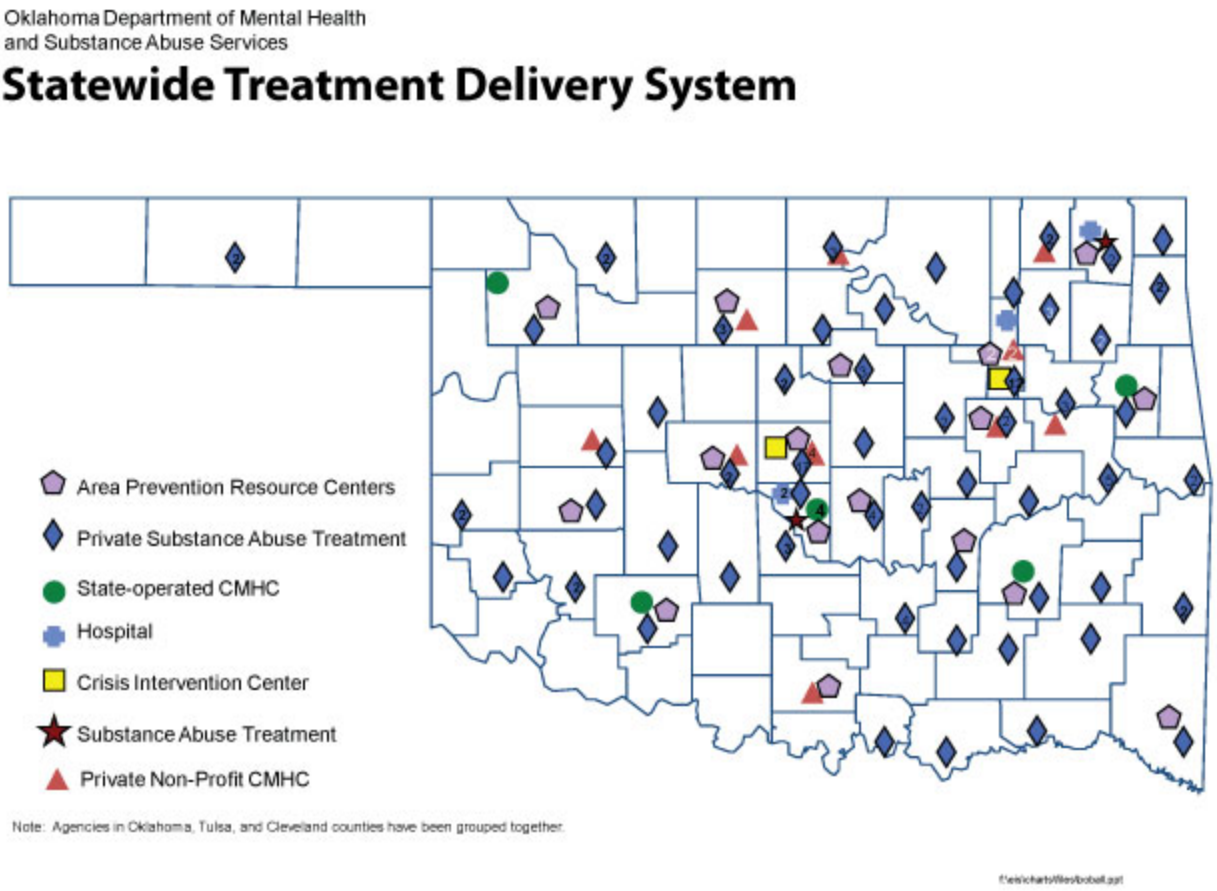
1. Percent of customers reporting a reduction in substance use: 54%
2. Percent of customers reporting a reduction in number of arrests: 75%

Percent of customers NOT readmitting to Detox within 30 days: 96%

Evaluation

ODMHSAS maintains a comprehensive evaluation system of all processes and programs, involving a variety of data collection methods and statistical reports. Access to this information is available through the ODMHSAS website at www.odmhsas.org, or by calling the department's decision support services division at 405-522-3908.

Map



Contact Information	Jeffrey Dismukes, Director ODMHSAS Public Information 405-522-3907 jdismukes@odmhsas.org
Website	http://www.odmhsas.org

Domestic Violence Services

Agency	Description & Target Population
Office of Attorney General	The Office of Attorney General contracts with twenty nine community-based programs, to provide services for victims of domestic violence, sexual assault and stalking. At a minimum, they provide crisis intervention, safety planning and temporary shelter in a safe environment. Shelter stay traditionally is 30 days, although extensions are granted. Additionally these programs help battered women and their children navigate the court system, obtain protective orders, find legal counsel, seek jobs, childcare, new living arrangements, and locate additional community resources. Target Population: Victims of domestic violence, sexual assault and stalking.
Funding Source	
Funding for the domestic violence programs comes from state appropriations and federal funding through the Family Violence Prevention Services Act (FVPSA)	

Program Model

The intervention strategies for the DVSA agencies working with adult domestic violence/sexual assault /stalking victims is to provide SAFETY from physical, emotional, financial, and psychological harm with the ultimate goal of eliminating violence from their lives and their children. These strategies are based on an empowerment model, actively supporting each victim's right to self-determination. Additionally DVSA agencies recognize and promote partnerships with community resources such as law enforcement and the courts in order to reduce violence within our society, promote victim safety, reinforce abuser accountability and to advance the ethic of zero tolerance for domestic violence, sexual assault, and stalking in our communities.

Numbers Served

In federal fiscal year 2008 (according to the Oklahoma Victim Information System (OVIS) managed by the Oklahoma Coalition Against Domestic Violence and Sexual Assault, and other domestic violence agencies as reported (that are not on OVIS) DVSA programs provided assistance to 13,333 women and 4,754 dependent children and 597 male victims. There are currently 29 programs certified by the Office of Attorney General offering services to domestic violence victims and their children.

Please note: These numbers do not reflect the domestic violence/sexual assault victims served by the Native American Tribes.

Outcomes

The contracted certified programs are required to survey clients. The surveys examine changes that have occurred as a result of a services being provided. The outcomes examined are:

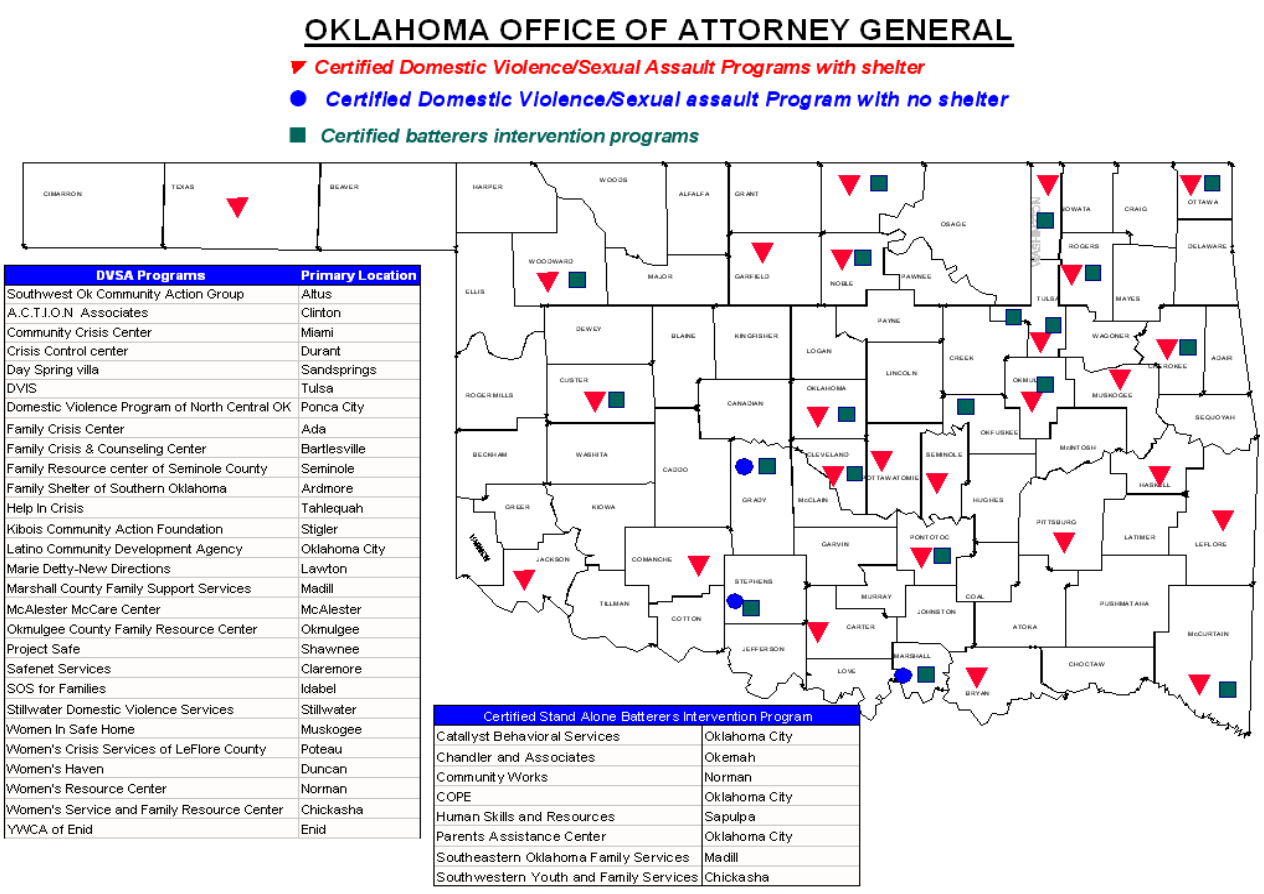
1. Clients know more ways to plan for their safety.
2. Clients know more about community resources.

Evaluation

Surveys are collected in four program areas: shelter, support services, advocacy and counseling. Therefore a client may be asked to fill out multiple surveys. The results of the surveys for reporting period October1, 2008 to September 30, 2009 are:

Survey Type	Number of Surveys Completed	Number of Yes Responses to Resource Outcome	Number of Yes Responses to Safety Outcome
Shelter Survey	1588	1519	1536
Support Services and Advocacy Survey	1913	1798	1812
Counseling Survey	1207	1057	1163
Support Survey	1244	1109	1207
Total	5952	5483	5718

Map



DVSA Programs	Primary Location
Southwest Ok Community Action Group	Altus
A.C.T.I.O.N Associates	Clinton
Community Crisis Center	Miami
Crisis Control center	Durant
Day Spring villa	Sandsprings
DVIS	Tulsa
Domestic Violence Program of North Central OK	Ponca City
Family Crisis Center	Ada
Family Crisis & Counseling Center	Bartlesville
Family Resource center of Seminole County	Seminole
Family Shelter of Southern Oklahoma	Ardmore
Help In Crisis	Tahlequah
Kibois Community Action Foundation	Stigler
Latino Community Development Agency	Oklahoma City
Marie Detty-New Directions	Lawton
Marshall County Family Support Services	Madill
McAlester McCare Center	McAlester
Okmulgee County Family Resource Center	Okmulgee
Project Safe	Shawnee
Safenet Services	Claremore
SOS for Families	Idabel
Stillwater Domestic Violence Services	Stillwater
Women In Safe Home	Muskogee
Women's Crisis Services of LeFlore County	Poteau
Women's Haven	Duncan
Women's Resource Center	Norman
Women's Service and Family Resource Center	Chickasha
YWCA of Enid	Enid

Certified Stand Alone Batterers Intervention Program	
Catallyst Behavioral Services	Oklahoma City
Chandler and Associates	Okemah
Community Works	Norman
COPE	Oklahoma City
Human Skills and Resources	Sapulpa
Parents Assistance Center	Oklahoma City
Southeastern Oklahoma Family Services	Madill
Southwestern Youth and Family Services	Chickasha

Contact Information	Susan Damron Krug Office of Attorney General (405) 521-4274
Website	www.oag.ok.gov

Oklahoma Drug Courts

Agency	Description & Target Population
Oklahoma State Department of Mental Health and Substance Abuse Services	The Oklahoma Department of Mental Health and Substance Abuse Services leads the development of drug courts statewide. Drug court pairs the court system with substance abuse treatment for non-violent offenders with addictions. The judicially monitored treatment program serves as an alternative to prison. A team of representatives from the judicial, criminal justice, law enforcement, and treatment fields meet weekly to screen potential drug court defendants and to review participants' progress. It costs approximately $19,000 to incarcerate one person for a year as opposed to an average of $5,000 per person per year for drug court. The average incarceration time is 7 years if the drug court participant fails the program.
Funding Source	
Funding for ODMHSAS drug court services is from state appropriations.	

Services

Drug Courts provide services which are both center-based and home-based to the program participants. Treatment services are provided primarily in the facility of the Drug Court treatment provider and include individual and group substance abuse and mental health treatment. Supervision services monitor participants' compliance with court orders and are provided at any location including, but not limited to, participants' homes, employment, school, as well as supervision offices.

Program Model

The Oklahoma State Legislature has set forth guidelines for the structure of the Adult Drug Court programs. Drug Court teams consist of a judge, district attorney, defense attorney, treatment representative, and coordinator, with additional staff being optional. Eligible offenders are adults who have a felony charge pending in district court and do not have a history of a felony conviction for a violent offense. The Drug Court program is a five (5) phased approach including treatment/supervision focused portions and supervision-only focused portions of the program. The treatment period is designed to be completed within twelve (12) months, but has the capacity to extend to twenty-four months (24). The supervision only portion of the program, also known as aftercare, extends for the twelve (12) months preceding treatment. Program participation does not exceed thirty-six (36) months. At completion of the program, the criminal case is disposed based on the written plea agreement.

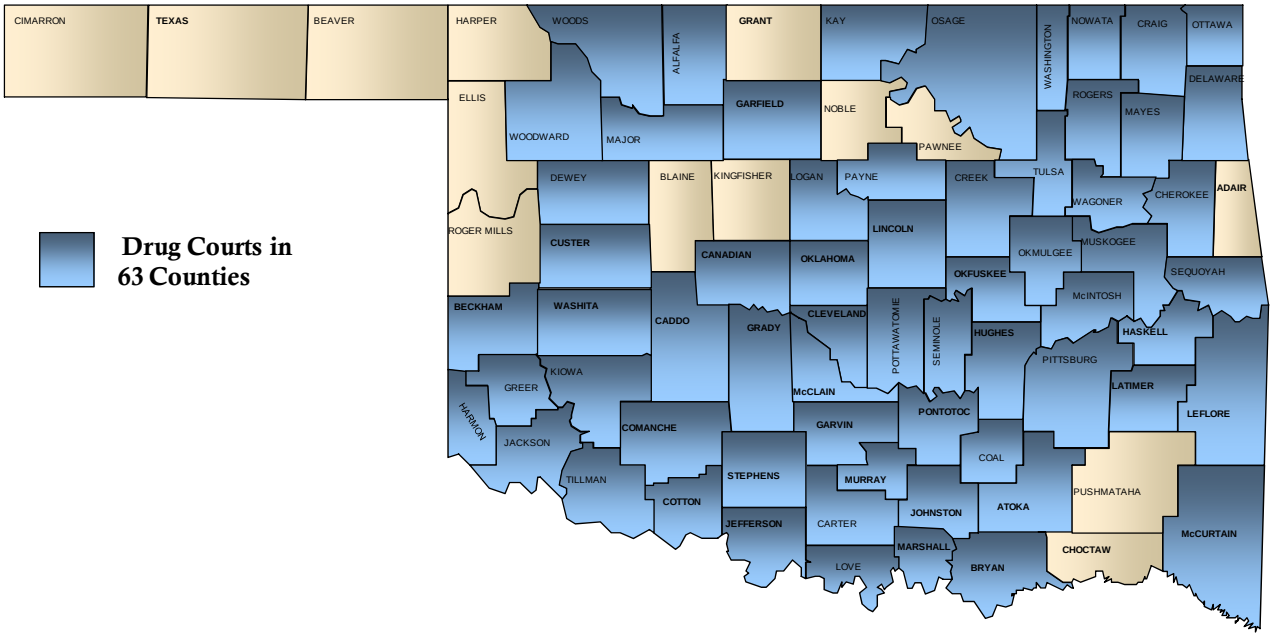
Numbers Served

The 53 Drug Courts that are operational across 63 counties served 5,577 participants in fiscal year 2007, 6,349 participants in fiscal year 2008, and 6,465 participants in fiscal year 2009. The program includes Adult, Juvenile, and Family Drug Courts across the state.

Outcomes

1. Data for FY2002 and FY2009 indicates that unemployment decreased by 87.1% between admission and graduation.
2. Data for FY2002 and FY2009 shows a 25.9% decrease among participants without a high school education between admission and graduation.
3. Data for FY2002 and FY2009 demonstrates that children living with their parents increased by 52.5% between admission and graduation.

Oklahoma Drug Courts Map



Contact Information	David Wright, Ph.D 405-522-6169 dwright@odmhsas.org
Website	www.odmhsas.org

Child Advocacy Centers

Agency	Description & Target Population
Private & Non-Profit Groups (For more information, contact The Family Support and Prevention Service of the Oklahoma State Department of Health)	Child Advocacy Centers are child-focused, center-based programs that work to prevent further victimization of children who have been sexually or physically abused or neglected. Centers work towards more immediate follow-up to reports of child abuse, efficient referrals to medical and mental health professionals, reduction of child interviews, increased successful prosecution, and support for the child and family. Centers offer a comprehensive approach to child abuse and neglect investigation and intervention and work in conjunction with multidisciplinary child abuse teams. Nineteen of the multidisciplinary teams have full National Children's Advocacy Alliance Membership.
Funding Source	
Varied, including income from the CAMA fund for centers with full membership with the National Children's Alliance.	

Program Model

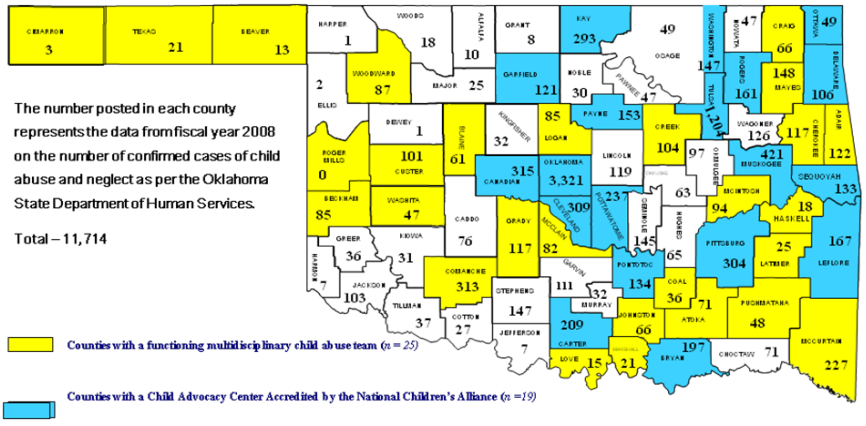
Standards provided by the National Children's Alliance

Components (10) to the National Children's Alliance full membership for centers

- Child-Appropriate/Child-Friendly Facility
- Multidisciplinary Team Approach
- Organizational Capacity (legal/financial/admin.)
- Cultural Competency and Diversity
- Forensic Interviews
- Specialized Medical Evaluation
- Therapeutic Intervention
- Victim Support and Advocacy
- Team Case Review
- Case Tracking System

Oklahoma Multidisciplinary Teams - FY 2009 - 2010

Child Abuse Training and Coordination Program
Oklahoma State Department of Health
Family Health Services
Family Support & Prevention Service



Total Number of Multidisciplinary Teams in Oklahoma = 45

Conntact Information	Pat Damron, CATC Program Coordinator; Patriciaad@health.ok.gov Shelagh Hadden, Program Manager; shelaghh@health.ok.gov Lisa Slater, Administrative Assistant; lisaj@health.ok.gov
Website	http://catcp.health.ok.gov

DESCRIPTION OF THE CHILD ABUSE AND NEGLECT PREVENTION NETWORK

The Child Abuse Prevention Act

In 1984, Oklahoma passed the Child Abuse Prevention Act (CAP Act), Title 63, O.S. Supp. 2004, Section 1-227. Prior to that time, the focus of child abuse and neglect efforts was on "after-the-fact" intervention (i.e. preventing the reoccurrence of child abuse and neglect in families). The Act declared that the prevention of child abuse and neglect was a priority in Oklahoma. The legislative intent was that:

- a comprehensive approach for the prevention of child abuse and neglect be developed for the state and used as a basis of funding programs and services statewide;
- multi-disciplinary and discipline-specific ongoing training on child abuse and neglect and domestic violence be available to professionals in Oklahoma with responsibilities affecting children, youth, and families; and
- the Office of Child Abuse Prevention (OCAP) within the Oklahoma State Department of Health (OSDH) was created for the purpose of establishing a comprehensive statewide approach towards the prevention of child abuse and neglect.

The CAP Act created the Child Abuse Prevention (CAP) Fund for the provision of community-based child abuse prevention programs. The Act established the Interagency Child Abuse Prevention Task Force (ITF) and statewide District Child Abuse Prevention Task Forces (DTF) that have collaboratively worked with the OCAP and with local community-based, prevention-focused, child abuse prevention programs from the prevention network in the past. In July 2007, the law was updated, eliminating district task forces as being a mandatory requirement although an emphasis on local input remains a priority via pre-existing community networks, local partnerships, and local task force initiatives.

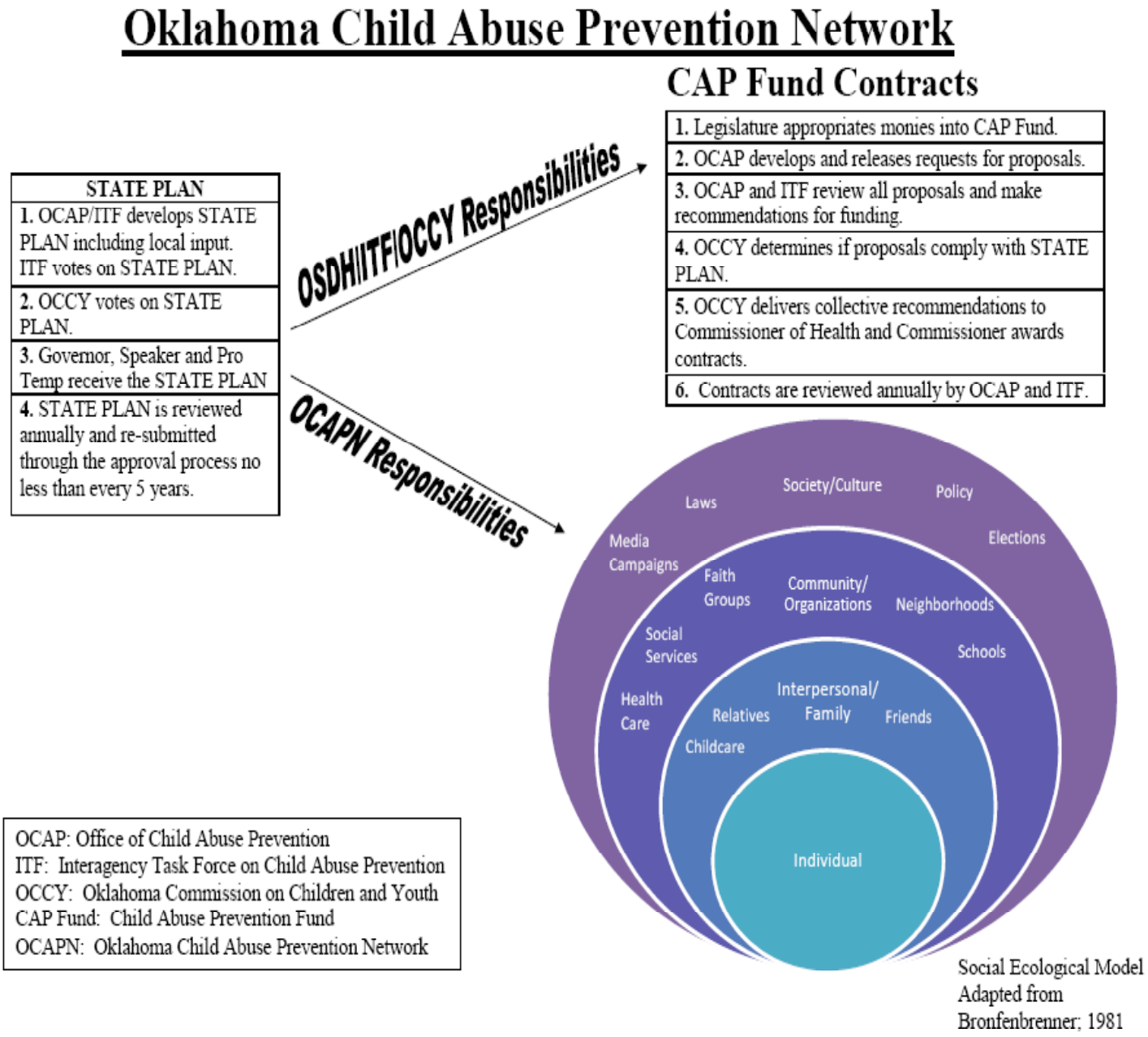
The ITF is composed of representatives from state agencies, the business community, parent participants of family support programs, child abuse prevention service providers from the private and public sector and professionals from the medical, legal and mental health fields. The ITF and OCAP prepare the Oklahoma State Plan for the Prevention of Child Abuse and Neglect (see attachment 'Ok State Plan 07 - 08'), which is a compilation of findings, recommendations and a plan for the continuum of comprehensive child abuse prevention services in Oklahoma. ITF members (including parent representatives), service providers, child advocates and program participants participate in the creation of the State Plan.

The Oklahoma Commission on Children and Youth (OCCY) is the state agency that provides oversight of all services for children in the State, including the State Plan and contract awards for The Office of Child Abuse Prevention Start Right Programs. With the direction and recommendations of the State Plan, the ITF, OCAP, other OSDH family resource and

support programs, other state agencies and other services providers provide a coordinated, collaborative continuum of services to prevent child abuse and neglect. The Office of Child Abuse Prevention Start Right Program proposals are peer reviewed at the local and ITF levels. The approved Office of Child Abuse Prevention Start Right Programs sign contracts with the OSDH to provide services.

How the Structure Directs the Prevention Network

An illustration of the structure is presented, followed by descriptions of each segment of the structure.



The Office of Child Abuse Prevention

The Oklahoma Child Abuse Prevention Act (CAP Act) created the Office of Child Abuse Prevention (OCAP) within the Oklahoma State Department of Health and defined the mechanisms by which the OCAP could fulfill its duties. The Commissioner of Health has fiscal and administrative duties to facilitate the implementation of the CAP Act. The duties and responsibilities of the Director of the OCAP are outlined in the CAP Act. The OCAP provides primary (statewide promotion of child abuse prevention), secondary (community-based family resource and support programs) and tertiary (training of professionals on identifying, reporting, investigating, and prosecuting child abuse and neglect) prevention services. The OCAP staff have formal education, training and/or expertise in the areas of prenatal health, child health and development, child safety, adult education, parent advocacy, fatherhood involvement, local social service resources, respite systems, program evaluation, family assessment, family support, Healthy Families America® approach, early childhood education, professional development, public awareness, child abuse and neglect prevention, and intervention.

The Interagency Child Abuse Prevention Task Force

The Interagency Child Abuse Prevention Task Force (ITF) has a mandated membership of representatives from: 1) public agencies with responsibilities for children and families, such as the Department of Health, Department of Education, Department of Human Services, Department of Mental Health and Substance Abuse, Office of the Attorney General and Judiciary/Law Enforcement agency; 2) private organizations such as the American Academy of Pediatrics and the Oklahoma Partnership for School Readiness Board; 3) private agencies and programs that specialize in the identification and intervention of child abuse and neglect; 4) local government or business community; and 5) parents participating in a family resource and support program. The Task Force is staffed by the OCAP. As directed by the CAP Act, the ITF reviews and evaluates all prevention program proposals submitted to the OCAP for funding through the CAP Fund, reports findings to the Oklahoma Commission on Children and Youth and makes recommendations to the Commissioner of Health, the final authority for contract awards. The ITF with its broad representation and expertise assists the OCAP in the development of the State Plan.

The Child Abuse Prevention Fund

The CAP Fund was created by the CAP Act as a mechanism for pooling state, federal and private funds for the development and implementation of community-based family support programs for the prevention of child abuse and neglect. Program proposals go through a multi-layer, multidisciplinary review. Approved proposals are awarded contracts by the Commissioner of Health and receive funding through the CAP Fund. The OCAP provides training, technical assistance, evaluation and assessment to the CAP Fund community-based family support prevention programs, including programs funded by CBCAP dollars.

Oklahoma State Plan for the Prevention of Child Abuse and Neglect

The State Plan written by the ITF and the OCAP is a compilation of findings, recommendations and efforts spanning the continuum of child abuse and neglect prevention in Oklahoma. It is written with the acknowledgment that the prevention of child abuse and neglect requires collaboration, coordination and commitment of public agencies, private agencies, private citizens, prevention and intervention professionals and the legal system. With this community approach for the prevention of child abuse and neglect, a draft of the State Plan is distributed statewide for comments and other public and private service providers, child advocacy agencies and private citizens.

Oklahoma Commission on Children and Youth (OCCY)

The Oklahoma Commission on Children and Youth (OCCY), a state agency, was created to provide oversight and improve services to children and youth. The OCCY facilitates planning and coordination among public and private agencies serving children and youth and provides administrative oversight for all children's programs and services. OCCY is mandated to ensure that the provisions of the CAP Act are implemented. Its duties include: 1) the review and approval of the Oklahoma State Plan for the Prevention of Child Abuse and Neglect; 2) the appointment of ITF members; 3) the appointment of CATCC members; and 4) the recommendations of prevention program proposals for funding to the Commissioner of Health.

State Early Childhood Comprehensive Systems (ECCS)

The Oklahoma State Department of Health (OSDH) Early Childhood Comprehensive Systems (ECCS) Project works collaboratively with the Oklahoma Partnership for School Readiness (OPSR) Board and Smart Start Oklahoma (SSO) to implement the Early Childhood Comprehensive State Plan. The mission of OPSR and ECCS is to lead Oklahoma in coordinating an early childhood system focused on strengthening families and school readiness for all children. If successful, it will be possible for all families with young children across the state to access services when needed in the areas of parent education and family support, primary health care, social and emotional support, and quality early care and education. The implementation of the early childhood comprehensive state plan will help achieve the vision of all Oklahoma children entering school safe, healthy, eager to learn and ready to succeed.

Child Abuse Training and Coordination Program (CATC)

As a part of the continuum, multidisciplinary and discipline-specific training programs for professionals with responsibilities affecting children, youth, and families are mandated responsibilities of the Child Abuse Training and Coordination Program (CATC). This program provides training, technical assistance and assessment of the developing and functioning county-level multidisciplinary child abuse and neglect teams throughout the state and improves education and training of professionals with responsibilities for children and families. The CATC program works with the Child Abuse Training and Coordination Council (CATCC) and Multidisciplinary Child Abuse and Neglect Teams (MDTs). Funding for the CATC Program and Council is provided through state appropriations and the Children's Justice Act Grant, a collaborative effort with the Oklahoma Department of Human Services.

Child Abuse Training and Coordination Council (CATCC)

Defined by the CAP Act, CATCC has the mandate to make available multidisciplinary and discipline-specific training on child abuse and neglect for professionals with responsibilities affecting children, youth and families. CATCC, comprised of a 22 member council, establishes multidisciplinary and discipline-specific training guidelines and objectives and makes curricula recommendations to other agencies with professionals who have responsibilities for children, youth and families.

In conjunction with the CATCC, the CATC program facilitates the multidisciplinary and discipline-specific trainings. The CATC Program provides training to child protective services, law enforcement, district attorneys, judges, medical personnel, mental health consultants and other professionals. Specific trainings have included: "Investigating Severe Neglect and Physical Injury of Children and Infants;" "Taking Your Investigation to the Courtroom;" and "Advanced Forensic Interviewing."

Examples of the functions of the CATC program are as follows: assists the Oklahoma Lawyers for Children and the Oklahoma District Attorney's Office with a Spring Seminar 2010 with the topic of Title 10 Update; partner with the Oklahoma CARE Center to provide training on team development; and assist with the 17th Oklahoma Conference on Child Abuse and Neglect and Healthy Families.

Community Partnership Boards

The Oklahoma Commission on Children and Youth, Office of Planning and Coordination, is implementing the visionary legislation passed in 1989 and 2000 by the Oklahoma Legislature, which developed the structure of the Community Partnership Boards for Services to Children and Youth. A statewide planning process was also designed to coordinate public and private agencies at the state level and local community level. These responsibilities were placed under the auspices of the Oklahoma Commission on Children and Youth. The legislation recognized that ownership and responsibility for finding solutions to children's problems belongs to local communities. In other words, the responsibility for assuring the future of Oklahoma's families and children must be shared by every citizen. Composed of local citizens and service providers, the purpose of the Community Partnership Boards is to collaboratively plan and implement programs and services, which benefit the children, youth and families in our communities. This structure unites communities across the state around common issues and identifies unique concerns and strategies within communities.

Drawing on the diverse as well as common issues faced by the larger community, the Community Partnership Boards are the working bodies of community leaders concerned with children's issues. They are the networks around which gaps, strengths, and needs in services to children, youth, and families in communities may be

identified using available reports, statistics, experiences, and wisdom. Further, they provide leadership and advocacy for the provision of family-centered, community-based, culturally sensitive approaches to meeting the needs of Oklahoma's children, youth and families. The boards also provide an opportunity for networking with many child advocates and service providers. At this time, there are forty-four (44) active boards statewide.

The focus of the Community Partnership Boards is to develop plans of action that will effectively move our communities toward a brighter future. It is an opportunity to provide a voice for the children, youth and families from local communities to the state and help focus priorities. The issues addressed cut across the myriad of problems of today's families ... violence, education, jobs, poverty, juvenile delinquency, deprived and neglected children, abuse, alcohol and drug abuse, teen pregnancy, and many more. Many of the local boards have collaborated to successfully address specific needs in their communities. Many of these efforts rely on coordination of existing resources and require little or no new money. Even in times of tight budgets, improved projects and programs can occur with communication, coordination and planning.

Home Visitation Leadership Advisory Coalition (HVLAC)

The Family Support and Prevention Service steers the efforts of the Home Visitation Leadership Advisory Coalition (HVLAC) by convening, hosting, and facilitating home visitation meetings in order to provide networking opportunities. Members from various agencies and programs working at all levels, from the supervisory role to the front lines, participate in this dynamic group that strives for best practice in home visitation. Comprised of representatives from state agencies, such as the Oklahoma State University and Public School Districts, as well as Youth and Family Services agencies, Prevent Child Abuse Oklahoma, Parent-Child Centers and other private, non-profits, the committee provides recommendations to improve services, coordinate efforts (for example, child abuse prevention month) and best use of funds of those involved in home visitation for child abuse prevention, school-readiness, child abuse intervention and early intervention as well as address other critical issues as it relates to home visitation. Members benefit from sharing resources, learning about each other's programs, special speaker presentations, and collaborating on various projects.

The Oklahoma Strengthening Families Initiative

The Oklahoma Strengthening Families Initiative has now been in existence for three years. Over the past year, those trained by the Zero to Three staff in the "Preventing Child Abuse and Neglect" curriculum (PCAN) continue to serve as trainers for childcare providers in the 'Strengthening Families' philosophy. Unfortunately, recent reductions in workforce have limited the number of trainers.

The Strengthening Families pilot sites have continued their collaboration with their local child-care centers and involvement in other community organizations and events, such as:

- Child Care Centers were able to be awarded mini grants to make some type of change in their center that would involve families more in their program. Some created clothing/diaper resource rooms for parents, while others make physical changes to their buildings that make them more family friendly.
- Pilot sites implemented parent involvement projects of their choosing such as parent resource libraries.
- One SF pilot site formed a pre-school soccer league for children whose families could not afford to participate in the city league.
- Organized a Strengthening Families pre-school soccer camp along with the Enid High Soccer Coach and Team to kick-off the 2nd soccer season for SF Sites.
- "Caregiver Café's" were launched and these café's have been extremely helpful in opening up the barriers between the Head Start providers, parents, and community. Social networks have been developed and families and staff look forward to the meetings.
- Distributed 1,200 parent education bags at Christmas parades in Stephens, Cotton, and Jefferson counties. Information included community resources, calendar of events for family-friendly activities in the community, family literacy, and a craft for parents to work on with children during the holidays.
- Ongoing mentoring and stipends to pilot sites to increase quality care. Spring training will include "role plays – approaching & listening to parents" and some Front Porch Training components. Fall will include mentoring at each pilot site for one morning and one afternoon per week for 3 months.
- Continued partnering opportunities are taking place with Oklahoma Department of Human Services/Child Welfare, Oklahoma State University Cooperative Extension Services, Tulsa Community College and the Early Childhood Program at the OU/Tulsa Campus.

Child Abuse Prevention Action Committee (CAP ACTION)

The CAP ACTION committee emerged almost four years ago with a small group of people from various programs and state agencies, including participants from the faith based groups, local libraries, child care centers, Head Starts, health department officials, and private citizens who wanted to make a difference in the lives of children. New ideas sparked new campaigns, one of which surprised many by the level of success that was achieved with an astonishing number of participants, who not only joined in at the heart of the campaign, but also took it to new heights… expanding on the original idea and making it their own (i.e., Blueberry Muffin Mondays at workplaces – one health department had every client place a blue ribbon on the tree outside to represent "caring for children", etc.). The group has continued to grow with new members seeking opportunities to get involved and participate in child abuse prevention on a regular basis. There are currently over 150 individuals on the CAP ACTION email distribution list. Several sub-committees were formed in the last few years with the group now having many different layers and linking partners together. The group meets approximately six to seven times per year with several of the sub-committees meeting separately multiple times throughout the year. While the group originated with a goal of focusing on the planning for Child Abuse Prevention Month and Child Abuse Prevention Day in April at the

Capitol (which typically are the same month), the group is now striving to generate a monthly campaign to engage everyone in Oklahoma to share this common cause, help fight child abuse and build strong Oklahoma families everyday. The group is seeking to create a year round "Trail of Prevention" that leads into April's major events

Smart Start Oklahoma

Established under the Oklahoma Partnership for School Readiness Act in 2003, Smart Start Oklahoma through a community approach is charged with increasing the number of children who are ready to succeed by the time they enter kindergarten. In 2008, the Partnership Board was designated by the Governor as the State's Early Childhood Advisory Council, as required by each state under the 2007 Head Start Reauthorization Act.

As a public-private partnership, Smart Start Oklahoma pursues strategies for improving learning opportunities and environments for children birth to age six. State legislation charges the Partnership to promote and enhance community collaboration for early childhood programs and services. To accomplish this, Smart Start Oklahoma has an 18-member community-based network serving 52 counties across the state that reaches 88% of children under the age of six. At the state level, Smart Start Oklahoma supports communities with grants, technical assistance and fiscal management. Smart Start Oklahoma focuses on four key strategy areas:

- Community Development;
- Public Engagement;
- Public Policy and Systems Development; and
- Resource Development.

Smart Start Central Oklahoma, a member of the community-based network, played a key role in collaboration with OCAP during Child Abuse Prevention Day at the Capitol in April 2009 and February 2010. Seven Smart Start Oklahoma communities continue to focus on the Strengthening Families Initiative.

Oklahoma Institute for Child Advocacy

The Oklahoma Institute for Child Advocacy (OICA) is a statewide, non-profit agency. OICA's goal is to create awareness, take action and change policy on behalf of children and youth. The OCAP staff actively participates with others in OICA's Legislative Fall Forum. At the Fall Forum, hundreds of child advocates gather to shape a children's legislative agenda. It is rare for one of the legislative issues not to be related to child abuse and neglect prevention.

Oklahoma Domestic Violence Fatality Review Board

The mission of the Oklahoma Domestic Violence Fatality Review Board is to reduce the number of domestic violence related deaths in Oklahoma. The Board performs multi-disciplinary case reviews of statistical data and information derived from disciplines with jurisdiction and/or direct involvement with cases. Their purpose is to make recommendations to improve policies, procedures and practices within the systems involved and between agencies that protect and serve victims of domestic abuse. The CATC program manager is the designee of the Commissioner of OSDH to this board. State law allows the Domestic Violence Fatality Review Board and the Child Death Review Board to jointly review cases.

Oklahoma Department of Human Services

The Family Support and Prevention Service (OSDH) pursues working collaboratively with the Oklahoma Department of Human Services (DHS) in many areas including Children and Family Services, Child Abuse Multidisciplinary Teams, Developmental Disabilities and Children with Special Health Care Needs. Joint projects include the respite care voucher system.

The OSDH and DHS benefit from working closely together because child abuse prevention spans a continuum ranging from prevention (an active, assertive process of creating conditions and/or personal attributes that promote the well-being of people) to treatment or remediation (reactive, corrective effort to rectify or bring about change related to a recognized problem or need). Human service activities can range all along the continuum. The purpose of the program or service determines whether the service is prevention or treatment/remediation. Treatment or remediation programs and services are often titled as tertiary prevention. Once a program moves along the purpose continuum past the mid-point between prevention and remediation, the purpose of the program is remediation (an overarching issue must be treated before positive parenting skills can be addressed).

Respite Care

Developed within the Developmental Disabilities Service at the Department of Human Services, the Respite Care Program has expanded to the idea of lifespan respite. Lifespan respite embraces the concept that the stress relief provided by respite can benefit families who care for children with developmental disabilities or special health care needs and dependent adults or who experience crisis that impact the family's ability to safely care for its members. Using a voucher system, family members hire their own respite providers and negotiate their own payment. After the care are provided, the vouchers are redeemed. Through the Oklahoma Respite Resource Network, the respite care program has expanded to accommodate many agencies and private foundations in providing respite. OCAP and Children First is a part of the network and will continue to utilize the DHS voucher system to provide respite care. In SFY 2009, 364 families served by child abuse prevention programs received respite using the DHS respite voucher system.

Oklahoma Department of Education

The Family Support and Prevention Service (FSPS) works collaboratively with the Oklahoma Department of Education (DOE) in the following ways:

- Oklahoma Parents As Teachers participate in the Home Visitation Leadership Advisory Coalition led by FSPS;
- The Department of Education also has a representative seat on the State Interagency Child Abuse Prevention Task Force (ITF);
- FSPS provides training opportunities to community-based DOE programs;
- SDE has a seat on the Child Abuse Training Council (CATC) which provides workshops and funding to MDTs across the state;
- Oklahoma law requires every certified and licensed Oklahoma teacher receive professional development annually on "Reporting and Recognition of Child Abuse and Neglect";
- The Safe and Healthy Schools section provides training on Child Abuse Prevention every year;
- The Department of Education provides opportunities for state child abuse prevention personnel to present programs at state-wide conferences;
- The Department of Education collaborates with the FSPS to provide professional development opportunities for public schools; and
- OPAT participated in the Child Abuse Prevention Day at the Oklahoma State Capitol, and sat on the CAP ACTION planning committee which plans both the Day at the Capitol and Child Abuse Prevention Month events, campaigns, and activities.

Center on Child Abuse and Neglect

The Center on Child Abuse and Neglect (CCAN) was established in the Department of Pediatrics, College of Medicine, at the University of Oklahoma Health Sciences Center in 1992. The purpose of CCAN is to

organize the Health Sciences Center's efforts in the treatment and prevention of child abuse and neglect. CCAN is a university-based center that has ten faculty and over 30 staff that focus on research, professional and public education, clinical services, and administrative programs in the field of child maltreatment. The Center directs research on child abuse fatalities, children with sexual behavioral problems, clinical interventions with parents with drug-exposed infants, family preservation programs, physical abuse treatment and evaluation of substance abusing services utilized by Native American parents. Administrative programs include the Oklahoma Child Death Review Board and the Oklahoma Advisory Task Force on Child Abuse and Neglect. In addition, the Center coordinates the University of Oklahoma's Interdisciplinary Training Program on Child Abuse and Neglect (ITP).

Oklahoma Conference on Child Abuse and Neglect (CCAN)

The Center on Child Abuse and Neglect and OCAP co-sponsor this annual event. In addition to providing

co-sponsorship, OCAP utilizes this conference to provide training to staff that work in various family support programs and also the ITF members, including the parent representatives.

Reaching for the Stars (CHILD CARE RATING SYSTEM PROMOTING QUALITY CHILD CARE)

Research has demonstrated that the quality of childcare impacts the cognitive, emotional, and physical development of a child. The Oklahoma Department of Human Services developed a child care rating system to provide an easily understandable guide to the quality of care available at licensed child care facilities, including centers, homes, and head start. The goals of the Stars program are to provide a system to help parents evaluate quality child care; improve the quality of child care by increasing the competence of teachers; and raise the Department's subsidy reimbursement rate, resulting in more slots for children whose families are receiving child care assistance. The criteria for the stars rating system are:

- One Star facilities meet minimum licensing requirements that focus on health and safety;
- One Star Plus programs meet the minimum requirements plus additional quality criteria that includes: additional training, reading to children daily and parent involvement;
- Two Star programs meet further quality criteria including master teacher/home provider qualifications and program evaluation or accredited by a national accreditation body; and
- Three Star programs meet additional quality criteria AND are nationally accredited.

Oklahoma Child Death Review Board

The Oklahoma Child Death Review Board (CDRB) has statutory authority to conduct case reviews of all deaths and near deaths of children less than 18 years of age and has been reviewing deaths since 1993. The mission of the CDRB is to reduce the number of preventable deaths through a multidisciplinary approach to case review. The Board collects statistical data and system failure information through case review in order to develop recommendations to improve policies, procedures, and practices within and between the agencies that protect and serve the children of Oklahoma. These recommendations are mandated to be submitted to the Oklahoma Commission on Children and Youth which then decides what, if any, recommendations will be adopted into the Commission's State Plan.

There are five review teams that comprise the Oklahoma Child Death Review Board, with review meetings occurring from once a month to once a quarter. The Chief of the Family Support & Prevention Service serves on the State Team of CDRB and has served as the Board's Chair, Ex-Officio, after two terms as Chair. Many accomplishments were made during the Chief's reign as Chair including, but not limited to:

- The creation of a public service campaign (print, radio, and television) aimed at reducing child fatalities;
- The expansion of the total number of review teams from three to five, including the expansion of the areas of coverage for a team; and

- Increased awareness on the legislative level of the Child Death Review Board and its activities.

In addition to case review, the CDRB is active in groups with a focus on reducing deaths and improving the quality of services including:

- Fetal Infant Mortality Review of Central Oklahoma;
- Maternal Mortality Review;
- Oklahoma Violent Death Reporting System;
- Improving Infant Outcomes-Abusive Head Trauma Committee; and
- Improving Infant Outcomes-Safe Sleep Committee.

The Child Death Review Board is also actively involved with the Domestic Violence Fatality Review Board. A statutory change in 2008 allows the two Boards to jointly review cases that involve a child death and determined to be the result of domestic violence. This includes cases ranging from family annihilations to interpersonal dating violence.

Oklahoma Family Resource Coalition

The Oklahoma Family Resource Coalition is a professional organization for those in the fields of human environmental science, early childhood education, child guidance, early intervention and other family resource areas. The Coalition is comprised of members from state agencies, non-profit organizations and educational institutes. The Family Support and Prevention Service collaborates with the coalition and its partners to provide training opportunities, resource sharing and networking in the area of school-readiness.

Family Matters Conference

The Oklahoma Family Resource Coalition, Department of Education, and FSPS co-sponsor this annual event. In addition to providing co-sponsorship, FSPS utilizes this conference to provide training to staff that work in various community-based programs and ITF parent seat representatives.

Oklahoma Department of Mental Health and Substance Abuse Services

The mental health services available through ODMHSAS encompass a broad range of needs. Community Mental Health Centers serve as the hub for the majority of the outpatient services and often host sites for other specialized programs. In addition, ODMHSAS offers a continuum of services from emergency assessment, mobile crisis services, community based crisis stabilization units, inpatient hospitalization and more for individuals in immediate crisis.

Substance abuse services are made available through ODMHSAS via contracts with 84 treatment providers and five residential treatment centers. In addition, Drug Courts, tobacco cessation programs, and treatment for compulsive gambling is also provided.

Systems of Care is a promising practice that empowers an interagency team to coordinate care children and youth at the highest risk of needing acute or residential treatment for emotional disturbances and/or substance abuse. The team works across state agency lines to ensure continuity of care, family choice and adequate resources.

The Oklahoma Attorney General Victim Services Unit

The mission of this unit is to improve services for crime victims and families who have suffered injustice at the hands of a perpetrator. The unit provides a 24-hour Safeline, criminal tracking along with victim notification, and certification for domestic violence, sexual assault and batterer intervention programs.

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APPENDICES

APPENDIX I

PROCESS FOR DEVELOPING THE STATE PLAN

The Oklahoma Interagency Child Abuse Prevention Task Force (ITF) is to work collaboratively with the Office of Child Abuse Prevention (OCAP) to prepare the "Oklahoma State Plan for the Prevention of Child Abuse and Neglect" (State Plan). The State Plan is a compilation of findings and recommendations that are to be used to shape and develop the 'Invitation to Bid' that ultimately distributes the Child Abuse Prevention Fund dollars. In addition, the State Plan is to serve as a guide for the coordination of prevention services across agencies and institutions to assure that there is a continuum of efforts across the state (or to highlight services that are absent).

During 2009-2010, staff met with various stakeholder groups, ranging from interviews with agency directors to sessions with various issue groups and parent focus groups. ITF members presented information and gathered recommendations from their respective stakeholder groups as well. Below are the common themes that emerged from these events:

- All families need information and support in order to parent their children in a safe and nurturing way.
- Cross-training of frontline staff on recognizing stressed families and techniques to intervene and support these families would prevent abuse and neglect.
- A public engagement campaign about prevention of child abuse and supporting families is greatly needed.
- Children need loving, stable nurturing relationships.
- Prevention of child abuse and neglect is an issue most programs and agencies have a part in through their focus on helping families.
- While Oklahoma has quality programs in place, these programs are not available statewide. A comprehensive, coordinated system is needed.

Below are listed some of the highlights of meetings on specific topics.

Mental Health:

- Families with members suffering from mental illness need support and appropriate treatment.
- Providing professionals with training related to recognizing signs of stress in families and how to assist them in a preventative, supportive manner would be beneficial.

Child Welfare:

- Families who can not meet basic needs are at higher risk for abuse and neglect. Many families are struggling to meet the most basic of needs for their children.
- A comprehensive approach is needed for at risk families; including preventative services (also known as differential, alternative or community response services) for families not screened into the child welfare system.

Domestic Violence:

- There is a growing need to address the children who experience or witness domestic violence.
- There is an ongoing dialogue between the child abuse prevention field and those working in the domestic violence arena regarding the balancing act between child safety and the rights of a non-offending parent.

Sexual Abuse:

- There are little-to-no comprehensive child sexual abuse prevention efforts in our state. The current recommendation is to focus on programs that place the emphasis on adult responsibility in prevention child sexual abuse. Oklahoma should develop a task force to review resources available to address sexual abuse and make recommendations as to what programs should be implemented in order to have a comprehensive approach.

Family Support:

- Parents want and need information on positive parenting and child development.
- Parenting and child development information must be easily accessible.
- Families need basic needs met such as employment, safe housing and nutritious food in order to provide a healthy and nurturing environment for their children.
- Home visiting programs provide needed support and information to families, but are not available to all who need such services.
- Parents need support and information in understanding typical child development and strategies for dealing with stressful situations with positive coping skills.

Substance Abuse:

- Media promotion of positive mental health and substance abuse issues initiatives that focus on the strengths of families.
- Teens need support through peer-to-peer mentoring and discussion.
- Resources on parenting a "typical" teen are needed, often materials are focused on problems.
- Parent Universities partner with schools so that youth, parents and teachers can engage in a life-skills training process.
- Provide 24-hour resource line for parents so they can access information and support at anytime. Have parent resource centers open 24 hours.

Economic Development:

- Parents need stable employment.
- Statewide Workforce Centers assist with unemployment and training.
- Families need employment with a living wage and benefits/insurance in order to adequately provide for their children and ultimately improve their children's outcomes.

Six parent focus groups were held in Oklahoma during 2009. Locations included Ponca City, Jay Oklahoma City and McAlester. Over 100 parents participated and were encouraged to provide feedback in written form. Some parents were part of prevention programs and others were engaged in court ordered activities. Parents were asked these questions: What are characteristics of a strong family and community? What supports do families need to raise their children?

Common themes among the sessions included:

- Stable jobs;
- Strong, caring relationships with quality time together;

- Support of family and friends (parents stated they often sought advice from friends and family when it came to parenting);
- Communities that are safe and family friendly;
- Neighbors that know each other;
- Employers that support family obligations; and
- Barriers to achieving the above needs included negative relationships, stress, lack of communication, over-scheduling, drugs, financial hardship and lack of support.

While parenting programs were identified as being helpful, parents focused on the support they get from neighbors, family and their community as necessary in their day-to-day job of raising children. To this end, programs that build community would be appreciated.

This information along with the interviews with staff from various prevention programs and research on best practices shaped the development of the strategies presented in this plan. The strategic plan is a "living document" that will continue to respond to the continued input from stakeholders and implementation of evidenced based practiced related to prevention of child abuse and neglect.

APPENDIX II

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