ADDRESSING COMMUNITY HEALTH THROUGH UPSTREAM DETERMINANTS: INCREASING CHILD RESILIENCE BY TRANSFORMING THE SOCIAL AND COMMUNITY CONTEXT IN CUMBERLAND COUNTY, NORTH CAROLINA

By

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Second Reader: Support Faculty

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ABSTRACT

Shane Chellani, Hannah Cheung, Laura Heslin, Mishka Peart: Addressing Community Health Through Upstream Determinants: Increasing Child Resilience by Transforming the Social and Community Context in Cumberland County, North Carolina

(Under the direction of Seema Agrawal and Celeste Davis)

Interactions with our community and social environment play a significant role in our overall health and wellbeing and are considered Social Determinants of Health (SDOH). One SDOH that impacts Cumberland County, North Carolina is the number of children aged 0-3 years old who have been abused or maltreated. This leads to multiple health issues including cardiovascular disease, strokes, and mental health issues and can perpetuate the cycle of violent crime. Due to this issue, we have formed the Cumberland County Child Resiliency Organization (CCCRO), an Accountable Care Community (ACC) whose goal is to addressing health outcomes by improving parenting strategies for caregivers to reduce the incidence of child abuse by 10% by 2024. The CCCRO will be working with a group of community stakeholders and partners to advocate for a federal ban on corporal punishment and to implement the Building Resilient Families program for parents and caregivers in Cumberland County.

ACKNOWLEDGEMENTS

We would like to acknowledge the contributions of Ms. De'Ja Black to this body of work. Ms. Black was an integral member of this team and helped with all aspects of the final product. Her contributions are woven throughout everyone's individual work as she gave valuable feedback to all team members during the semester. Her research into programming options gave shape to our interventions to address upstream determinants of health in Cumberland County, North Carolina. Thank you, De'Ja for all your hard work and help.

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LIST OF ABBREVIATIONS

ACC	Accountable Care Community
ACES	Adverse Childhood Experiences
ACLU	American Civil Liberties Union
ACS	Alternative Care Setting
CCCRO	Cumberland County Child Resiliency Organization
CPS	Child Protective Services
FLSA	Fair Labor Standards Act
FMLA	Family and Medical Leave Act
FPL	Federal Poverty Level
IPV	Interpersonal Violence
MIECHV	Maternal, Infant, Early Childhood Home Visiting
OECD	Organization for Economic and Cooperation Development
PTSD	Post Traumatic Stress Disorder
SDOH	Social Determinant of Health
SOAR	Strengths in Overcoming Adversity thru Resiliency
TANF	Temporary Assistance for Needy Families
WHO	World Health Organization

COMMON PROPOSAL

I. Cumberland County Child Resiliency Organization (CCCRO) Aims and Goals

An individual's social and community context is more likely to impact their health than their behaviors (State Innovation Model, 2021). This determinant of health includes social supports, norms or disorder, community resources, public safety, and overall social cohesion. Not only are children who are exposed to stressors such as child maltreatment and abuse more likely to experience poorer health outcomes such as mental health issues, heart attack, diabetes, and stroke, but they are also more likely to perpetuate violence as adolescents and adults (CDC, 2020). This is important because the rate of child maltreatment in Cumberland County is over 3,700 for every 100,000 young children between the ages of 0 – 3 years old, compared to 1,340 per 100,000 older children at the state level (Green, 2020). Similarly, residents in Cumberland County are more than twice as likely to become a victim of a violent crime when compared to the state of North Carolina overall: 1 in 115 vs. 1 in 269 (Neighborhood Scout, 2021). Both child maltreatment and community violence have a negative impact on child wellness and resiliency. Programs and policies supporting protective factors that decrease the risk of these events occurring are needed to bolster childhood resilience in Cumberland County.

To transform Cumberland County's social and community context and increase the proportion of children who show resilience to challenges and stress, the Cumberland County Child Resiliency Organization (CCCRO) will be created. This proposal requests funding for $500,000 annually over three years for a total grant amount of $1,500,000 to accomplish the following goals:

1. Implement a Building Resilient Families program to provide healthy parenting classes that discuss ways to manage family stress and offer alternatives to corporal punishment. CCCRO's objective is to enroll at least 25% of eligible families by 2024.
2. Advocate for a federal policy that effectively bans corporal punishment in daycares and at home.
3. Attain a 10% decrease in the rate of child maltreatment reported by 2024.

II. Proposed Innovation and Transformation

The CCCRO is in the unique position of having experts examine the upstream determinants of health in Cumberland County, NC. Because of the breadth of experience of the members of CCCRO, we have been able to determine key policy and programming to be pursued in the county.

In order to include the goals of the community in our decisions, we have created a broad coalition of community stakeholders including parents and caregivers, Cumberland County Department of Social Services, and county commissioners. Through stakeholder input and peer reviewed and grey literature evaluation, we determined effective parenting strategies for families and caregivers to be the focus of both our policy and program intervention (Positive Choices, n.d).

Our policy recommendation is a federal ban on corporal punishment. While many states have already taken to banning this, there is no federal ban and corporal punishment is legal in the home in all 50 states as well as in alternative care settings in 10 states (Global Initiative to End All Corporal Punishment of Children, 2021). By federally banning the use of corporal punishment we will be signaling values to the community that this discipline is not the norm. Beyond being ineffective, corporal punishment is associated with increased violent behavior later in life as well as mental health issues and low academic achievement (Gershoff & Font, 2016). While North Carolina has banned this in schools, children 0-3 years old need more

engagement and understanding from parents and caregivers to be effective Child Welfare Information Gateway, 2019). In addition to the recommended policy, we will incorporate a program specifically designed to provide resources and education to parents in order to achieve the goals of the community and avoid unintended consequences of implementing policy without a strategy to re-engage those impacted (Cole, 2018).

To that, we will be implementing an adaptation of the Building Resilient Families Program, which has been shown to improve parenting skills (Positive Choices, n.d.). While the program has been studied with school aged children and parents in school settings, our ability to partner with Sunshine House Day Care in Fayetteville and involve parents have allowed us to modify the school-based portions of the program and focus on parental classes. This program will give parents resources to reduce stress and implement strong parenting techniques which have been shown to reduce the prevalence of ACEs (Child Welfare Information Gateway, 2019). It is because of our adaptation to a younger population and caregivers that we will start with a smaller pilot program and expand after evaluation. We will be opening our program to parents and caregivers in the county who earn under 250% Federal Poverty Level (FPL) who have at least one child ≤3 years old (Green, 2020 & Statisticalatlas.com, n.d).

Both the policy and program recommendation address child maltreatment and ACEs. By intervening at this young age, we will be able to reduce real time rates of child maltreatment, as well as create a healthier future for Cumberland County (CDC, 2020).

III. Public Health Impact

Child maltreatment and abuse are stressors that negatively impact the health status of children, who are vulnerable populations. Not only does maltreatment and abuse lead to mental, physical, and social health issues later on in life, it can result in the continuation of violence in communities (CDC, 2020). In order to address the downstream effects of violence in the community, it is imperative to address the upstream effects of building resiliency in response to

these stressors. The success and impact of the Building Resilient Families Program is based on three project aims: (1) enrollment of at least 25% of eligible families by 2024, (2) Advocate for the value of implementing a federal policy that effectively stops the use of corporal punishment in daycares and at home, and (3) produce a 10% decrease in child maltreatment rates in the county by 2024.

The impact of a federal policy stopping corporal punishment in these settings would be effective in conveying the message that this type of discipline should not be used. Since this type of policy is federal, it's reach is both statewide and national by sending a direct message that corporal punishment is not condoned. By design, the Building Resilient Families Program is adaptable in a variety of settings. Since the program will be piloted in the first year on a small scale, evaluation of potential problems will be identified and fixed before the program is scaled up in the second and third year of the program. Challenges and proposed solutions are identified in Table 1.

Table 1: Anticipated Challenges and Proposed Solutions

Challenge	**Proposed Solution**
Political feasibility	Create media strategy to highlight negative health impacts of corporal punishment used in daycares and homes. This includes sending the message and offering resources/education/services for parents and/or caregivers to learn strong parenting strategies. To help with enforcement of ban, 2 additional social workers will be hired for the county to work on child abuse and maltreatment complaints and cases.
Recruitment/Retention	In-kind contributions from local restaurants, farmers markets, and local businesses will serve as incentives for program participation, recruitment, and retention. Free child-care on site will be offered to caregivers who participate. Additional marketing of the program through social services and doctors' offices will help with recruitment.

IV. Outcomes, Milestones and Deliverables

In the Cumberland County Child Resiliency Organization, success will be defined as accomplishing the quantitative goals discussed above. The milestones we aim to reach include a 25% rate of enrollment into the Building Resilient Families program and an outcome of 10% decrease in the rate of child maltreatment reported by Cumberland County. The organization also strongly advocates for policy changes, with success being measured by the progression of implementation.

The Building Resilient Families program will be evaluated following the initial small-scale pilot. The key milestone at year one will consist of assessing the state of the program in terms of enrollment and graduation, as well as on the rate of violence in Cumberland County and whether or not it has declined since our initial implementation. Key deliverables include the yearly report on the rate of violence in Cumberland County, a lesson plan detailing the program curriculum, and feedback from program participants as identified in a follow-up focus group to the program. Potential problems will be identified and mitigated in the assessment before the program is scaled up in the following years.

The program funds will be sustained over the course of several years with the estimated budget plan and coordination of resources across teams. Intervention programs with disadvantaged children already demonstrate significant cost-benefit ratios, and the return on investment includes significant cost savings in crime reduction in the long-term (Schweinhart et al, 2011).

V. Team

It is essential that a multitude of stakeholders from different backgrounds are engaged as members of our ACC. Efforts to engage stakeholders is important to effectively address and reduce the prevalence of ACEs in the family household so that ultimately the rate of violent crimes reduces in Cumberland County and the social and community context is improved.

Stakeholders from the sectors including community, local government, and human and health services agencies are needed to implement the program and policy effectively and successfully for change. The table below lists the included stakeholders and their role as members of the ACC.

Table 2: ACC Proposed Partners

Partners	Roles
State Representatives/Lawmakers	Approves policy; provides grant funding
County Commissioners	Helps put policy into action and push it to the state level.
Cumberland County Public Health Department	Experts of the subject matter; provide professionals (health educators, nurse-family partnerships, certified parenting instructor who will conduct training; serve as members of the advisory committee
Cumberland County Department of Social Services	Home-visits; provide services that will help with reducing stress in the family home; has family violence prevention center: serve as members of the advisory committee
Parents/Caregivers of Children ages 0-3	Standing members in the ACC; consumers and owners; provide feedback for evaluation and quality improvement of the program.
Daycares	Site for conducting program sessions and referral source for recruiting families who qualify to participate in the program.

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APPENDIX A: GROUP CHARTER

Team Name: Cumberland County Child Resiliency Organization (CCCRO)

Group Members: Shane Chellani, Hannah Cheung, Laura Heslin, Mishka Peart

SDOH: Social and Community Context- increasing the proportion of children that show resilience to stress and challenges

Objective:

- The purpose of the team is to create an evidence-based policy or program that will address the rising rate of violent crime in Cumberland County, NC. The team's mission is to create an accountable care community that addresses upstream social determinants of health in the social/community context. It is our hope that we will discover the root cause of why violent crime has been increasing in Cumberland County, NC and how it connects to other health outcomes.

Goals/Values:

- We will be successful if our program/policy is rooted in evidence, considerate of all stakeholders, has sound financial underpinnings, and produces measurable outcomes. Our goal is to create a program that is sustainable for at least 3-5 years. For the purposes of the capstone project, our individual goals are to produce high quality graduate-level work in a timely manner.

Team Strengths:

- Our team members value clear communication and organization. Laura, Hannah, and Mishka have clinical backgrounds and are in the health policy concentration. They will bring their unique perspectives from their fields and think of the program through a policy standpoint. Shane is in the leadership concentration, and their skills and background will help us stay organized, on task, efficient, and productive in and outside meetings.

Topic:

- For our topic, we will be focusing on the rising rate of violent crimes in Cumberland County, NC. The violent crime rate in Cumberland County is 670.7 per 100,000 population, compared to 374.9 per 100,000 people in North Carolina. We will determine if a more specific population of interest is needed after further investigation of the problem.

Deliverables:

- We will individually research the problem of violent crime in Cumberland County, NC. We will come to weekly meetings with expected deliverables including outlines, drafts, and products.
- Team Charter due Sunday 11:55pm 1/17/21 after Class 2

  Individual Problem Statements due Sunday 11:55pm after Class 4

  Individual Outline due Tuesday 11:55pm after Class 5

  Individual Drafts due Thursday 6pm in class, Class 7

  Individual Analysis due Sunday 11:55pm after Class 8

  Individual Plans due Sunday 11:55pm after Class 10

  Group Proposal due Sunday 11:55pm after Class 11

  Full Group Packet due 11:55pm due Tuesday before class 12

  Group Presentation week 13

Milestones:

- In order to stay on track and meet course deadlines, we will make sure that individual deliverables must be completed the day before our team meetings. Since we meet on Friday evenings, individual deliverables should be completed by Thursday night. We will create a Google shared folder and upload all documents in that folder.

All group deadlines are the Thursday of the week listed, unless otherwise specified.

Task/Milestone	Group Deadline	Assignment Due Date
Outline and draft of individual problem statements	**Week 3-4**	**o outline of individual problem statement (week 3 - 1/21)** **o draft of individual problem statement (week 4- 1/28)** **DUE: Jan 31st - Submit individual problem statement by 11:55pm to 2CH**
Individual Concentration Assignment (outline) - Leadership (evidence-based options) - Health Policy (policy analysis)	**Week 5**	**Feb 4 - upload individual outlines to Google Folder** **DUE: Outlines 2/9 @11:55pm**
Decide on program/policy used to develop proposal	**Week 6**	**Decide by 2/11**
Individual Concentration Assignment - **Leadership - Stakeholder analysis draft** - Health Policy - Policy Analysis Draft	**Week 7**	**DUE: Bring <u>drafts</u> to class 2/18**
	Week 8	**DUE: Submit policy analysis and stakeholder analysis 2/28 @11:55pm**
Individual Concentration Assignment	**Week 9**	**Due: bring drafts to class (3/4)**
- **LP - Engagement Plan Draft** - HPM - Draft budget & budget narrative	**Week 10**	**Due: Submit on 3/14 @11:55pm on 2CH**

TEAM - Title page - Copyright page - Abstract (150 words) - Table of contents - References - appendices	**Week 11**	**DUE: Submit on 3/21 @11:55pm on 2CH**
Full Packet with individual appendices **Draft presentation**	**Week 12**	**DUE: Submit on 3/23 @11:55pm on 2CH**
Proposal Presentation	**Week 13**	**Due: 4/1**

Roles/Responsibilities:

- Hannah - will be in charge of taking meeting notes and will send out debrief emails following each meeting summarizing topics discussed, tasks assigned, and team deadlines for individual and team deliverables.
- Mishka - will be responsible for disseminating upcoming meeting agendas via email and checking in with team members on action items/deliverables.
- Shane - will be responsible for reminding team members about upcoming meetings and due dates for individual and team deliverables.
- Laura - will serve as the team liaison to the instructors, sending emails to the instructors if we need clarification or have any questions.

Expectations:

- Performance: It is expected that each member will produce work that is of the highest quality that the assignment dictates. For example, a rough draft will require further edits. It is also expected that each team member will attend all group meetings and be prepared for high quality discussion and collaboration.

- Participation: It is expected that each member will participate fully in all activities, including but not limited to, the decision-making process, meeting team deadlines, providing feedback on teammates' work, and contributing to the review of the overall complete product.
- Conduct: It is expected that each member will conduct themselves in a professionals and respectful manner. We will all agree to respect the thoughts and opinions of fellow peers. We will have an open and safe space to discuss ideas and will find a compromise if we cannot come to a mutual agreement.

Decision Making, Communication and Feedback:

- Major decisions will be discussed as a group and we will arrive at a consensus with all individual decisions carrying equal weight throughout the project. We will strive for unanimity. Realizing that unanimity may not always be possible, and compromise may be needed at times, we will aim for a decision that all members of the team are comfortable with.
- As a group, we have decided that our preferred means of communication is via phone/text messages, particularly for urgent issues. We have agreed to respond to text messages within 24 hours.

Preferred Methods of Feedback:

- Mishka: immediate feedback, written or verbal are both acceptable for receiving feedback. This is the preferred method for providing feedback, as well.
- Laura: I prefer immediate written or verbal feedback when appropriate.
- Shane: immediate, written or verbal
- Hannah: For providing and receiving feedback, I prefer immediate written or verbal.

Meetings:

- Team meetings will take place on **Fridays at 7:30pm EST**. We will all plan to keep 7:30pm available on our schedules every week. However, there may be some weeks

that a meeting may not be necessary. We will primarily communicate through text. Should any team member be running late or cannot attend the meeting, a text should be sent out prior to the scheduled meeting time to notify the rest of the team.

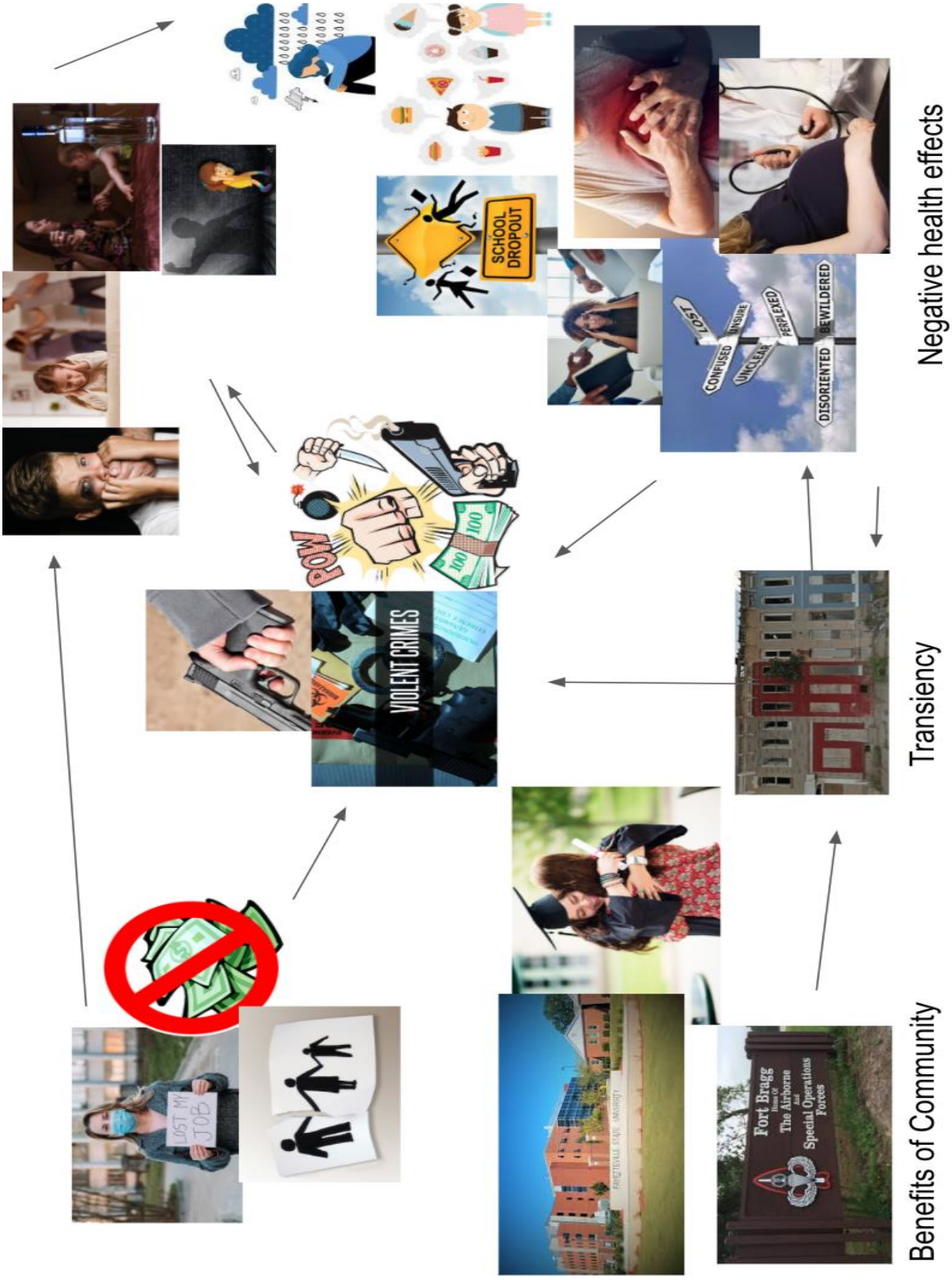
Limitations/Constraints:

- A potential constraint that may impact the team during the course of the project is time conflict because Laura lives in another time zone/country (currently 16 hours ahead, will change to 15-hour time difference after week 10). We do not see this as being a debilitating constraint because we have set up a means of how we will communicate.

Conflict Resolution:

- Our team agrees that we do not like non-productive meetings. We will strive to be efficient during meetings and respectful of each other's time. In order to be productive as a team, we agree to come prepared, having done all work that we committed to prior to the meetings. We have set this expectation outright and will hold team members accountable.

APPENDIX B: RICH PICTURE

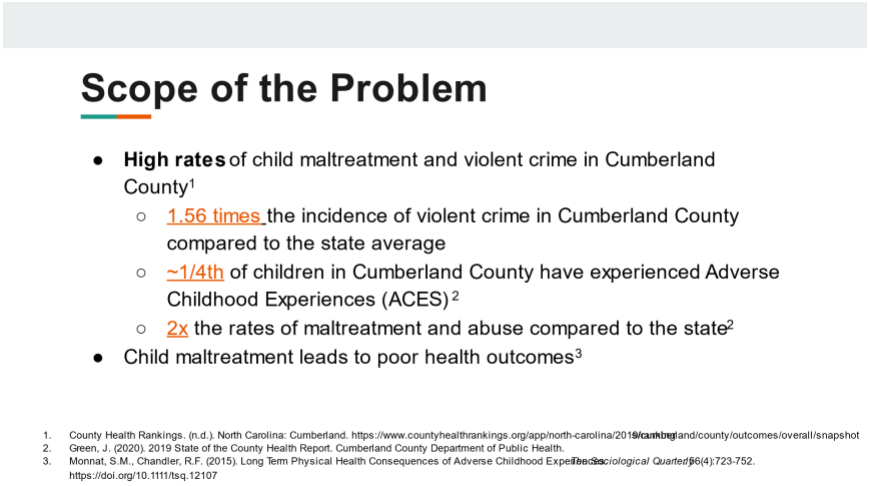


APPENDIX C: GROUP PRESENTATION

Figure 1: Title Slide

Hannah: Good evening everyone. We are from the Cumberland County Child Resiliency Organization. I, along with my colleagues, Shane Chellani, Laura Heslin, and Mishka Peart will be presenting on increasing child resilience by transforming the social and community context in Cumberland county today.

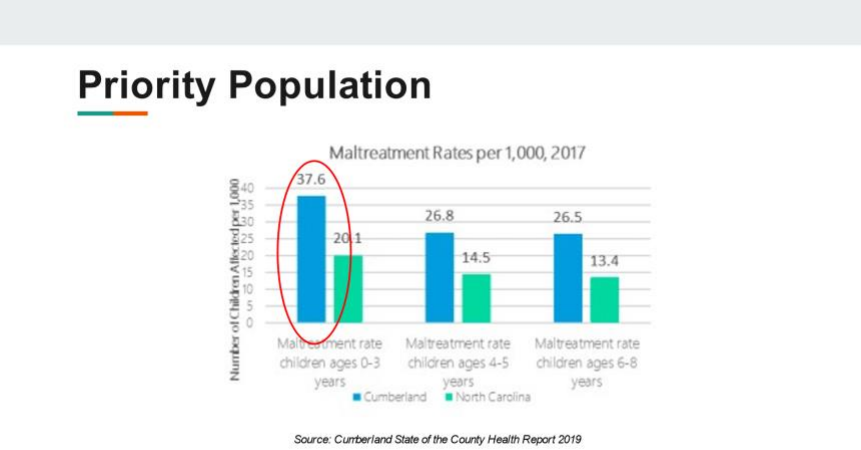
Figure 2: Scope of the Problem



Shane: Cumberland County has a high violent crime and child maltreatment rate compared to the state average. Child Maltreatment and abuse is one of ten Adverse Childhood Experiences

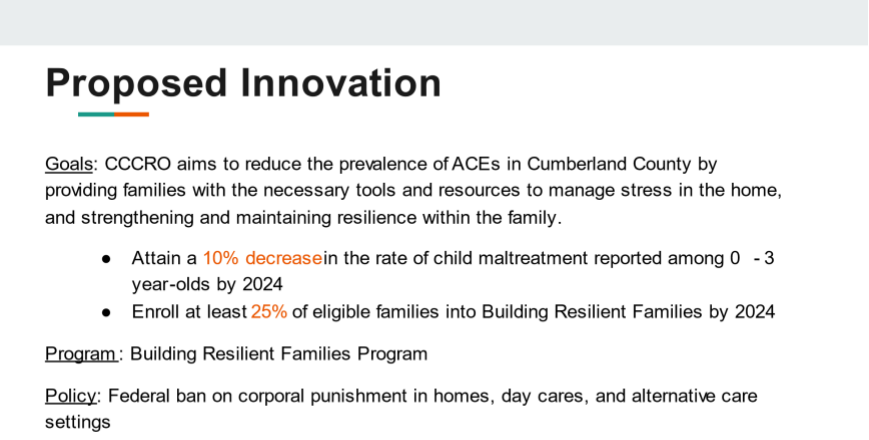
(ACEs) that are linked with initiating a cycle of adult violence. In Cumberland County almost 25% of the children experience ACEs, and the rate of maltreatment and abuse in children under 8 years-old is almost double the state average. It is important to address ACEs such as abuse and maltreatment because these challenges and stressors are associated with multiple chronic health conditions.

Figure 3: Priority Population



Shane: As you can see, all children under 8 are more likely to experience maltreatment in Cumberland County, but those in the age group 0-3 years-old experience abuse at a higher rate of 37.6 events per 1,000 in 2017.

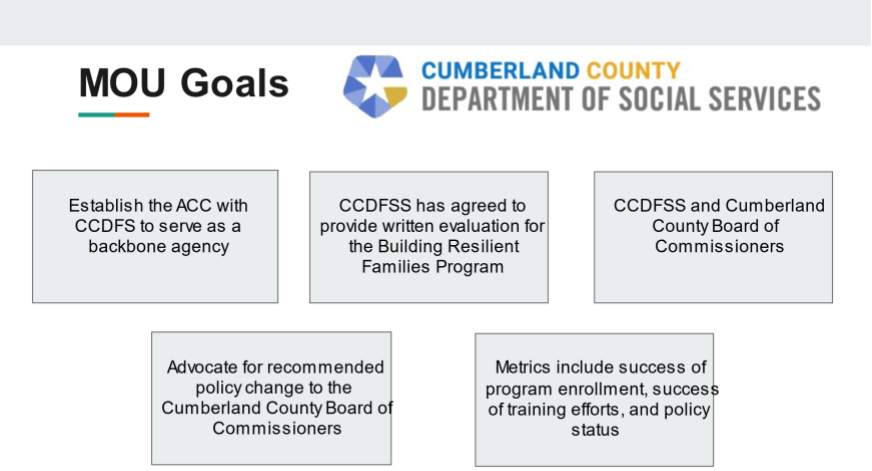
Figure 4: Proposed Innovation



Shane: To address this problem in our population we propose both a policy and program that will impact Cumberland County. First, we will run a program called Building Resilient Families Program which will offer classes to parents and caregivers in the county. We will also advocate for a policy that imposes a federal ban on corporal punishment.

The goals of the CCCRO are to reduce the prevalence of ACEs in the county, specifically a 10% decrease in the rate of child maltreatment reported among children aged 0-3 and to enroll at least 25% of our eligible families in our program, both by 2024.

Figure 5: MOU Goals



Shane: We will establish the Accountable Care Community (the CCCRO) that brings together various stakeholders with the common goal of improving the social and community context of adverse childhood experiences to reduce violent crime.

We have a Memorandum of Understanding between the Cumberland County Department of Family and Social Services and the Cumberland County Board of Commissioners in order to sustain the partnership of mutual agreement and to assist the CCCRO.

The Department of Family and Social Services has agreed to provide resources to the CCCRO for implementing and evaluating the Building Resilient Families program, as well as advocating for recommended policy change to the Cumberland County Board of

Commissioners. Metrics include success of program enrollment, success of training efforts, and policy status upon completion. The Cumberland County Child Resiliency Organization believes that with combined efforts of multiple stakeholders, the program and policy will be effective in reducing rates of violent crime.

Figure 6: ACC Stakeholders and Partners

Shane: Our stakeholders include multiple departments in Cumberland County including the health department, the department of family and social services, and the board of commissioners. As our program will be run at Sunshine House Daycare they will also be an important partner in our program.

Figure 7: Program and Policy Complement

Shane: We are proposing the implementation of the Building Resilient Families Program to the Cumberland County Department of Family Services and its staff. Building Resilient Families is an evidence-based program that provides healthy parenting classes that discuss ways to manage family stress and offer alternatives to corporal punishment. The pilot program will run for one year and will be held at Sunshine House Daycare. CCCRO's objective is to enroll at least 25% of eligible families by 2024.

Licensed Clinical Social Workers at the Cumberland County Department of Family and Social Services will be recruited to join the CCCRO to be involved in the program training and facilitation and will provide valuable contributions and insights to our targeted population. As experts in their fields, they are best equipped to cultivate a safe learning environment, providing lessons on how to address and manage certain issues that may arise within the programs, as well as how to communicate information to parents and families.

The proposed policy is a federal ban on corporal punishment. With our program and policy combined, we hope to reach our long-term goal and produce a 10% decrease in child maltreatment rates in the county by 2024. My colleagues will address this though the following series of pitches.

Figure 8: Policy Pitch: Prevent Child Abuse America

Laura: We will now present to a House of Representatives committee. Good Evening, my name is Laura Heslin, and I am speaking to you today on behalf of the North Carolina chapter of Prevent Child Abuse America. Chairwoman Agrawal and Chairwoman Davis, thank you for inviting me to speak today. I am here to ask you to support passage of HB 246, the federal ban on corporal punishment.

As president of North Carolina's Prevent Child Abuse America I can say that Cumberland County, North Carolina, and children all across America need the opportunity to be healthy and not be victims of abuse. Corporal punishment is a form of abuse. Studies show that this abuse leads to adult violent crime and a host of chronic health issues including poor mental health.

Even worse, those who are victims of this form of abuse are more likely to continue the cycle of violence in future generations. Our inaction is preventing this and future generations from reaching their full potential. That is why a federal ban on corporal punishment will send the message that we care about our children. While corporal punishment has been banned in many places throughout the country, it is still allowed in the home and in certain care facilities. Because of this, our youngest children are most vulnerable, and parents and caregivers are disciplining their children in not just ineffective ways, but harmful ones.

We are behind the times and wasting our money; countries that ban corporal punishment do see a reduction in child abuse when these bans are enacted. The United States is spending billions of dollars addressing the fall out of child abuse and maltreatment each year. The CDC (2012) says the cost of treating one victim of child abuse over their life is more than treating someone with type two diabetes or someone who has suffered a stroke. At Prevent Child Abuse America, we are already working with the community, parents, and caregivers to break the cycle and give them the tools they need to raise healthy children and prevent the abuse before it happens – this includes effective parenting strategies.

By banning corporal punishment, we will send the message that we care about children's futures. Voting "yes" on HB 246 tells our children that they are worth protecting- for the health and wellbeing of us all. I turn my time over to the next organization.

Figure 9: Policy Pitch: Global Initiative to End All Corporal Punishment of Children

Hannah: Thank you, Ms. Heslin. Members of the committee, please refer to the fact sheet that has been distributed. My name is Hannah Cheung, and I am a representative from the Global Initiative to End All Corporal Punishment of Children. I am here today to speak in support for House Bill 246, which calls for a federal ban on corporal punishment in homes, daycares, and alternative care settings.

Corporal punishment is the most common form of violence against children. It includes any punishment in which physical force is used and intended to cause some degree of pain or discomfort, which can be cruel and degrading. Research has shown that children who experience abuse and maltreatment suffer from higher rates of depression, suicidal thoughts, and other mental disorders in addition to negative physical outcomes. Children who are abused also show a higher tendency for hostile behaviors, which correlates with higher chances of committing violent crime in adolescence and adulthood. This can cause further detriment in the community by continuing the never-ending cycle of violence for children if no decision is made.

In closing, I want to reiterate my support for this bill, and I am asking members of the committee to vote “yes” to HB 246. Any corporal punishment violates children’s right to human dignity and physical integrity. Its legality in the majority of states – unlike other forms of interpersonal violence – violates their right to equal protection. It is time to make a change. Thank you, and now I yield my time to Dr. Peart from the American Academy of Pediatrics.

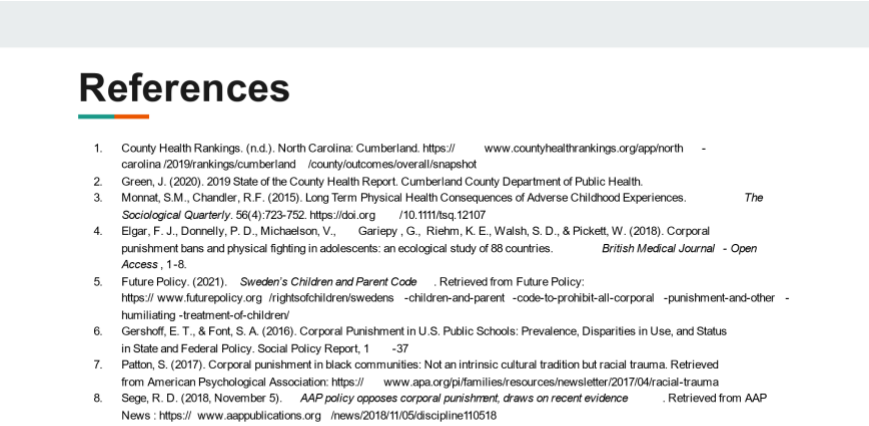
Figure 10: Policy Pitch: American Academy of Pediatrics

Mishka: Good evening legislators and thank you for allowing me to speak during tonight’s meeting. My name is Mishka Peart, and I am here representing the American Academy of Pediatrics (AAP). I come before you today asking for your support of House Bill 246—a federal policy which, if approved, would ban corporal punishment in homes, daycares, and alternative care settings.

Corporal punishment is a harmful and ineffective way to correct undesirable behavior, and this is recognized globally. The United States is the only country that has not ratified the United Nations’ Convention of the Rights of the Child. The convention states that all parties “have the obligation to prohibit and eliminate all physical violence against children in all settings including the home” (Future Policy, 2021). Children who experience corporal punishment are more likely to suffer from mental health disorders such as anxiety, depression, and post-traumatic stress disorder (Sege, 2018). They are also at higher risk for cognitive issues and

learning disorders (Sege, 2018). Corporal punishment also leads to increased aggression among children both at home and school, and negative family dynamics. Children are vulnerable to injury, particularly those under the age of 18 months, or those experiencing increasing severity of punishments (Sege, 2018). Research has previously shown that within ten minutes of punishment, 73% of children had resumed the offending behavior, demonstrating how ineffective corporal punishment really is (Sege, 2018). Almost sixty countries have implemented corporal punishment bans, to date. Among countries with a ban, researchers found a 69% reduction in violent crime among males and a 42% reduction among females (Elgar, et al., 2018). As a representative of the largest organization of child health providers, I implore you to support House Bill 246 and implement a national ban on corporal punishment. The risks of corporal punishment far outweigh any benefit, and it does not contribute to the health, safety, or resiliency of our children. It is time for the United States to stand with the global community and reject corporal punishment. Thank you for your time, and you can find my fact sheet on the wall. We are happy to answer any questions that you may have.

Figure 11: References



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APPENDIX D: SHANE CHELLANI'S INDIVIDUAL DELIVERABLES

SHANE CHELLANI'S INDIVIDUAL PROBLEM STATEMENT

Social Determinant of Health (SDoH)

This project will be addressing the social determinant of health of violent crime through the social and community context lens by focusing on adverse childhood experiences, specifically physical abuse as it relates to youth violence in Cumberland County, NC. One of the HP 2030 objectives calls for an "increase in the proportion of children and adolescents who show resilience to challenges and stress." Adverse Childhood Experiences [ACEs] are defined by Kalmakis and Chandler (2015) as "childhood events, varying in severity and often chronic, occurring within a child's family or social environment that cause harm or distress, thereby disrupting the child's physical or psychological health or development" (p. 1495). The 10 adverse childhood experiences assessed in the original ACE Study included physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, violence against a mother, parental divorce, household member having problems with substances, household member having problems with mental illness, and incarceration of a household member (Dube et al., 2003; Felitti et al., 1998). The short-term effects of ACEs on childhood health may include mental distress, reduced quality of life, physical pain, injury, or premature death. The long-term effects include mental and behavioral health issues, anxiety, PTSD, depression, disordered eating, suicidal ideation, substance and tobacco use, and risk-taking behavior. Continued victimization perpetuates the cycle of violent crime within the community. In addressing violent crime through a social and community context, we can seek upstream determinants like adverse childhood experiences and their associated health issues in order to develop more effective methods of harm reduction.

Geographic and Historical Context

Cumberland County, North Carolina has a population of over 319,413 people according to the 2019 census. It has a majority white population. Specifically, the racial makeup of the county was 51% White, 39% Black or African American, 1.8% Native American, 2.8% Asian, 0.4% Pacific Islander, and 4.8% from two or more races. 11.9% of the population were Hispanic or Latino of any race. Vulnerable populations include persons with disabilities (13.2%), persons with income below the poverty level (17%), as well as persons 65 years and older(11.2%) and persons 0-19 (27.9%). The life expectancy of people living in Cumberland County is less than in North Carolina overall. 87% of the population reside in urban areas, while the remaining 13% reside in rural areas. The unemployment rate is higher than that of North Carolina overall (5.1% > 3.9%).

Cumberland County has more than twice the rate of veterans in North Carolina overall at 20.9% versus 8.3% respectively. This is due to the military base, Fort Bragg, located in the major city of Fayetteville in Cumberland County. Fort Bragg, originally Camp Bragg, was activated in 1942. Fort Bragg is the largest US Army base by population, serving a population of 545,926 active-duty Soldiers, though deployments keep the community transient.

Priority Population

The priority population of interest for the social determinant of violent crime include the direct victims of abuse: children and adolescents ages 0-17. It can be broadened to include caregivers, parents, or guardians as second populations as involved individuals (OECD, 2013). Vulnerable populations include orphans, homeless children, or those in child-led households (Ohene et al, 2006). In children, trauma and toxic stress can incite adaptive responses that may manifest as maladaptive and destructive tendencies in juvenile years. In adults, ACEs increase the chance of social risk factors, mental health issues, substance abuse, intimate partner violence, and risky behavior, all of which can affect parenting negatively, thereby perpetuating the cycle of violence across generations (Monnat & Chandler, 2015).

Measures of Problem Scope

The violent crime rate in Cumberland County is 11.1 deaths per 100,000, which is significantly higher than the rest of the state at 6.2 deaths per 100,000. Child maltreatment rates were also significantly higher in Cumberland County at 30 average per 1,000 in 2017 in ages 0-8 years old, as compared with rates in North Carolina overall.

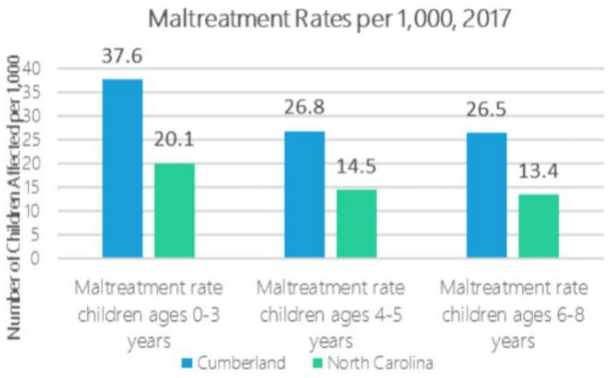


Figure 1. Child maltreatment rates in Cumberland County

Rationale/Importance

Addressing the rate of violent crime is essential because it was listed as one of the top needs in the Cumberland County Health Assessment of 2019 and requires immediate action. The NC Healthy People 2020 goal is to decrease the age-adjusted death rate to 6.2 deaths per 100,000 individuals, and decrease the child maltreatment rate, as well as increase in the proportion of children and adolescents who show resilience to challenges and stress. One way to address violent crime rates is in looking at Adverse Childhood Experiences because of its impact on violence. With early intervention and training programs for caregivers, we may be able to have a long-term impact on the community.

Disciplinary Critique

A health policy professional needs to address violent crime in order to trace its upstream determinants and develop appropriate models of care. A policy intervention may have the

capability and resources needed to address the root of the problem in order to have long term outcomes in harm reduction.

SHANE CHELLANI'S STAKEHOLDER PLAN

Introduction

Our group is focusing on social determinants of health in the social and community context. One of the HP 2030 objectives calls for an increase in the proportion of children and adolescents who show resilience to challenges and stress. Cumberland County has a high violent crime rate, 548 per 100,000, compared to the rest of North Carolina, 351 per 100,000 (County Health Rankings, 2019). Additionally, it shows that violent crime rates have been increasing since 2014. Numerous studies have found that Adverse Childhood Experiences [ACEs] are an upstream cause of violent crime (Reavis et. al, 2018). The 10 adverse childhood experiences assessed in the original ACE Study included physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, violence against a mother, parental divorce, household member having problems with substances, household member having problems with mental illness, and incarceration of a household member (Dube et al., 2003; Felitti et al., 1998). It's important to address ACEs such as child abuse and maltreatment because these challenges and stressors can lead to violent crime in a community (Monnat & Chandler, 2015).

Policy & Program

After reviewing each policy and program contribution from each team member, we decided to choose one policy and one program to move forward as a solution to the violent crime problem in Cumberland County.

We believe that the Building Resilient Families Program (BRF) is the best evidence-based program because it is designed to reduce stress in families by providing lessons on how to address and manage certain issues that may arise within the family that will cause excessive stress and threaten the resilience of the family (Shaykhi, Ghayour-Minaie, & Toumbourou,

2018). This addresses the Healthy People 2030 objective of building resilience in response to challenges and stress. Additionally, BRF addresses our priority population in their design implementation, children 0-3 years old. A recent study found that “families with less conflictual parent–child relationships had more optimal school readiness relative to families with higher conflict and less financial strain,” so this would be helpful to the community-based program that is being developed (Anderson, 2018). Additionally, intervention programs with disadvantaged children already demonstrate significant benefit-cost ratios, with “$5.70 for every dollar spent on a child by the time the child became an adult aged 27 and, when projected into the rest of their lives, $8.70 cost savings in crime reduction,” (Schweinhart et al., 2011).

The ban on corporal punishment is a federal policy that we chose because it is the most politically feasible policy and would garner more bipartisan support. National bans on corporal punishment have been linked to a decrease in youth violence; 69% reduction among males and 42% among females (Elgar, et al., 2018). This has been studied in other countries and there is a direct reduction in violence when national bans are implemented (Cole, 2018) (Hendrikson, Blackman, 2015).

Legislated bans send a clear message that this kind of discipline is not acceptable, but to be effective and enforced, bans “need to be paired with programs that help parents learn what to replace corporal punishment with” (Cole, 2018). This led the team to support a program that may have synergy with this policy. The program and policy complement each other because the BRF program will help teach families alternative ways of coping with stress, which increases resilience to stressors and will potentially reduce child maltreatment rates in Cumberland County.

Potential Alternatives

Alternative Policy 1: Increasing the income eligibility for Temporary Assistance for Needy Families (TANF) from 200% Federal Poverty Level (FPL) to 250% FPL. In North Carolina TANF

is called Work First Family Assistance (North Carolina Department of Health and Human Services [NCDHHS], n.d.)

- Advantages include immediate and direct help to families, but this policy was ultimately not chosen because of its lack of actual impact and lack of political feasibility to effect real change. There is currently a waiting list for services due to lack of funding and the format of the program as a block grant. Increasing the number of people eligible will not have any impact without changing TANF to an entitlement program in the state.

Alternative Policy 2: Federal policy for paid parental leave for up to 12 weeks for all employees, at 100% equivalence of the employee's typical pay/salary

- Advantages include immediate and direct help to families and communities, as well as pandemic relief during this stressful time. This policy was unfavorable due to low political and financial feasibility; secondly business associations would likely lobby aggressively against this option due to the already difficult year they have experienced during the pandemic. Thus, acceptability from pretty powerful constituents would have been low.

Alternative Program 1: Program modeled after Florida's "Peace 4 Tarpon" informed community initiative.

- This is advantageous as it includes detailed methods to build upon for our program
- This initiative addresses the issues of domestic violence, bullying, unemployment, poverty, and substance abuse through means of community partnerships. However, it is an unfavorable option because it is solely focused on the community aspect rather than the actual internal family dynamics.

Alternative Program 2: Program utilizing existing work, providing additional support to an already existing organization.

- Advantageous to have the work done for us, can focus on improvement

- This was ultimately not chosen because it would likely remain in control of their structuring and systems, while we are developing new methods and programs to affect change from within.

Stakeholder Analysis

A 2D power-interest matrix can be utilized to analyze the influence of stakeholder power compared with the level of support of the selected policy/program in order to identify which stakeholders should be targeted by strategies.

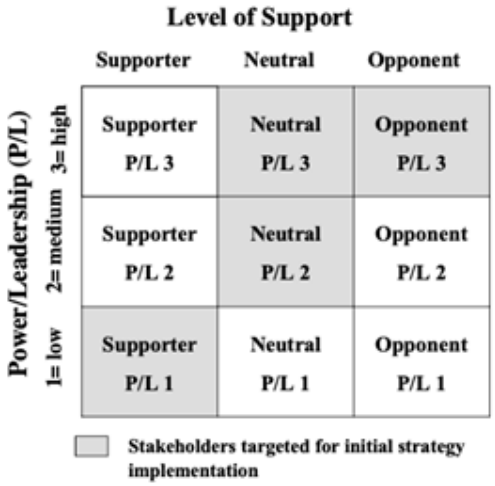


Figure 2. 2D power/support level matrix

High Power, High Support: Cumberland County Department of Family Services

High Power, Neutral Support: Senators for Cumberland County

High Power, Opponent: Budget Committee; Lobbyist Groups

Medium Power, High Support: Licensed Clinical Social Workers, Health Educators, Certified Parenting Instructors

Medium Power, Neutral Support: Teachers, Parents/Caregivers

Medium Power, Opponent: Concerned Parents

Low Power, High Support: Community Members

Low Power, Neutral Support: Children

Low Power, Opponent: Uninterested Families

Key Stakeholders

The Cumberland County Department of Family and Social Services shares the goal of reducing violence in families and in the community and have offered to provide resources and support for the recommended program and policy. They are classified as High Power/High Support for their well-established programs in the community, including assistance in domestic violence situations via the CARE Family Violence Program which provides “domestic violence services to victims, children and the abusers” and “strives to end violence in the home and assist individuals to establish and maintain positive, nonviolent relationships.” This program addresses similar social services addressing children and families and would likely provide a good base of resources for the BRF program.

Senators and politicians may have varying opinions on the policy. The recommended federal policy is likely to gain bipartisan support when framed as child resilience and improved health through behavior change, including better parent-child relationships for a healthier social context for children and fewer unplanned medical visits for injury care (since episodes of child abuse may result in the need for acute care). This policy will also require minimal cost to enact. This policy would be palatable to politicians due to its low cost for implementation and overall feasibility. They are classified as High Power/Neutral Support and should be targeted for the initial strategy implementation of convincing them to support the policy and increasing their power and leadership where necessary.

Licensed Clinical Social Workers, Health Educators, and Certified Parenting Instructors are classified as Medium Power, High Support. These individuals will be heavily involved in the program-making and will provide valuable contributions and insights to our targeted population. As experts in their fields, they are best equipped to cultivate a safe learning environment for families, providing lessons on how to address and manage certain issues that may arise within the family.

Other stakeholders include children, local community leaders, and families that may or may not be interested in the voluntary program but will be affected by the implemented federal policy, though more research needs to be done to ascertain interest. By addressing Adverse Childhood Experiences and the impact they have on violence, the selected policy and program implementation will be effective and successful.

SHANE CHELLANI'S INDIVIDUAL SLIDE DECK AND SCRIPT

Overview

- Group problem
- Defined community and priority population of interest
- Group MOU goals
- Key partners (proposed for ACC)
- Specific outreach to a key stakeholder

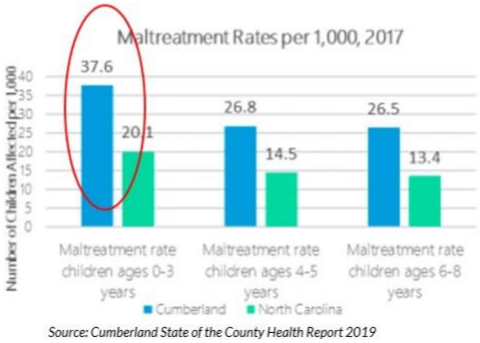
Group Problem

- **High rates** of child maltreatment and violent crime in Cumberland County[1]
  - 1.56 times the incidence of violent crime in Cumberland County compared to the state average
  - ~1/4th of children in Cumberland County have experienced Adverse Childhood Experiences (ACES)[2]
  - 2x the rates of maltreatment and abuse compared to the state[2]
- Child maltreatment leads to poor health outcomes[3]

1. County Health Rankings. (n.d.). North Carolina: Cumberland. https://www.countyhealthrankings.org/app/north-carolina/2019/rankings/cumberland/county/outcomes/overall/snapshot
2. Green, J. (2020). 2019 State of the County Health Report. Cumberland County Department of Public Health.
3. Monnat, S.M., Chandler, R.F. (2015). Long Term Physical Health Consequences of Adverse Childhood Experiences. *The Sociological Quarterly*. 56(4):723-752. https://doi.org/10.1111/tsq.12107

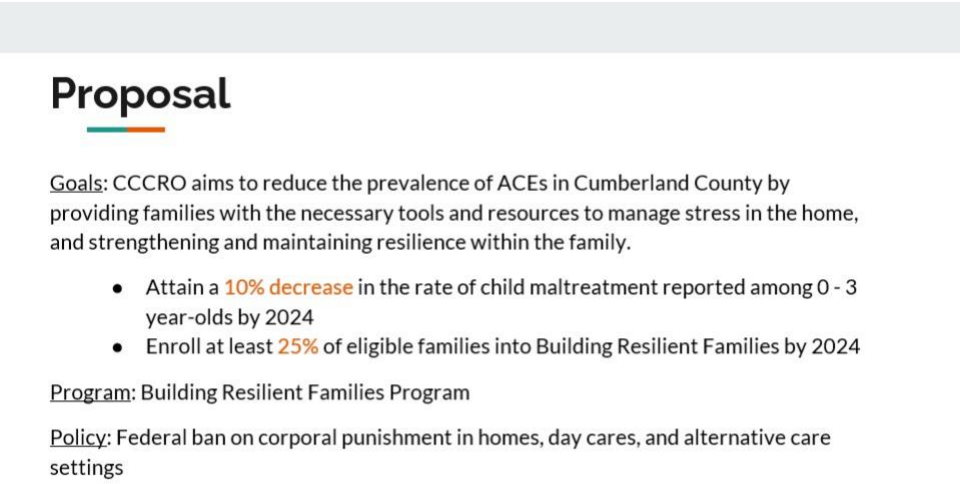
Cumberland County has a high violent crime and child maltreatment rate compared to the state average. Child Maltreatment and abuse is one of ten ACEs that are linked with starting a cycle of adult violence. In Cumberland County almost 25% of the children experience ACEs, and the rate of maltreatment and abuse in children under 8 is almost double the state average. It's important to address ACEs such as abuse and maltreatment because these challenges and stressors are associated with multiple chronic health conditions.

Community & Priority Population of Interest

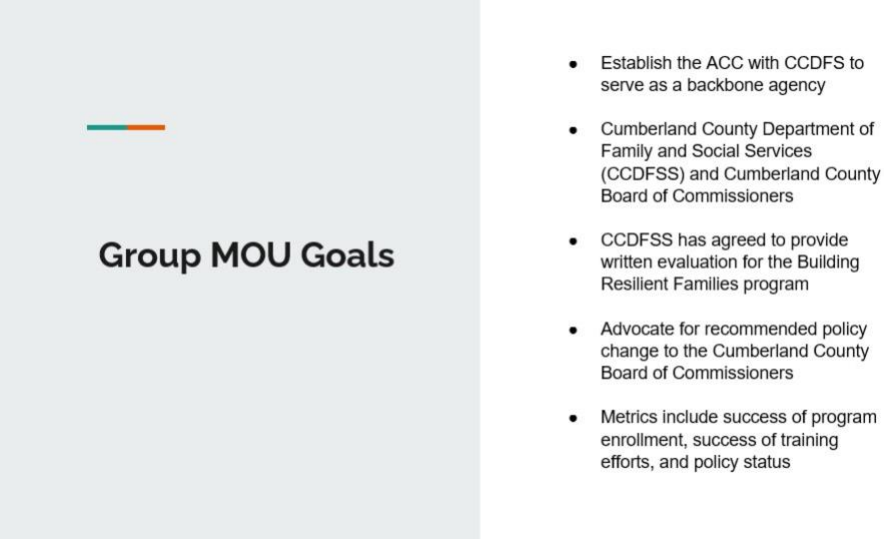


Source: Cumberland State of the County Health Report 2019

As you can see, all children under 8 are more likely to experience maltreatment in Cumberland County, but those in the age group 0-3 years old experience abuse at a higher rate of 37.6 events per 1,000 in 2017.



To address this problem in our population we propose both a policy and program that will impact Cumberland County. First, we will run a program called Building Resilient Families Program which will offer classes to parents and caregivers in the county. We will also advocate for a policy that imposes a federal ban on corporal punishment. The goals of the CCCRO are to reduce the prevalence of ACEs in the county, specifically a 10% decrease in the rate of child maltreatment reported among children aged 0-3 and to enroll at least 25% of our eligible families in our program, both by 2024.



We will establish the Accountable Care Community (the CCCRO) that brings together various stakeholders with the common goal of improving the social and community context of adverse childhood experiences to reduce violent crime. We have a Memorandum of Understanding between the Cumberland County Department of Family and Social Services and the Cumberland County Board of Commissioners in order to sustain the partnership of mutual agreement and to assist the CCCRO. The Department of Family and Social Services has agreed to provide resources to the CCCRO for implementing and evaluating the Building Resilient Families program, as well as advocating for recommended policy change to the Cumberland County Board of Commissioners. Metrics include success of program enrollment, success of training efforts, and policy status upon completion. The Cumberland County Child Resiliency Organization believes that with combined efforts of multiple stakeholders, the program and policy will be effective in reducing rates of violent crime.

We request that Licensed Clinical Social Workers at the Cumberland County Department of Family and Social Services be recruited to join the CCCRO to be involved in the program training and facilitation and will provide valuable contributions and insights to our targeted population. As experts in their fields, they are best equipped to cultivate a safe learning environment, providing lessons on how to address and manage certain issues that may arise within the programs, as well as how to communicate information to parents and families. The proposed policy is a federal ban on corporal punishment. With our program and policy combined, we hope to reach our long-term goal and produce a 10% decrease in child

maltreatment rates in the county by 2024. CCDFSS is an essential partner for our organization and individuals involved will be compensated for their time.

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APPENDIX E: HANNAH CHEUNG'S INDIVIDUAL DELIVERABLES

HANNAH CHEUNG'S INDIVIDUAL PROBLEM STATEMENT

Social Determinant of Health (SDOH)

The World Health Organization (WHO) defines health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (International Health Conference, 2002). Health outcomes are not just related to physical problems in the body. Additional factors, SDOHs, have a great effect on an individual's health status and opportunity to be healthy (CDC, 2021). Healthy People 2030 states that SDOHs are environmental conditions that have a major impact on an individual's health, well-being, and quality of life. The social and community context is a SDOH that focuses on people's relationships and interactions with family, friends, co-workers, and community members.

Adequate social support and a safe community can have a large impact on a person's health and well-being (USDHHS, n.d). Challenges and dangers, such as unsafe neighborhoods, high crime rates, and violence are examples of threats to a person's ability to be healthy in the social and community context. In particular, children who experience negative relationships at home and in the community, where a parent may be in jail or the child is physically abused, often develop negative health consequences later on (CDC, 2020). These can have a lasting negative effect on an individual's health and safety throughout life. Adverse childhood outcomes (ACEs) are defined as "potentially traumatic events that occur in childhood" (CDC, 2020). An example of one of the ten ACEs includes physical abuse, which can threaten a child's health from a social and community context (Felitti, et al., 1998)**.** Studies have shown that ACEs have been linked with chronic health problems, mental illness, substance misuse, and violence in adulthood (Monnat & Chandler, 2015).

ACEs have negative short- and long-term effects on the health and well-being of individuals. Short term impacts of ACEs involve premature death, injury, physical pain, mental stress, and reduced quality of life (Felitti, et al., 1998). However, ACEs can also have significant lasting effects, resulting in increased risky and violent behaviors, mental illness, substance abuse, and negative systemic health outcomes (Monnat & Chandler, 2015). Monnat & Chandler's research showed that these childhood experiences affect the body's stress response functions, leading to long-term physical and chemical changes in the brain and body. Five of the top ten leading causes of death are associated with ACEs, and adults who have experienced four or more ACEs are at increased risk of heart disease, stroke, cancer, COPD, diabetes, Alzheimer's, and suicide (Center for Youth Wellness, 2017).

One of the Healthy People 2030 objectives calls for an "increase in the proportion of children and adolescents who show resilience to challenges and stress." As indicated above, there is extensive evidence suggesting stress and harm from ACEs can lead to negative physical, emotional, and social health outcomes and can lead to an ongoing cycle of violence in a community.

Geographic and Historical Context

Cumberland County is the 5th most populous county in NC, with an estimated population of 332,861 residents (AccessNC, 2021). The history of the county began as a settlement between 1729 and 1736 by European migrants. The area soon became a vital transportation link to other major settlements due to its proximity to roadways and waterways (Cumberland County, 2017). The county seat is Fayetteville, which is the largest city located within the county. Fayetteville is also home to 211,657 residents, which makes up more than half of the total residents in Cumberland County (U.S. Census, 2019). Fort Bragg, formerly known as Camp Bragg, served as an artillery and temporary training facility in 1918. The opening of this

base contributed to an economic boost for Fayetteville following a major fire in 1831 (Cumberland County, 2017).

While Fort Bragg is considered and asset for the county, the facility may lead to a transient community since groups of people may not stay in the area for long. Another asset of the area is the presence of several colleges and universities. Cumberland County is home to Fayetteville State University, Methodist University, and Fayetteville Technical Community College. These institutions bring in new students, which helps to drive economic development, especially in Fayetteville. The 2019 State of the County Health Report provides an overview of demographics in the areas. White and African American communities are the largest racial/ethnic groups in the county, making up 51.1% and 39% of the population respectively (Green, 2020). 17% of the population in Cumberland County live in poverty in comparison to the state percentage, 11.8% (Green, 2020). In 2020, Cumberland County partnered with the N.C. Department of Public Safety to fund a local Juvenile Crime Prevention Council, which created a continuum of care for juvenile offenders by creating prevention programs, early intervention programs, and graduated sanctions for repeat offenders (Cumberland County, 2020).

Priority Population

Evidence shows that children who experience ACEs, like maltreatment and physical abuse, are more likely to participate in risky behaviors, which can lead them to the path of crime and violence (Fox, et al., 2015). To address ACEs as it relates to rising violent crime rates in Cumberland County, the CCCRO will focus on the priority population of children, ages 0-3 years. Under the 2019 State of the County Health Report, maltreatment rates for children ages 0-3 years are higher than that of other age groups. Additionally, the Cumberland County Child Resiliency Organization (CCCRO) will evaluate caregivers, parents, and guardians as the secondary population because they are legally responsible children of this age group. About 1 in

8 reported violent crimes in the U.S. are committed by a juvenile offender (FBI, 2012). In Cumberland County, the child maltreatment rates are higher than the rest of NC (Green, 2020).

Problem Scope

In 2019, the violent crime rate in Cumberland County was 670.7 per 100,000 compared to 374.9 per 100,000 people in North Carolina (Cumberland County, 2019). The violent crime rate in the county is consistently higher than the state across four measurement periods from 2013 to 2016 (Green, 2020). Additionally, the child maltreatment rate in Cumberland County for age groups of 0-3 years, 4-5 years, and 6-8 years was 37.6, 26.8, and 26.5 per 1,000, respectively (Green, 2020). Across all three age groups, but especially in the 0-3 years group, child maltreatment rates were higher in the county compared to N.C.

Importance

Based on the data, violent crime rates and child maltreatment are higher in Cumberland County compared to North Carolina as a whole. Data from the County Health Rankings show that Cumberland County has a high violent crime rate, 548 per 100,000, compared to the rest of North Carolina, 351 per 100,000. Additionally, the violent crime rate has continued to increase since 2014, leading to negative long term health effects. Studies show that child abuse and maltreatment continue the cycle of violence in the community (Fox, et. al, 2015). Short-term impacts of abuse can lead to injury and premature deaths (Monnat & Chandler, 2015). Long-term effects of abuse and maltreatment include higher instances of risky behaviors, which can lead to repeated juvenile offences (Monnat & Chandler, 2015). If the cycle continues, this leads to the path of serious, violent, and chronic offences in adulthood (Fox, et. al, 2015). If nothing is done to address this issue, violence may likely continue to increase in the county and negative short- and long-term health outcomes will continue to occur.

Health Policy Perspective

Leeuw et al., 2014 state that “the establishment of policy is key to the implementation of actions for health.” In order to have successful interventions, policy is necessary to drive the development and implementation of programs or plans that address a particular SDOH. Health Policy professionals study the development process by analyzing the evidence and data. Utilizing the information available, they provide best recommendations to improve health inequities and inequalities for a given population and issue. With the evidence needed to drive change, policy professionals can work with local, state, and federal governments to implement actions, enact policies, and improve health outcomes of vulnerable populations. Therefore, it is imperative that policy professionals are integral in the public health team to research, educate, and promote positive outcomes through addressing various social determinants of health.

HANNAH CHEUNG'S POLICY ANALYSIS

Background

Adequate social support and a safe community can have a large impact on a person's health and well-being (USDHHS, n.d). Challenges and dangers, such as unsafe neighborhoods, high crime rates, and violence are examples of threats to a person's ability to be healthy in the social and community context (USDHHS, n.d). In particular, children who experience adverse childhood outcomes (ACEs), such as abuse or maltreatment, can result in lasting negative health effects and safety throughout life (Felitti, et al., 1998).

ACEs can also have significant social and community consequences, resulting in increased risky and violent behaviors, mental illness, substance abuse, and negative systemic health outcomes (Monnat & Chandler, 2015). Examples of such negative health outcomes are heart disease, obesity, depression, and suicide (Monnat & Chandler, 2015). Evidence shows that the challenges and stressors from ACEs, such as physical abuse and maltreatment, can lead to violent crime in a community (Reavis et. al, 2013). This is important because data from County Health Rankings show that there is a high violent crime rate, 548 per 100,000, in Cumberland County compared to the rest of North Carolina, 351 per 100,000. Currently, there is a group called Strengths in Overcoming Adversity thru Resiliency (SOAR) in Cumberland County, which unveiled a Community Child Abuse Prevention Plan aimed to build the capacity of parents to advocate for the prevention of child abuse and to cultivate prevention-focused partnerships (SOAR, 2017).

While SOAR is a group focused on building and implementing programs that provide families and caregivers with the necessary tools to prevent child abuse, its impact can be combined with a federal policy to further decrease instances of child abuse and maltreatment in

the county. In this analysis, the Cumberland County Child Resiliency Organization (CCCRO) will review potential policy options available to help lower instances of child abuse and maltreatment, which would have a downstream effect on lowering violent crime rate in the county.

The Policy Goal

In order to address the issue of high violent crime rates in Cumberland County, NC, the goals of the policy options are to identify impactful solutions that would decrease the prevalence of ACEs in the community as evidence suggests that these experiences contribute to negative health outcomes and the perpetuation of violence in the community (Reavis et. al, 2013). By analyzing two different policy options based on carefully selected assessment criteria, one policy recommendation will be identified as the most effective and recommended solution.

Proposed Policy Options and Assessment Criteria

Two policy options were analyzed: (1) Federal ban on corporal punishment at home, daycares, and alternative care settings; and (2) Raising the federal minimum wage. Each policy option was evaluated based on five assessment criteria: (1) political feasibility, (2) cost to the government, (3) impact to children, (4) resources needed, and (5) ease of implementation.

Each assessment criterion was ranked from one (lowest) to five (highest). Since the ultimate goal of this policy analysis to find an impactful solution, the metrics for impact to children was double-weighted. Additionally, the metrics for political feasibility was double-weighted because support from key stakeholders is important to consider in the selection and implementation of an effective policy option.

Policy Option 1: Federal ban on corporal punishment at homes, daycares, and alternative care settings

One possible option to address child abuse and maltreatment is to impose a federal ban on corporal punishment in homes, daycares, and alternative care settings. National bans on corporal punishment in schools have been associated to a decrease in youth violence, 69%

reduction in males and 42% among females (Elgar, et al., 2018). Additionally, countries with implemented national bans have shown direct reductions in violence (Elgar, et al., 2018). Research shows that corporal punishment is not necessary to get children from doing an undesirable behavior (Smith, 2012). Not only can it be painful and cruel, corporal punishment often comes with detrimental long-term effects (Smith, 2012). Examples of these long-term effects include increased aggression, antisocial behavior, physical injury, and mental health issues in children (Smith, 2012).

As of 2021, there are 19 states in which corporal punishment of students is allowed, mostly in the South, Southwest, and Midwest states (Kennedy, 2021). This has not changed significantly since 2008, when the American Civil Liberties Union (ACLU) reported that 21 states allowed corporal punishment (ACLU, 2008). The topic of corporal punishment use is politically and morally divided. Most of the conservative states in the South are in support of this form of punishment, while generally more progressive states oppose (ACLU, 2008). Additionally, some parents and teachers believe that corporal punishment is an effective form of discipline as it may result in immediate correction of behavior (ACLU, 2008). However, with multiple evidence citing that this punishment is not necessary to produce effective results, it is still used today (Smith, 2012). A federal ban on corporal punishment is a contentious and bold option; however, it may stand to have the most immediate impact to stop child abuse and maltreatment.

Policy Assessment #1 – Federal ban on corporal punishment

Political Feasibility	(3/5)	Contentious option. Likely would be divided among party lines. Opponents would say it is overreaching, while proponents would say this outdated practice is morally wrong and should be banned.
Impact	(5/5)	This approach would directly limit child abuse and maltreatment.
Cost to Government	(3/5)	Moderate cost. States would need to employ more workers to enforce ban is in place and document violations at home, daycares, and alternative care settings.

Resources Needed	(3/5)	This would require more infrastructure in place to facilitate this policy and ensure that violations are documented.
Ease of Implementation	(2/5)	NC has already banned corporal punishment in schools. Extending that ban to daycares, homes, and alternative care settings should be fairly easy to implement since a policy is in place. Opposition could come from those who say method of punishment is a personal preference/right that they should decide. It would also be difficult to determine extent of corporal punishment use since it can't always monitor what goes on in homes.

Policy Option 2: Raising the federal minimum wage

Another policy option that may potentially reduce child maltreatment and abuse rates would be to raise the federal minimum wage. The federal minimum wage was established in 1938 as a component of the Fair Labor Standards Act (FSLA) to establish fair compensation of work would provide a decent quality of life (Cooper, 2019). By design, Congress has the authority to reassess the FLSA and make adequate changes to the minimum wage to reflect changing economic conditions (Cooper, 2019). If the 2021 Raise the Wage Act was passed, it would incrementally increase the federal hourly minimum wage to $15 by 2025. An increase to $15 would raise wages for the parents of 14.4 million children, which is nearly 1/5th (19.6%) of all U.S. children (Cooper, 2019). As a result of increased wages and better quality of life, more economic security would help alleviate parental stress in families and help establish a stable household, which are two factors that can help protect children from abuse and neglect (Hendrikson & Blackman, 2015).

A 2017 study from Raissian and Bullinger investigated the relationship between minimum wages among states and changes in child maltreatment rates. They found that increases to the minimum wage led to a decline in child maltreatment reports. The decline in maltreatment was especially concentrated among young children ages 0-5, an age group of particular focus in the CCCRO. Their research suggests that policies aimed at improving the financial situation for low-income families improved child welfare substantially.

Proponents of this policy argue that raising the minimum wage, which has not been changed in over 11 years, would lower annual government expenditures on major public assistance programs because more families would be lifted out of poverty (Zipperer, Cooper & Bivens, 2021). Opponents to this policy have cited that increasing the minimum wage would result in increased unemployment as employers would absorb the cost of having to pay employees more (Merrefield, 2019). However, evidence shows that incremental increases would not result in high rates of unemployment (Cooper, 2019). Nonetheless, the debate over the minimum wage has largely been divided along party lines, and the fear of the unknown consequences can play a factor in political resistance. The impact of a federal $15 minimum wage would be positively felt in homes, especially those with young children, by helping to protect them further from abuse and neglect due to parental stress over finances.

Policy Assessment #2 – Raising the federal minimum wage

Political Feasibility	(2/5)	A politically polarizing topic with classical economists saying it could be detrimental. However, with Democrats controlling the White House and Congress, this might be more feasible in the Biden administration.
Impact	(4/5)	Evidence shows that this approach would reduce poverty. Increasing economic security and self-sufficiency alleviates parental stress, which can help protect children from abuse and neglect.
Cost to Government	(3/5)	Savings for the federal government. If wage was increased to $15, EITC, CTC, and SNAP expenditures would decrease because workers would have more economic security. Cost would be to employers who are paying higher wages. This could also affect taxes – potentially fewer corporate taxes and higher individual income taxes.
Resources Needed	(3/5)	Less resources would be needed in public assistance programs because more people would be lifted out of poverty. However, resources would be needed to address non-compliance from employers and to address unemployment.
Ease of Implementation	(1/5)	Would be difficult to implement due to political differences surrounding this issue. Even with previous Democratic administrations, the federal minimum wage hasn't been raised since 2009.

Policy Recommendation

Analyses of the two options indicated that the most effective solution to lower child abuse and maltreatment rates is by passing legislation to ban the use of corporal punishment at homes, daycares, and alternative care settings. Scores for political feasibility and impact to children, which were double-weighted criteria, were higher than that of raising the federal minimum wage due to existing bans in place for corporal punishment in many schools. Banning corporal punishment in homes, daycares, and alternative care settings would extend the existing ban to a larger variety of settings where young children may reside. Extending that corporal punishment ban would provide for safer spaces where children may visit or reside, leading to a downstream effect on improving health outcomes for children and lowering violent crime rates in the community as a result.

Policy Options Evaluation Matrix						
Policy Option	**Political Feasibility**	**Impact**	**Cost to Government**	**Resources Needed**	**Ease of Implementation**	**Total Score**
Weight	*2x*	*2x*	*1x*	*1x*	*1x*	-
Federal ban on corporal punishment in homes, daycares, and alternative care settings	3	5	3	3	2	24
Raising the federal minimum wage	2	4	3	3	1	19

HANNAH CHEUNG'S PROGRAM BUDGET

Program Summary

In order to address the issue of high violent crime rates in Cumberland County, NC, programs that build resilience are needed in order to reduce the prevalence of adverse childhood experiences (ACEs), such as child abuse and maltreatment because research shows that negative childhood experiences lead to the perpetuation of violence in the community (Reavis, et. al, 2013). Our Accountable Care Community (ACC) proposes implementing the Building Resilient Families Program, which aims to reduce stressors in families with young children by providing lessons on how to address and manage certain issues that may arise within the family that may threaten the resilience. Our program is modeled after the Resilient Families Program from Royal Children's Hospital Melbourne, Australia. Research studies evaluating this program suggests that it has been successful in (1) reducing the use of alcohol and reducing progression to frequent or heavy use, (2) reduced general substance use, (3) reduced delinquent behavior, and (4) reduced teenager-parent conflict (Shaykhi, et. al, 2018; Buttigieg, et. al, 2015; Toumbourou, et. al, 2013; Shortt, et. al, 2007; Toumbourou & Gregg, 2002).

Our program consists of 8-week sessions, which occur twice a year. These sessions are held for 1 evening per week for 2 hours. For each 8-week session, the program will have a cohort of 20 families. Full-time employees will be hired to oversee and implement the program as well as train our ACC staff. The program will be piloted in the first year (Y1) in partnership with one Sunshine House Daycare location. This daycare accepts the childcare subsidy program and has multiple locations around Cumberland County, which are assets in our program implementation for year 2 (Y2) and year 3 (Y3). In Y1, there will be 2 cohorts, a total of

40 families served. In Y2, the program will expand to 2 locations, doubling our program capacity. 40 families are served in each 8-week session, and a total of 80 families will be served in Y2. The program will double again in Y3, serving 80 families per 8-week session. 160 families will be served in Y3 across multiple locations. In order to eligible to participate in the program, families must have at least 1 child between 0-3 years old. In Y1, Core components include (1) providing guidance in building social relationships in families, (2) training on how to identify and handle stressors and challenges at home, and (3) providing parenting education for families with young children.

Budget Narrative

Direct Costs

- Salary – 2 program coordinators and 1 social worker will be hired full-time to oversee operations and implementation of the program in addition to training our ACC staff to train families in multiple locations. Median salaries for the job positions were obtained using information from indeed.com and salary.com. The budget includes an annual 2% salary increase for Y2 and Y3.

Indirect Costs

- Benefits – A negotiated rate of 30% of salary with a 2% increase per year was assumed for employees and are included in Y2 and Y3 costs.
- Training – Food and beverage costs for the training sessions are allocated in the budget. $500 per session is allocated in the budget for food and beverage purchase. Training of ACC staff includes a one-time cost of $800 in Y1.
- Travel – $5000 per year has been allocated for partial gas reimbursement at the standard mileage rates for 2021 (.56 cents per mile) according to the IRS (https://www.irs.gov/tax-professionals/standard-mileage-rates). ACC staff, including program coordinators, social worker, and trained employees, will be traveling to

surrounding daycare locations to implement the program. Partial gas reimbursement for all traveling ACC staff.

- Supplies – General office supplies (i.e., ink, pens, paper) will be included in the budget at $40/month for 3 years. Additionally, educational books will be distributed to parents who attend the sessions. We are estimating $3000 for 300 educational books, which will be distributed to 280 participating families in the 3 years.

Funding/Resources

- Funding Grant – This budget assumes a $250,000 grant per year will be awarded to our ACC for the 3 years the program will be implemented, a total of $750,000.
- In-kind contributions – Donations of restaurant vouchers, farmers market vouchers, and prizes from local stores are considered in-kind donations and will be used as incentives for program participation. Due to our partnership with Sunshine House Daycare, facility costs are considered an in-kind contribution.

Program Budget: Building Resilient Families						
Expense Item	Unit Cost	No. Units	Year 1 Total	Year 2 Total	Year 3 Total	Total
A. Personnel						
A.1 Salary						
Program Coordinator	$63,000.00	2	$126,000.00	$128,520.00	$131,090.40	$385,610.40
Social Worker	$53,000.00	1	$53,000.00	$54,060.00	$55,141.20	$162,201.20
Personnel subtotal			$179,000.00	$182,580.00	$186,231.60	$547,811.60
A.2. Fringe Benefits at negotiated rate of 30% of salary						
Program Coordinator	$18,900.00	2	$37,800.00	$38,556.00	$39,327.12	$115,683.12
Social Worker	$15,900.00	1	$15,900.00	$16,218.00	$16,542.36	$48,660.36
Fringe Benefits subtotal			$53,700.00	$54,774.00	$55,869.48	$164,343.48
B. Training						
ACC Staff Training	$800.00	1	$800.00	$0.00	$0.00	$800.00
Food and Beverage	$500.00	8	$4,000.00	$4,000.00	$4,000.00	$12,000.00
Training subtotal			$4,800.00	$4,000.00	$4,000.00	$12,800.00
C. Travel						
Partial Gas Reimbursement	.56 cents/mile		$5,000.00	$5,000.00	$5,000.00	$15,000.00
D. Supplies						
Office Supplies	$40 per month		$480.00	$480.00	$480.00	$1,440.00
Educational Books	$1,000.00	100	$1,000.00	$1,000.00	$1,000.00	$3,000.00
Supplies subtotal			$1,480.00	$1,480.00	$1,480.00	$4,440.00
Project Total			**$243,980.00**	**$247,834.00**	**$252,581.08**	**$744,395.08**
E. Revenue						
Funding Grant			$250,000.00	$250,000.00	$250,000.00	**$750,000.00**

HANNAH CHEUNG'S POLICY PITCH

Thank you, Ms. Heslin. Members of the committee, please refer to the fact sheet that has been distributed. My name is Hannah Cheung, and I am a representative from the Global Initiative to End All Corporal Punishment of Children. I am here today to speak in support for House Bill 246, which calls for a federal ban on corporal punishment in homes, daycares, and alternative care settings.

Corporal punishment is the most common form of violence against children. It includes any punishment in which physical force is used and intended to cause some degree of pain or discomfort, which can be cruel and degrading. Research has shown that children who experience abuse and maltreatment suffer from higher rates of depression, suicidal thoughts, and other mental disorders in addition to physical negative health outcomes. Children who are abused also show a higher tendency for hostile behaviors, which correlates with higher chances of committing violent crime in adolescence and adulthood. This can cause further detriment in the community by continuing the never-ending cycle of violence for children if no decision is made.

In closing, I want to reiterate my support for this bill, and I am asking members of the committee to vote "yes" to HB 246. Any corporal punishment violates children's right to human dignity and physical integrity. Its legality in the majority of states – unlike other forms of interpersonal violence – violates their right to equal protection. It's time to make a change. Thank you, and now I yield my time to Dr. Peart from the American Academy of Pediatrics.

HANNAH CHEUNG'S POLICY FACT SHEET

SUPPORT HB 246

Federal Policy to End Corporal Punishment in Homes, Daycares, and Alternative Care Settings

CHILDREN DESERVE EQUAL PROTECTION

- Corporal punishment is the most common form of violence against children.[1]
- Children who are abused can suffer from depression, suicide, and mental disorders.[2]
- Children who are abused exhibit aggressive behaviors, leading to violent crimes later on.[3]

Any corporal punishment violates children's right to respect for human dignity.

VOTE 'YES' ON HB 246

GLOBAL INITIATIVE TO End All Corporal Punishment of Children

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APPENDIX F: LAURA HESLIN'S INDIVIDUAL DELIVERABLES

LAURA HESLIN'S INDIVIDUAL PROBLEM STATEMENT

Over the past thirty years researchers have grasped that health is a complex concept that cannot be distilled simply into interactions with the medical profession (Braverman & Gottlieb, 2014). Interactions with our community and peers play a significant role in our overall health and wellbeing and are considered Social Determinants of Health (SDOH) (U.S. Department of Health and Human Services, 2020). Healthy People 2030 has targeted SDOH including increasing the proportion of children and adolescents who show resilience to challenges and stress as a key indicator due to its importance in creating the next healthy generation (U.S Department of Health and Human Services, n.d.).

Many factors impact whether a child is able to demonstrate resiliency including whether the child lives in an area of high violent crime and whether they experience abuse or maltreatment (County Health Rankings, n.d. & Freeze, 2019). These two factors on their own can lessen the health of a community and are also linked, creating a cycle of violence and poor health through myriad factors (Riina, 2016).

Experiencing violent crime in the community creates increased stress for individuals and weakens community ties. Both of these things are associated with higher rates of child maltreatment and abuse (Centers for Disease Control and Prevention [CDC], 2020a, & Riina, 2016). Child abuse and the sequela that emerge can also prevent individuals from pursuing other healthy behaviors due to the lack of safety in the neighborhood (County Health Rankings, n.d.). The stress from living in a community with high crime can exacerbate multiple chronic physical and mental health outcomes including Post Traumatic Stress Disorder (PTSD) and leads to poorer birth outcomes (Coussons-Read, 2013; Pahl et al., 2020). Compounding this, children who experience maltreatment or abuse are more likely to participate in violent crime

later in life, and those who live in communities with high rates of violent crime have higher rates of high blood pressure, obesity, and poorer mental health, among other chronic conditions (Margolin et al. 2010). Child abuse and maltreatment has been included as one of ten Adverse Childhood Experiences (ACEs) that are linked with poor health outcomes in adulthood (Felitti et al., 1998). Both child maltreatment and violent crime detract from a child's ability to demonstrate resilience, which can have ramifications throughout development if not addressed (CDCb, 2020).

Geographic and Historic Context: Cumberland County, North Carolina

Fayetteville, originally Campellton, is the largest city in the county (Cumberland County, n.d.) Fayetteville's growth was setback as fires ravaged the city as part of Sherman's March to the Sea during the Civil War. A key driver of economic growth in the rebuilding was the creation of Camp Bragg as an artillery and training facility (Cumberland County, n.d.). Eventually, Camp Bragg closed and reopened as Fort Bragg, the largest military training facility in the country (Cumberland County, n.d.). To this, Cumberland County has a high population of veterans and active military with one in five individuals having served, more than double that of North Carolina's average (Green, 2020). Cumberland County is diverse and young, with 39% of the population identifying as African American and almost 28% of the population under age 19 (Green, 2020).

Fort Bragg and the multiple schools in the area including Fayetteville State University generate a significant amount economic activity for Cumberland county (Blake, 2018). However, due to the nature of student and military movement, there is transience in the neighborhood which can weaken community ties (Ovaska, 2019).

Scope of the Problem: Violent Crime and Child Maltreatment in Cumberland County

In 2019, Cumberland County had a violent crime incidence of 548 incidents per 100,000 (County Health Rankings, n.d.). This is significantly higher than the state average of 351 incidents per 100,000 and much higher than the national average of 61 incidents per 100,000

(County Health Rankings, n.d.). On average, almost twice as many children in Cumberland County will suffer from maltreatment or abuse, with an average of 30.3 incidents per 1,000 versus 16 incidents per 1,000 in children eight and under (Green, 2020).

Priority Population

While the rates of abuse and maltreatment are high for all children in the county with almost a quarter of children experiencing ACEs, of particular importance is that children three years old and younger are experiencing maltreatment more than any other age group (Green, 2020). These young children in the county are experiencing abuse at a rate of 37.6 incidents per 1,000 and because of their age and inability to advocate for themselves, require focused attention and intervention (Green, 2020).

Rationale/Importance

As of November 2020, the county unemployment rate is 8.4%, which is higher than the state average (NC Department of Commerce, 2021; US Bureau of Labor Statistics, n.d.). Studies have shown that the increased stress created by COVID-19 and other resultant changes to typical life are creating a surge in child abuse in the past year (Taitz et al., 1987 & Kuehn, 2020).

Multiple factors feed into this stress and abuse including the percentage of the population who live in concentrated disadvantage (America's Health Rankings, n.d.). While poverty alone does not predict abuse, it is a component of neighborhood disadvantage; In Cumberland County 17% of the county lives in poverty, compared to 11.8% of North Carolina on the whole (Green, 2020).

Disciplinary Critique

Violent crime is a problem that on its face can be addressed in a somewhat individual fashion. Health policy professionals are educated in strategies to evaluate data to determine expected costs, impacts, and feasibility from a number of different perspectives. They are also skilled in negotiations, grassroots mobilization, and framing issues to improve support and

adherence. Addressing change through policy can cast a wide net as it will have implications for all people who live in the community depending on how the policy is crafted. It is through this lens that policy is able to address inequities in the community and improve population health.

LAURA HESLIN'S POLICY ANALYSIS

Current evidence shows that the majority of a person's health is determined by social and economic conditions are out of individual control, including our social and neighborhood constructs (U.S. Department of Health and Human Services, 2020). These are the Social Determinants of Health (SDOH), and to improve population health Healthy People 2030 lists improving the proportion of children and adolescents who show resilience to challenges and stress as a key objective (U.S Department of Health and Human Services, n.d.). One thing preventing children from growing up resilient is living in communities with high levels of violent crime (CDCb, 2020). Communities with high levels of violent crime have higher levels of stress, obesity, and other chronic conditions including cardiovascular disease (Margolin et al., 2010). A predictor of violent crime later in life is having been the victim of child abuse or maltreatment which aside from direct injury, can start a cycle of violence that leads to multiple chronic health conditions later in life (Springer et al., 2003).

Cumberland County has high rates of both violent crime and child abuse with 548 incidents of violent crime per 100,000 people in 2019 and higher than average child maltreatment rates (County Health Rankings, n.d. & Green, 2020). Specifically, children 0-3 are at risk in Cumberland County with over 15 more incidents per 100,000 than the state average (Green, 2020).

Existing resources/programs to address the problem

Multiple programming and policy initiatives exist at both the state and federal level to provide social services and address child abuse and in turn resilience. There are many federal programs which are run through the state that provide necessary services to children including Early Intervention and Head Start. Early Intervention gives children access to medical and social

programs if they are screened in (Centers for Disease Control and Prevention, 2019). Head Start gives children access to preschool which gives them necessary social and educational skills to improve resilience (U.S. Department of Health and Human Services, 2020). Because of the disjointed nature of these programs, not all who are eligible receive services (Sarakatsannis & Winn, 2018).

Residents of Cumberland County have introduced programs to address maltreatment including Strengths in Overcoming Adversity through Resilience (SOAR) which works with both parents and children through education and intervention and creates partnerships and with other coalitions and organizations (Prevent Child Abuse North Carolina, 2021).

Due to the piecemeal nature of current programming to address decreased resilience in Cumberland County, further policy must be enacted to improve the future health of the community.

Overview of Policy Options and Evaluation Criteria

The two policy options being considered are increasing the state income eligibility for Temporary Assistance for Needy Families (TANF) and increased federal funding for the Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program. TANF is a federal program that provides funding to each state in the form of a block grant. Funds from TANF can be used for many services including childcare. The MIECHV Program provides funding for programs in the state to provide home visits for pregnant women and new mothers. These home visits can reduce parental stress and improve health outcomes.

The criteria for evaluating the policy options are as follows:

Domain	Description	Weight
Cost	Cost to both the state and federal government, as appropriate.	1
Impact	Includes the number of individuals that could be helped by the policy and how much each individual could be helped.	2
Political Feasibility	The amount of support or push back the policy would likely receive in passage.	2

Equity	Whether the policy solution will serve those in the community who are at risk.	2
Sustainability	Working on the SDOH requires a sustainable policy to see a lasting impact on future generations.	1

Policy Option #1: Increase the Income Eligibility for TANF in North Carolina

While the state of North Carolina contributes their own funding, a block grant means that each state is given a certain dollar amount from the federal government and, with certain limitations, set criteria for eligibility and services (Center on Budget and Policy Priorities, n.d.). In North Carolina, many of the services that TANF covers support basic needs and services which are protective against child maltreatment and abuse (Centers for Disease Control and Prevention [CDC], 2020). In North Carolina TANF is available to families that earn up to 200% of the federal poverty level (FPL) (North Carolina Department of Health and Human Services, n.d.). Given the average household size the income limit is $38,960, while the median household income in the county is $45,716 (Green, 2020). Increasing the threshold to 250% FPL would raise the income qualification to $48,700 which is still below the state's median income of $52,413 (Green, 2020).

Currently approximately 40,000 families qualify for TANF services and increasing to 250% FPL would extend eligibility to approximately 10,000 more families (statisticalatlas.com, n.d.). In Cumberland County, Black residents disproportionately live in poverty therefore this would likely be an equitable solution to address the problem of child abuse and maltreatment (Green, 2020).

This policy would be met with significant push back from a conservative legislature who have opposed expansion of other welfare programs like Medicaid. Because there are myriad services that TANF funds can be used for, a broad coalition of supporters could be built from the community like the Chamber of Commerce who would likely support access to job training benefits (North Carolina Department of Commerce, n.d.).

Policy Option #2: Increase Funding for the MIECHV Program

Many programs offer home visits for pregnant women and new parents throughout the state with varying frequencies and durations (Bryant et al., 2018). Voluntary participation in evidence supported programs reduces maternal stress, improves child health, and reduces rates of child maltreatment (Pew Center on the States, 2011). Federal funding is allocated to programs that offer home visits and have evidentiary support for their methods, and in North Carolina eighteen programs meet the criteria including Early Head Start, the Nurse Family Partnership, and Healthy Families America all which have proven outcomes in reducing incidence of maltreatment (Administration for Children & Families, n.d.). Currently, there are 29 evidence-based sites throughout Cumberland County (Jordan Institute for Families, 2020).

MIECHV funding comes through multiple sources aside from the federal government including the state, private grants, and donations (Bryant et al., 2018). The tenuous nature of funding leads to a significant shortfall in needy families having access to services with roughly one percent of eligible families receiving services throughout the state (Bryant et al, 2018). Given North Carolina's limited financial ability to contribute through state funding like TANF and Medicaid, increasing federal funding for the MIECHV will offset the state level burden and improve access to home visiting programs.

Cumberland County is a priority county and is in the bottom 30 percent of counties in the state (Jordan Institute for Families, 2020). Fifty percent of the over 700,000 children in North Carolina who could benefit from MIECHV programs are two years old or younger (Jordan Institute for Families, 2020). In 2018 there were 5,402 live births in Cumberland County, and with a higher-than average percent of the population living in poverty in the county, additional federal funding would benefit the children of Cumberland County and reduce rates of child maltreatment in our priority population (Green, 2020).

This policy would likely be supported by multiple organizations including the American Academy of Pediatrics, though would be contested by fiscal conservatives who oppose increased spending for myriad programs (American Academy of Pediatrics, n.d.).

Final Recommendation: Increase Federal Funding for the MIECHV Program

	Cost to the Government	Impact on the Problem	Political Feasibility	Equity	Sustainability	Total
Weight	1x	2x	2x	2x	1x	
Policy Option 1: Increase Income Eligibility for TANF	3 Under current block grant funding would only theoretically impact cost	2 Impact stunted by waiting lists for services	3 A small raise in income eligibility will be more feasible	3 Will need outreach with community to ensure application	3 Variable depending on funding	22
Policy Option 2: Increased MIECHV Funding	2 Would increase spending	5 Substantial health and economic benefits	3 Moderate difficulty due to partisan nature of increasing spending	3 Cumberland County considered a priority county for intervention	2 Would depend on ongoing financial funding	26

Raising the income threshold for TANF could theoretically address the SDOH but practical limitations weaken this proposal. The primary drawbacks are that there is currently a waiting list for services, and as a block grant, expanding the income eligibility would not address underlying funding constraints (Cumberland County Department of Social Services, n.d.). There is also not a guarantee that funding would directly be used for childcare. To expand the impact of TANF at the state level it would have to be changed to an entitlement program, which provides services to all who are eligible (U.S. Senate, n.d.). Increasing federal funding will be more controversial due to the optics of welfare programming.

Increasing federal funding for the MIECHV program will also face political challenges, but it is better suited to address the number of children who show resilience. The many benefits of home visits can be tied back to a focused intervention that has gained national attention which will help improve political palatability: improving maternal and child health. There is also a significant economic impact in improving childhood outcomes with a return of $5.70 for every dollar invested in home visiting programs (Pew Center on the States, 2011).

When Connecticut studied their home visiting programs, they saw a 22% reduction in Child Protective Services (CPS) involvement and have seen positive trends in the number of children who are taken out of the family (Chaiyachati et al., 2018). A reduction in involvement may not be directly in line with a reduction in incidence, but the trends should not be ignored. CPS is overrepresented in Black communities (Patton, 2017). Since Cumberland County has a large population of Black individuals, this positive trend has the ability to benefit Cumberland County substantially. Due to the significant potential equitable impact and national attention surrounding early childhood and maternal health outcomes, increasing federal funding for the MIECHV program is the recommended policy to improve the proportion of children who show resilience to challenges and stress.

LAURA HESLIN'S BUDGET AND NARRATIVE

Program Overview – Building Resilient Families, Cumberland County

To increase the number of children aged 0-3 in Cumberland County, NC who show resilience to challenges and stress, the Cumberland County Child Resiliency Organization (CCCRO) will adapt the Resilient Families Program. In this age group, parental stress is a significant factor; therefore, we will target parents and caregivers in our adaptation of the Resilient Families Program, which has been proven to help adolescents as well as parents engage with their children (Positive Choices, n.d.). Our program will partner with Sunshine House Daycare which accepts the childcare subsidy program and has multiple locations in the county.

The program will be available to parents and caregivers who earn up to 250% of the federal poverty level (FPL) and have at least one child under three years old. Participants for the pilot program will be recruited through Sunshine House and local pediatrician offices. Each session will consist of eight two-hour classes, to be held once a week. During each class, a social worker and a day care professional will guide caregivers through an interactive curriculum that includes conflict resolution techniques, emotional awareness, stress reduction, and family responsibilities (Positive Choices, n.d.). In order to prevent barriers of attendance, child-care will be offered on site during the classes for participants.

Running the pilot at Sunshine House offers opportunities to draw on their multiple locations, staffing pools, and client populations to assist with the facilitation of our first year. In our pilot year we will serve 20 families in each of two eight-week session, for a total of 40 families served in the first year. In the second year we will double our capacity to two sites, allowing us to serve 40 families in each eight-week session, for a total of 80 families in the

second year. The third year will have our program double again to serve 80 families in each session, and 160 families in the year. This will allow us to reach 280 families in our first three years, for an average cost of $1,097.86 for each family served per session. The total cost of this three-year program will be $250,862.06.

Please see the budget spreadsheet for details.

Cumberland County Child Resiliencey Organization Program Budget

Program Personnel	Year 1 Hourly Rate with 30% Fringe	Year 1 Hours per Year	Year 2 Hourly Rate with 30% Fringe	Year 2 Hours per Year	Year 3 Hourly Rate with 30% Fringe	Year 3 Hours per Year
Program Coordinator	$ 25.63	2,080	$ 26.14	2,080	$ 26.66	2,080
Social Worker Site 1 Lead	$ 34.38	80	$ 35.06	80	$ 35.76	80
Social Worker Site 2 Lead	-		$ 35.06	80	$ 35.76	80
Social Worker Site 3 Lead	-		-		$ 35.76	80
Social Worker Site 4 Lead	-		-		$ 35.76	80
Day Care Worker Site 1	$ 13.00	40	$ 13.26	40	$ 13.53	40
Day Care Worker Site 2	-		$ 13.26	40	$ 13.53	40
Day Care Worker Site 3	-		-		$ 13.53	40
Day Care Worker Site 4	-		-		$ 13.53	40
Baby Sitter 1, Site 1	$ 10.00	32	$ 10.20	32	$ 10.40	32
Baby Sitter 2, Site 1	$ 10.00	32	$ 10.20	32	$ 10.40	32
Baby Sitter 1, Site 2	-		$ 10.20	32	$ 10.40	32
Baby Sitter 2, Site 2	-		$ 10.20	32	$ 10.40	32
Baby Sitter 1, Site 3	-		-		$ 10.40	32
Baby Sitter 2, Site 3	-		-		$ 10.40	32
Baby Sitter 1, Site 4	-		-		$ 10.40	32
Baby Sitter 2, Site 4	-		-		$ 10.40	32

Revenue (Grant)	$ 250,862.06

Expenses	FY 2021-1 site each session		FY 2022 - 2 sites each session		FY 2023- 4 sites each session		Total
Direct	Session 1	Session 2	Session 1	Session 2	Session 1	Session 2	
Salary	$28,794.500	$ 28,415.50	$ 31,557.78	$ 30,784.62	$ 36,651.21	$ 35,073.96	$ 191,277.58
Program Materials	$666.670	$ 666.67	$ 680.00	$ 680.00	$ 693.60	$ 693.60	$ 4,080.55
Location Site	$0.000	$ -	$ 1,060.80	$ 1,060.80	$ 3,246.05	$ 3,246.05	$ 8,613.70
Indirect							
Mileage	$1,000.000	$ 1,000.00	$ 2,040.00	$ 2,040.00	$ 4,161.60	$ 4,161.6000	$ 14,403.20
Farmers Market Vouchers	$1,600.000	$ 1,600.00	$ 3,264.00	$ 3,264.00	$ 6,658.56	$ 6,658.5600	$ 23,045.12
Refreshments	$400.000	$ 400.00	$ 816.00	$ 816.00	$ 1,664.64	$ 1,664.6400	$ 5,761.28
Office Supplies	$200.000	$ 200.00	$ 408.00	$ 408.00	$ 832.32	$ 832.3200	$ 2,880.64
Initial Trainer Fee	$800.000	$ -	$ -	$ -	$ -	$ -	$ 800.00
TotalCost per 8 week sessic	$33,461.170	$ 32,282.17	$ 39,826.58	$ 39,053.42	$ 53,907.98	$ 52,330.73	$ 250,862.06
Cost per family*	$1,673.059	$ 1,614.11	$ 995.66	$ 976.34	$ 673.85	$ 654.13	
*20 per session/site max							
In Kind							
Raffle Prize 1	($100)	($100)	($200)	($200)	($400)	($400)	($1,400)
Raffle Prize 2	($100)	($100)	($200)	($200)	($400)	($400)	($1,400)

Average Cost Per Family Per 8 week session	$1,097.86	Total Expenses	$ 250,862.06
Average Cost Per Family Per Class	$ 137.23		

Funding Source – Building Resilient Families, Cumberland County

Requesting $250,862.06 in grant funding for the three-year program.

Budget Narrative – Building Resilient Families, Cumberland County

Direct Costs

- *Personnel: Program Coordinator (1 for the program)*- They will handle all staffing, oversight, payroll, and other administrative tasks. They will liaise with the public health department, representatives from Building Resilient Families for training, and with social workers for each session. This will be advertised and recruited as a full-time position. Annual salary based on Glassdoor estimation (Glassdoor.com, n.d.).
- *Personnel: Social Worker (1 at each site)* – They will work with the program coordinator before the program begins to prepare materials for 20 hours each session, attend an annual 8-hour training sessions, and run each 2-hour session. This is a part time position for 80 hours throughout the year, 44 hours in session one, 32 hours in session two. Hourly salary based on Glassdoor estimates (Glassdoor.com, n.d.). Will post job opportunity at the Department of Public Health and Department of Social Services.
- *Personnel: Day Care Worker (1 at each site)* – They will attend an 8-hour training session each year and assist the social worker in facilitating each 2-hour session. This is a part time position for a total of 40 hours throughout the year, 24 hours in session one, 16 hours in session two. Hourly salary based on Glassdoor estimates (Glassdoor.com, n.d.). Will draw on Sunshine House's current staff pool for pilot year staffing.
- *Personnel: Baby-Sitter(s) (2 at each site)* – They will provide onsite child-care during each two-hour class to alleviate attendance barriers for a total of 32 hours a year, 16 hours each session. No additional program training required, not a benefits eligible position. Will post advertisements with local community groups.
- *Program Materials* – Purchased in bulk from Building Resilient Families for $1000/100 booklets. We will purchase 400 for the 280 families with additional 120 in case

replacements are needed. Cost evenly dispersed throughout all three years (Positive Choices, n.d.).

- *Location Fee* – No cost in the first year as the program will take place at our partner's location: Sunshine House. Year two and three will require one and three sites, respectively. Cost estimation based on rental fee at Hope Mills Recreation Center of $65/hour (Town of Hope Mills, n.d.).

Indirect Costs

- *Mileage Reimbursement* – Based on 2021 IRS recommendations, reimbursement will be $0.56/mile with a maximum of $200 per staff member, per session (Internal Revenue Service, 2021).
- *Farmers Market Vouchers* – To encourage participation and retention, each caregiver will receive a $10 voucher to a farmer's market at the end of each class.
- *Refreshments* – We have budgeted $50 to provide refreshments to caregivers at each class.
- *Office Supplies* – We have budgeted $200 for office supplies for each eight-week session, per site.
- *Initial Trainer Fee* – Building Resilient Families will provide initial staff training for a one-time fee of $800. In year two and three, previous staff will train new staff (Positive Choices, n.d.).
- *In Kind Donations* – We have received two $100 vouchers that will be given away as a raffle at each site at the end of each session. They are kindly provided by local businesses, Surge Adventure Park and Fascinate-U Children's Museum.

LAURA HESLIN'S POLICY PITCH

Good Evening, my name is Laura Heslin, and I am speaking to you today on behalf of the North Carolina chapter of Prevent Child Abuse America. Chairwoman Agrawal and Chairwoman Davis, thank you for inviting me to speak today. I am here to ask you to support passage of HB 246, the federal ban on corporal punishment.

As president of North Carolina's Prevent Child Abuse America I can say that Cumberland County, North Carolina, and children all across America need the opportunity to be healthy and not be victims of abuse. While this may seem like an obvious statement, there is an ongoing problem with maltreatment and abuse that we cannot ignore. Corporal punishment is a form of abuse. Studies show that this abuse leads to adult violent crime and a host of chronic health issues including poor mental health.

Even worse, those who are victims of this form of abuse are more likely to continue the cycle of violence in future generations. Our inaction is preventing this and future generations from reaching their full potential. That is why a federal ban on corporal punishment will send the message that we care about our children. While corporal punishment has been banned in many places throughout the country, it is still allowed in the home and in certain care facilities. Because of this, our youngest children are most vulnerable, and parents and caregivers are disciplining their children in not just ineffective ways, but harmful ones.

We are behind the times and wasting our money; countries that ban corporal punishment do see a reduction in child abuse when these bans are enacted. The United States is spending billions of dollars addressing the fall out of child abuse and maltreatment each year. The CDC (2012) says the cost of treating one victim of child abuse over their life is more than treating someone with type two diabetes or someone who has suffered a stroke. At Prevent

Child Abuse America, we are already working with the community, parents, and caregivers to break the cycle and give them the tools they need to raise healthy children and prevent the abuse before it happens – this includes effective parenting strategies.

By banning corporal punishment, we will send the message that we care about children and we care about their futures. Voting “yes” on HB 246 tells our children that they are worth protecting- for the health and wellbeing of us all.

LAURA HESLIN'S FACT SHEET

LAURA HESLIN'S REFERENCES

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APPENDIX G: MISHKA PEART'S INDIVIDUAL DELIVERABLES

MISHKA PEART'S INDIVIDUAL PROBLEM STATEMENT

Social Determinant of Health (SDoH)

Improving individual or community health oftentimes requires practitioners to look beyond the exam room. This is because the time spent with a provider comprises only a minute part of people's lives. That said, when discussing health and health outcomes, it is pertinent to consider the environments in which people are born, live, learn, work, play, and worship (Office of Disease Prevention and Health Promotion, 2020). This is the concept of social determinants of health. Different areas, or determinants, include education, economic stability, social and community context, the neighborhood environment, and health and healthcare. Addressing these social and physical conditions that envelop an individual may help bolster the success and impact of policies and programs aimed to improve health (Office of Disease Prevention and Health Promotion, 2020).

This report will focus on the social and community context of children between the ages of 0 – 3 years-old. This determinant includes social supports, norms, or disorder, community resources, public safety, and overall social cohesion. Research has shown that children exposed to stressors, such as child maltreatment and abuse, are more likely to perpetuate violence as adolescents and adults (CDC, 2020). The importance of this is reflected in the fact that the rate of violent crime in Cumberland county is almost twice that of North Carolina, and more than eight times higher than the nation's safest counties (University of Wisconsin Population Health Institute, 2021).

Violent crimes include murder, manslaughter, rape, robbery, and assault (Cumberland County Public Health Department, 2019). While the short-term health impacts of such violence may seem obvious, how it affects individuals who are both directly and indirectly involved is

more subtle. Immediate health outcomes of these acts include premature death, non-fatal injury leading to hospitalization, and physical pain and mental distress that leads to a reduced quality of life (Office of Disease Prevention and Health Promotion, 2020). It has also been shown that people residing in areas of higher crime engage in less physical activity, barring them from reaping the benefits of leading an active lifestyle. Additionally, people who experienced past child maltreatment and abuse are more than twice as likely to suffer a heart attack or stroke than those who do not, more likely to be diagnosed with diabetes, and rate their health as poor (Goldsmith, 2018).

Children are among those most impacted by violent crime, and the effects are similar regardless of if they are victims, witnesses, or hear secondhand about a crime (Office of Disease Prevention and Health Promotion, 2020).

Geographic and historical context

According to the 2020 census, Cumberland county has a population of approximately 335,000 residents (United States Census Bureau, 2020). Despite a small outward migration in 2018, the net population has continued to grow since 2010, by five percent (United States Census Bureau, 2020). When compared to the overall North Carolina population, Cumberland county is more diverse, with black and Hispanic residents making up significantly more of the populace. Cumberland county is also younger: every one-in-four people are under the age of 18 years-old, as seen in Appendix 1, Table 1.

Cumberland county is home to Fort Bragg military base, which opened for training in 1921, and has since established a strong military presence in the area. The proportion of residents who identify as military members is ten times higher than the state (Cumberland County Public Health Department, 2019). Fayetteville State University and Methodist University both attract young adults to the area, making the 18 – 34-year-old demographic the largest. However, these same community assets also contribute to the growing transiency of the county, as people get redeployed, change stations, or graduate (Sanders, 2013).

Priority population

The population of interest are children between the ages of 0 –3 years-old in Cumberland county, since they are at highest risk of experiencing child maltreatment (Green, 2020). Children exposed to violence are more vulnerable to victimization *and* perpetration of violence later in life, thus perpetuating a harmful cycle of violence (CDC, 2020). Youths exposed to violence are at risk for developing mental or behavioral issues such as depression, anxiety, post-traumatic stress disorder (PTSD), disordered earing, and suicidal ideation. When exposed to violence in early life, these individuals are more likely to display signs of aggression in school, engage in substance use, and participate in risk-taking behaviors (Office of Disease Prevention and Health Promotion, 2020).

Studies have demonstrated that a history of child abuse and maltreatment, among other adverse childhood experiences, or ACEs, also increase a person's risk for future violence perpetration (Egerter, Barclay, Grossman-Kahn, & Braveman, 2011). Further, a recent study found that 90% of juvenile offenders have experienced at least one ACE (Freeze, 2019). Like violence exposure, research has revealed a strong positive relationship between child abuse and aggressive behavior later in life (Reavis, Looman, Franco, & Rojas, 2013). Children who become crime-involved may not acquire full learning or earning potentials due to increased interactions with the criminal justice system, missed days at school, and poorer educational performance (Taylor, 2016). Childhood maltreatment is just one of several upstream factors contributing to poorer health outcomes and the rising rate of violent crime in Cumberland county. For these reasons, addressing childhood resiliency through the lens of the social and community context, as outlined in Healthy People 2030, is integral to the overall health of the community.

Measures of problem scope

Fayetteville is the county seat for Cumberland county. The average constituent here is more than twice as likely to become a victim of a violent crime when compared to the state of

North Carolina overall—1 in 115 vs. 1 in 269 (Neighborhood Scout, 2021). Fayetteville has a crime index of six, meaning that it is safer than only six percent of the nation's cities (Neighborhood Scout, 2021). While there is no local data about the racial/ethnic distribution of crime in Cumberland county, national data demonstrates that among violent crimes, a larger percentage of murders, manslaughters, and robberies were committed among black individuals, meanwhile aggravated assaults and rapes were frequent among whites (Criminal Justice Information Services Division, 2018). At the national level, overall violent crimes however were more frequent among whites, as demonstrated in Appendix 1, Table 2. Given Cumberland county's racial diversity, it is unclear if national data is generalizable to this region.

Child maltreatment is defined as the abuse or neglect of a child younger than age 18 by a parent, guardian, or caregiver (Green, 2020). Child abuse, on the other hand, is a subset of child maltreatment that involves physical, sexual, or emotional abuse (Cumberland County Public Health Department, 2019). The rate of child abuse in Cumberland county has remained consistently higher than that of North Carolina for almost a decade. Data from 2017 demonstrate a Cumberland County child abuse rate of 35 per 100,000 children, compared to approximately 22 per 100,000 throughout the state, as can be seen in Appendix 1, Figure 1. When we look at the rate of overall child maltreatment in Cumberland county, it is as high as over 3,700 for every 100,000 young children between the ages of 0 – 3 years-old, who are most at risk. This is almost three times the rate of older children at the state level, shown in Appendix 1, Figure 2. While there have been no studies to date about how race and ethnicity intersects with the rate of child abuse in Cumberland county, studies on the national level have demonstrated that black and Hispanic children were exposed to more childhood adverse events such as child abuse than white children, which is outlined in Appendix 1, Table 3.

Rationale/Importance

Addressing violent crime Cumberland county was identified as a top need in the most recent community health assessment and listed as one of the top five topics that required

attention (Cumberland County Public Health Department, 2019). Child maltreatment is also considered a type of violence. The intersectionality of violent crimes and child maltreatment and their effect on health outcomes is important to consider because of the potential short- and long-term issues discussed earlier, and their negative feedback on child resiliency.

Disciplinary critique

Public policies that affect determinants of health can significantly impact health outcomes within a community. Policy can help shape an environment and influence positive behavior changes among the population. Whenever attempting to address a complex problem and its drivers, such as factors contributing childhood resilience in a community, a health in all policies approach is important to improve the health of all people and take steps to achieve health equity. If endeavoring to consistently effect change across various sectors, policy should be a fundamental consideration.

People of color tend to experience poorer health outcomes than their white counterparts. This said, a policy or program addressing childhood resiliency is anticipated to reduce violence and poorer health outcomes more greatly in Cumberland county's communities of color, contributing to overall health equity.

MISHKA PEART'S POLICY ANALYSIS

Background and Problem Statement

The social and community context, including social supports and public safety, can influence child resilience in many ways. Child maltreatment and community violence have a negative impact on child wellness and resilience. This policy analysis describes policy options that will transform Cumberland county's social and community context to decrease risk factors and increase the proportion of children between the ages of 0 – 3 years old who show resilience to challenges and stress.

Child maltreatment is defined as the abuse or neglect of a child younger than age 18 by a parent, guardian, or caregiver (Green, 2020). Child abuse, on the other hand, is a subset of child maltreatment that involves physical, sexual, or emotional abuse (Cumberland County Public Health Department, 2019). The rate of child maltreatment among children under age three years old in Cumberland county is almost three times the rate of older children at the state level, 3,760 vs. 1,340 affected per 100,000 respectively (Green, 2020).

Research has shown that children exposed to stressors such as child maltreatment and abuse are more likely to perpetuate violence as adults, repeating a harmful cycle of violence (CDC, 2020). This is important given the violent crime rate per 100,000 is 548 in Cumberland county compared to 351 in North Carolina (University of Wisconsin Population Health Institute, 2021). Community violence likewise has a negative impact on the public's health. Children residing in areas where violence is high experience a reduced quality of life, increased reports of mental distress, and engage in less physical activity (Office of Disease Prevention and Health Promotion, 2020). While there are various small programs in Cumberland county that tackle adverse childhood experiences such as child maltreatment, they focus largely on secondary and

tertiary prevention. Policy options supporting the primary prevention of child maltreatment and reinforcing protective factors for child resilience is needed.

Policy Options and Assessment Criteria

This analysis includes two policy options that could reduce the rates of child maltreatment in Cumberland county and increase the proportion of children between the ages of 0 – 3 years old who show resilience to challenges and stress: (1) establishing a federal policy requiring paid parental leave at 100% equivalence for a duration of 12 weeks; and (2) instituting a federal ban on the use of corporal punishment at home, daycares, and alternative care settings. Both policy options will be evaluated on the cost to the federal government, impact, political feasibility, and acceptability.

Policy Option #1: Establish a federal policy requiring paid parental leave at 100% equivalence for a duration of 12 weeks

The Family and Medical Leave Act (FMLA) states that eligible employees working for covered employers are entitled to twelve weeks of unpaid job-protected leave for specified reasons such as the birth of a child[1] (U.S. Department of Labor, n.d.). Currently only 14% of American civilian workers have access to paid parental leave, and only 6% of lower wage workers will actually take leave after the birth of a child (Brainerd, 2017 and National Partnership for Women and Families, 2017). Further, the United States' current FMLA leave standards have been found to only benefit children of educated mothers, and not those of less educated or single mothers (OECD, n.d.). This policy would require that eligible employees of covered employers be entitled to twelve weeks of *paid* job-protected leave under the amended FMLA. Studies have shown that paid family leave is associated with reductions in child maltreatment, hospitalizations, and lower rates of family stressors and risk factors (Prevent

[1] A covered employer is any public agency, public or private school, or any private sector employer with 50 or more employees. Eligible employees are employed by a covered employer, has worked for the employer for 12 months for greater than 1,250 hours of work.

Child Abuse America, 2020). Recent evidence from California—one of only three states that require paid family leave—has shown that it is associated with a decrease in pediatric abusive head trauma admissions, a major cause of child abuse morbidity and mortality in young children (Prevent Child Abuse America, 2020). Providing families with financial security leads to less family stress and conflict, which in turn decrease child maltreatment rates and increase resiliency of these children (Prevent Child Abuse America, 2020). As of 2018, OECD countries enjoy approximately twenty weeks of paid familial leave, on average, compared to zero in the United States. Global comparisons of the average duration and percent compensation of paid family leave can be found in Appendix 2.

Policy Option #2: Institute a federal ban on the use of corporal punishment at home, daycares, and alternative care settings (ACSs)

Corporal punishment is defined as a disciplinary method in which a supervising adult deliberately inflicts pain upon a child in response to a child's unacceptable behavior, according to the American Academy of Child and Adolescent Psychiatry (2014). Currently, corporal punishment is legal at home in all 50 states and in in alternative care setting such as foster homes, in ten states (Global Initiative to End All Corporal Punishment of Children, 2021). Additionally, twenty states either do not have statutes outlawing corporal punishments in daycares or have exemptions to allow for it in certain institutions such as parochial institutions (Global Initiative to End All Corporal Punishment of Children, 2021). This option describes a national ban on corporal punishment at home, daycares, and ACSs.

Studies have shown that corporal punishment increases the risk that a child will victimize, fight with, and bully others (Ohene, Ireland, McNeely, & Borowsky, 2006). It has also been shown that it is not effective at promoting compliance or moral behavior, and that children who receive corporal punishment are more likely to misbehave over time (Gershoff & Font, 2016). Corporal punishment can lead to injury, higher rate of mental health issues, lower

academic achievement, and a higher risk of experiencing physical abuse (Gershoff & Font, 2016). Many prominent organizations have advocated for the end of corporal punishment.

Globally, fifty-nine countries, including half of Organization for Economic and Cooperation Development (OECD) countries have fully banned corporal punishment (ConnectUS, 2019 and OECD, 2013). Research shows that national bans on corporal punishment are linked to a decrease in youth violence (Elgar, et al., 2018). Specifically, they found a 69% reduction in violent crime among males and a 42% reduction among females after the implementation of national ban (Elgar, et al., 2018).

Policy Analysis

Of the two policy options, requiring paid parental leave scores lower for the first criteria, cost to the federal government (2/5 vs. 5/5). One of the most common models utilized by other countries to fund paid time off from work is a mixed model in which benefits are financed through a combination of social security paid by general taxpayers and employer contributions. Unless the social security tax is increased to generate more revenue to cover the expense of this policy option, it would decrease the general funds available to finance other activities. The cost of implementing a national paid family leave policy was estimated at $12.7 billion, when theoretically applied to eligible employees who filed for family leave in 2017 (Gitis, 2018). The federal ban on the use of corporal punishment receives the maximum score (5/5) for cost to the federal government. If certain entities such as daycares or ACSs are found to be in violation of this policy they can be fined, creating a new potential source of revenue for the federal government. Additionally, private organizations may receive indirect aid from the government in the form of vouchers (Department of Health and Human Services, 2014). Those organizations who violate this policy may lose their supplementary aid for a predefined period of time, again contributing to government savings. Additional compliance officers may be needed to track complaints and perform investigations, which could incur a small cost. However, this could also be added to the Administration for Children and Families without significant increase in cost.

Paid family leave scores 4/5 in terms of impact. The most compelling evidence are the studies from California discussed earlier that demonstrated a decrease in childhood hospitalizations associated with child maltreatment after the enactment of paid family leave (Brainerd, 2017). For some children, however, having parents at home may increase their vulnerability to child maltreatment. This consideration precluded the paid family leave option from obtaining maximum points for impact. The corporal ban policy option achieves the maximum points for impact (5/5) due to the fact that studies have reported an increase in positive child-family dynamics and decreased likelihood of engaging in violence (Elgar, et al., 2018). Additionally, Sweden—the first country to prohibit corporal punishment in all settings in 1978—has demonstrated the success of implementing a corporal punishment ban. Before the ban, over 90% of Swedish parents used corporal punishment; in 2016, about 5% of parents admitted to using any form of corporal punishment in a national survey (Waterson & Janson, 2020).

The political feasibility of instituting a federal paid family leave policy utilizing a mixed model financing method is low (2/5). With the number of people in the workforce shrinking as the baby boomer generation ages into retirement, further increasing the social security tax to cover paid family leave will place a large tax burden on working Americans. Further, there is already much concern about the future of social security and the aging population, making it unlikely that financing paid family leave through social security taxes will become a reality. Business associations—particularly small business associations—which have much lobbying power, may be against supporting paid family leave citing no benefit to their businesses. Experts however have determined that paid leave policies improve worker retention and decreases employee turnover, which businesses may find appealing (National Partnership for Women and Families, 2017). Further, Google found that paid leave decreased the turnover of new mothers, and determined their policy to be cost neutral, due to less onboarding and training activities of new employees (National Partnership for Women and Families, 2017). So, while

costs to businesses may be high initially, it may lead to cost savings in the long-term, as well as helping employers recruit and retain top talent (National Partnership for Women and Families, 2017).

On the other hand, the corporal punishment ban scores moderately (3/5) in terms of feasibility. Research has traditionally shown a bipartisan divide when it comes to corporal punishment: democrats are less likely to support its use when compared to republicans and even independents (Enten, 2014). Further, some Republicans, such as Representatives Steve Riley and Kevin Bratcher, both of Kentucky, are in favor of banning corporal punishment and are actively pursuing legislation to prohibit it in Kentucky schools (Paul, 2019). Even so, obtaining the senate's 60-vote majority needed to pass legislation would still prove challenging. Reconciling this policy option with a budget bill to bypass a filibuster and allow for the 51-vote majority would make political feasibility more likely. It is worthwhile to discuss the logistical feasibility of a federal corporal policy ban at home, daycares at ACSs. Under this policy, daycares and ACSs would be at risk of losing federal funding (or vouchers if a private entity) if found to be noncompliant. Enforcing this policy in the home, however, proves more challenging. In Sweden, no penalties are associated with violations in the home, unless the violence is associated with abuse or assault (Future Policy, 2021). The policy was "intended to change the public perception of corporal punishment in the home and [serve] as a guide for parents". In this setting, social workers and other public service employees such as police officers have the authority to contact caregivers and remind them that corporal punishment is against the law and offer resources to the family if needed (Gumbrecht, 2011).

Both policy options received the same score for acceptability (4/5). According to Pew Research, 82% of Americans believe that a mother should be entitled to paid time off after the birth or adoption of a child, meanwhile 69% of Americans believe that the same holds true for fathers (Horowitz, Parker, Graf, & Livingston, 2017). Over half of Americans also agree that the federal government should require employers to provide paid leave (Horowitz, Parker, Graf, &

Livingston, 2017). Likewise, many small business owners are actually in support of paid family leave citing a competitive advantage, however they prefer that the decision to provide paid leave be left to individual employers (The Opportunity Agenda, 2019). Paid family leave did not receive the maximum points for acceptability given that it would be partially financed through raising social security taxes, an action that some Americans may disapprove of. Individual constituents may not support a corporal ban policy, given that 81% of parents privately support hitting their children (Morin, 2020). Further, such a policy may make some people uncomfortable with the level of government regulation, particularly in their own homes. However, as referenced above, Sweden is an example of how the culture of a nation can change with policy and time. The summary of this policy analysis can be found in Appendix 3.

Policy Recommendation and Conclusion

The policy analysis indicates that a federal policy prohibiting corporal punishment at home, daycares, and alternative care settings is the best intervention to increase the proportion of children who show resilience to challenges and stress. National bans are currently in place in 59 countries, and research shows that corporal punishment bans have been linked to a reduction in youth violence. Corporal punishment is ineffective, associated with injury and mental health issues, and places children at higher risk of experiencing physical abuse and continued violence perpetuation. Implementing a federal ban is a cost-effective way to send a message that this violence against children is unacceptable. Sweden was able to enact this policy alongside an aggressive public health campaign titled “Can you bring up children successfully without smacking and spanking?” (Waterson & Janson, 2020). Even in the presence of the comprehensive national ban, the campaign was important in shifting the culture to understand that corporal punishment is not necessary. Considerations for this policy include the potential to increase the workload of an already overburdened social work and public safety sector. This is particularly true when it comes to ‘proving’ whether corporal punishment has actually occurred, especially if there is no physical evidence. The United Nations Convention on

the Rights of the Child states that all parties “have the obligation to prohibit and eliminate all physical violence against children in all settings including the home” (Future Policy, 2021). The convention has been ratified by 196 countries. The United States is the only country that has not ratified the convention, meaning there is no legal obligation to uphold the provisions of the convention (Unicef, 2021). Enacting this policy would signal to Americans and the rest of the world that ensuring the safety and resiliency of children is valued and sends a clear message that corporal punishment in any setting is not supported. Appendix 4 describes the global status of corporal punishment.

MISHKA PEART'S BUDGET AND JUSTIFICATION

Summary of the Program

In order to increase the proportion of children between the ages of 0 – 3 years old who show resilience to challenges and stress, the Cumberland County Child Resiliency Organization (CCCRO) proposes implementing an adaptation of the Building Resilient Families program. Cumberland county's Building Resilient Families program will be a group program held one evening per week over eight weeks that provides parents and caregivers with structured activities to increase positive family interactions and manage stress. People will be eligible for the program if they are parents or primary caregivers of children in low-income families up to 250% of the federal poverty level and have at least one child between the ages of 0 – 3 years old. Participation is voluntary, and incentives will be provided to caregivers who participate each session. CCCRO's Program Facilitators will lead each interactive group session. Sessions will take place at Sunshine House Daycare, a community partner which has multiple locations throughout Cumberland county and accepts childcare subsidies. In addition to direct family involvement, Building Resilient Families will also provide professional development sessions for daycare staff to engage in positive and meaningful interactions with families, and discuss effective non-physical disciplinary techniques for infants and toddlers in alternative care settings.

CCCRO proposes that Building Resilient Families begin as a pilot program at a single Sunshine House location. The program will serve 20 families during each 8-week session, with a total of five sessions in year one (100 families total). The proposal outlines a plan for scaling up to two locations in year two (200 families), and three locations in year three (300 families), with the goal of reaching 600 families in the first three years of existence. The overall three-year

program cost is $808,202.00, or $1,347.00 per family. Similar programs have demonstrated a cost-savings of $7.10 for every dollar invested (Schweinhart, 2013). Thus, Building Resilient Families has the potential to save Cumberland county $8,216.70 for every family enrolled.

Budget Narrative

Funding Sources

- **Child Resilience Grant:** This proposal assumes that the Child Resilience grant will be awarded over three years, for a total of $808,202.
- **In-kind contributions:** Several assumptions about in-kind contributions were made. (1) students from Fayetteville State University majoring in Birth-to-Kindergarten Education will volunteer to provide childcare services during weekly sessions; (2) the Sunshine House daycare facilities where the sessions will take place will be available after-hours for use by the Accountable Care Community (ACC) without cost; and (3) local businesses such as farmers markets, family restaurants, and amusement centers will donate vouchers to be used as incentives for caregivers to attend sessions.

Direct Costs

- **Salary for human Resources:** This includes the salaries for seven new employees over three years. Three program facilitators, three social workers, and a program director will be hired in phases, until all three sites are active. The salaries for the social workers and program director were inferred from local job postings. The program facilitator salary was projected assuming a single facilitator will complete one session per week for 40 weeks, for a total of 40 sessions (5 consecutive cohorts) annually. Program facilitators will earn a flat rate of $250 for each completed session. Job descriptions for each position are outlined below:

  Program Director (1): will supervise the Building Resilient Families program. Specific duties will include hiring, payroll, marketing and communications, and holding regular

staff meetings with the program facilitators and social workers. The expected annual starting base salary is $62,019.

Program Facilitator (3; 1 at each site): will lead 40 caregiver group sessions annually and semi-annual professional development training sessions for daycare staff. The expected annual support is $10,000, based on the above. Facilitators will be chosen from a pool of graduate student assistant/intern applicants studying Birth-to-Kindergarten child education.

Social Worker (3; 1 at each site): Attend group sessions with the program facilitators to provide support to parents and caregivers. Serves as a resource to caregivers, providing information on additional community resources and conducting individual appointments with families as needed. The expected annual starting base salary is $56,284.

- **Caregiver educational materials:** The bulk pricing for 100 guidebooks is $1,000, or $10 per book. The ACC expects to host 100 caregivers in year one, 200 in year two, and 300 in year three.
- **Concessions:** This budget assumes concessions will cost $4/per person/per session. There will be 40 sessions in year one, 80 in year two, and 120 in year three. Each session will host 20 individuals.
- **Training materials:** The budget assumes that two daycare workers from each of three sites will be trained, with supplies costing $15 per employee.
- **Professional staff training sessions:** The personnel cost to train daycare staff is $600 per session. The ACC will hold two training sessions annually.

Indirect Costs

- **Human resources taxes and benefits:** 30% fringe was added to salaries of all employees.

- **Office supplies:** This budget assumes that each of the three sites will purchase $25 worth of supplies (easel, markers, pens, name tags) each year to facilitate meetings.
- **Marketing and communication:** 1000 brochures and 1000 flyers will be disseminated annually at a cost of $0.10 and $0.40, respectively.

Building Resilient Families Program

Funding Sources

	Year 1	Year 2	Year 3	Total
Child Resilience Grant	$ 172,750.00	$ 268,204.00	$ 367,248.00	$ 808,202.00

Budget Categories

	Year 1	Year 2	Year 3	Total
Total Direct Costs	$ 133,733.00	$ 208,110.00	$ 285,245.00	$ 627,088.00
Total Indirect Costs	$ 39,017.00	$ 60,094.00	$ 82,003.00	$ 181,114.00
Total Costs	**$ 172,750.00**	**$ 268,204.00**	**$ 367,248.00**	**$ 808,202.00**

Direct Costs

Human Resources	*FTE*	*Base Salary*	*Year 1 Salary*	*Year 2 Salary (2% increase)*	*Year 3 Salary (2% increase)*	*Total*
Program director	1.0	$ 62,019.00	$ 62,019.00	$ 63,260.00	$ 64,526.00	$ 189,805.00
Program facilitator	1.0	$ 10,000.00	$ 10,000.00	$ 10,200.00	$ 10,404.00	$ 30,604.00
Program facilitator	1.0	$ 10,000.00		$ 10,200.00	$ 10,404.00	$ 20,604.00
Program facilitator	1.0	$ 10,000.00			$ 10,404.00	$ 10,404.00
Social Worker	1.0	$ 56,284.00	$ 56,284.00	$ 57,410.00	$ 58,559.00	$ 172,253.00
Social Worker	1.0	$ 56,284.00		$ 57,410.00	$ 58,559.00	$ 115,969.00
Social Worker	1.0	$ 56,284.00			$ 58,559.00	$ 58,559.00
Salary Subtotal			**$ 128,303.00**	**$ 198,480.00**	**$ 271,415.00**	**$ 598,198.00**

Other Direct Costs	*Unit Cost*	*Year 1 Total*	*Year 2 Total*	*Year 3 Total*	*Total*
Caregiver educational materials	$ 10.00	$ 1,000.00	$ 2,000.00	$ 3,000.00	$ 6,000.00
Concessions for sessions	$ 4.00	$ 3,200.00	$ 6,400.00	$ 9,600.00	$ 19,200.00
Training materials	$ 15.00	$ 30.00	$ 30.00	$ 30.00	$ 90.00
Professional staff training session	$ 600.00	$ 1,200.00	$ 1,200.00	$ 1,200.00	$ 3,600.00
Childcare staff	in-kind	in-kind	in-kind	in-kind	in-kind
Family Incentives	in-kind	in-kind	in-kind	in-kind	in-kind
Other Direct Costs Subtotal		**$ 5,430.00**	**$ 9,630.00**	**$ 13,830.00**	**$ 28,890.00**
Total Direct Costs		**$ 133,733.00**	**$ 208,110.00**	**$ 285,245.00**	**$ 627,088.00**

Indirect Costs

Human Resources	*FTE*	*Base Salary*	*Year 1- 30% Fringe*	*Year 2- 30% Fringe*	*Year 3- 30% Fringe*	*Total*
Program director	1.0	$ 62,019.00	$ 18,606.00	$ 18,978.00	$ 19,358.00	$ 56,942.00
Program facilitator	1.0	$ 10,000.00	$ 3,000.00	$ 3,060.00	$ 3,122.00	$ 9,182.00
Program facilitator	1.0	$ 10,000.00		$ 3,060.00	$ 3,122.00	$ 6,182.00
Program facilitator	1.0	$ 10,000.00			$ 3,122.00	$ 3,122.00
Social Worker	1.0	$ 56,284.00	$ 16,886.00	$ 17,223.00	$ 17,568.00	$ 51,677.00
Social Worker	1.0	$ 56,284.00		$ 17,223.00	$ 17,568.00	$ 34,791.00
Social Worker	1.0	$ 56,284.00			$ 17,568.00	$ 17,568.00
Fringe Benefits Subtotal			**$ 38,492.00**	**$ 59,544.00**	**$ 81,428.00**	**$ 179,464.00**

Other Indirect Costs	*Unit Cost*	*Year 1 Total*	*Year 2 Total*	*Year 3 Total*	*Total*
Marketing and communication	varies	$ 500.00	$ 500.00	$ 500.00	$ 1,500.00
Office supplies	$ 25.00	$ 25.00	$ 50.00	$ 75.00	$ 150.00
Facility rental	in-kind	in-kind	in-kind	in-kind	in-kind
Other Indirect Costs Subtotal		**$ 525.00**	**$ 550.00**	**$ 575.00**	**$ 1,650.00**
Total Indirect Costs		**$ 39,017.00**	**$ 60,094.00**	**$ 82,003.00**	**$ 181,114.00**

MISHKA PEART'S POLICY PITCH

Good evening legislators and thank you for allowing me to speak during tonight's meeting. My name is Mishka Peart, and I am here representing the American Academy of Pediatrics (AAP). I come before you today asking for your support of House Bill 246—a federal policy which, if approved, would ban corporal punishment in homes, daycares, and alternative care settings.

Corporal punishment is a harmful and ineffective way to correct undesirable behavior, and this is recognized globally. The United States is the only country that has not ratified the United Nations' Convention of the Rights of the Child. The convention states that all parties "have the obligation to prohibit and eliminate all physical violence against children in all settings including the home" (Future Policy, 2021). Children who experience corporal punishment are more likely to suffer from mental health disorders such as anxiety, depression, and post-traumatic stress disorder (Sege, 2018). They are also at higher risk for cognitive issues and learning disorders (Sege, 2018). Corporal punishment also leads to increased aggression among children both at home and school, and negative family dynamics. Children are vulnerable to injury, particularly those under the age of 18 months, or those experiencing increasing severity of punishments (Sege, 2018). Research has previously shown that within ten minutes of punishment, 73% of children had resumed the offending behavior, demonstrating how ineffective corporal punishment really is (Sege, 2018). Almost sixty countries have implemented corporal punishment bans, to date. Among countries with a ban, researchers found a 69% reduction in violent crime among males and a 42% reduction among females (Elgar, et al., 2018).

As a representative of the largest organization of child health providers, I implore you to support House Bill 246 and implement a national ban on corporal punishment. The risks of corporal punishment far outweigh any benefit, and it does not contribute to the health, safety, or resiliency of our children. It is time for the United States to stand with the global community and reject corporal punishment.

Thank you for your time, and I am happy to answer any questions that you may have.

MISHKA PEART'S POLICY FACT SHEET

SUPPORT HB 246

Federal ban on corporal punishment in homes, daycares, and alternative care settings‡

CORPORAL PUNISHMENT HAS NO PLACE IN THE LIVES OF RESILIENT CHILDREN

Children who experience corporal punishment are more likely to[1]:

- Suffer from mental health disorders and cognitive issues
- Display more aggressive behaviors
- Experience physical injury from punishments

Corporal punishment is not safe or effective[2]

National corporal punishment bans are linked to a reduction in youth violence [3]

FOR MORE INFORMATION CONTACT:

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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‡Examples of alternative care settings include group homes, foster cares, and shelters

1 Sege, R. D. (2018, November 5). AAP policy opposes corporal punishment, draws on recent evidence. Retrieved from AAP News : https://www.aappublications.org/news/2018/11/05/discipline110518

2 Sege, R. D., & Siegel, B. S. (2018). Effective Discipline to Raise Healthy Children. *Pediatrics*, 2018-3112

3 Elgar, F. J., Donnelly, P. D., Michaelson, V., Gariepy, G., Riehm, K. E., Walsh, S. D., & Pickett, W. (2018). Corporal punishment bans and physical fighting in adolescents: an ecological study of 88 countries. British Medical Journal- Open Access, 1-8.

MISHKA PEART'S INDIVIDUAL APPENDICES
APPENDIX 1- PROBLEM STATEMENT TABLES AND FIGURES

Cumberland County and North Carolina Demographics, 2019

	Cumberland County	North Carolina
Population	335,509	10,488,084
Population growth/loss since 2010 (%)	+5	+10
Race/Ethnicity (%)		
White alone	51.1	70.6
Black alone	39.1	22.2
Two or more races	4.8	2.3
Hispanic/Latinx	12.1	9.8
Age (%)		
Persons under 5 years	7.5	5.8
Persons under 18 years	24.7	21.9

Table 1*. Cumberland county and North Carolina Demographics, obtained from 2019 U.S. Census data (United States Census Bureau, 2020).*

Percent Distribution of Violent Crime Arrests in the United States by Race, 2017

	Black	White
Murder/manslaughter	53.1	44.2
Rape	28.7	67.5
Robbery	54.3	43.6
Aggravated assault	33.5	62.1
Overall violent crime	37.5	58.5

Table 2. *National data of violent crimes by race, obtained from Federal Bureau of Investigation Uniform Crime Reporting (Criminal Justice Information Services Division, 2018).*

Child Abuse Rates in Cumberland and Health ENC* Counties and North Carolina (2014 – 2017)

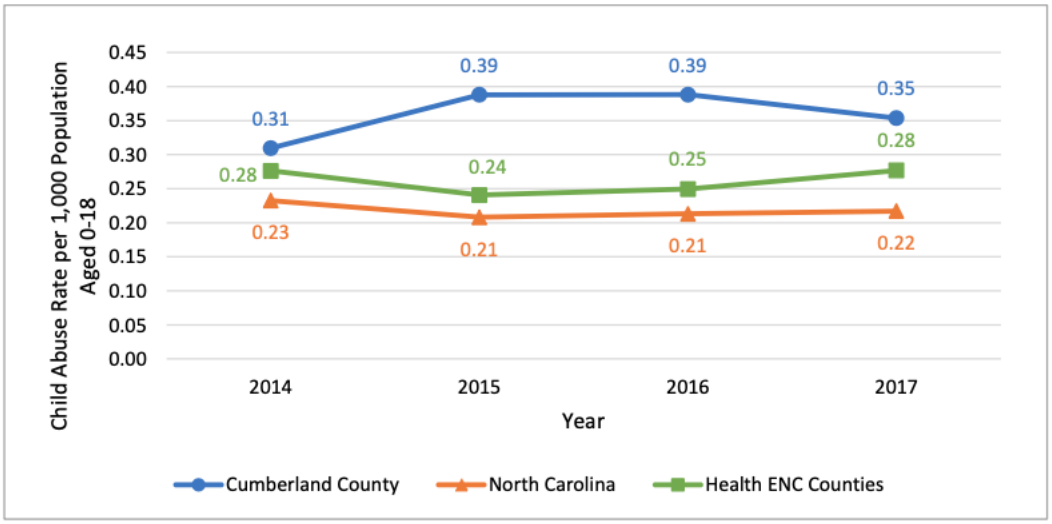


Figure 3. *Child abuse rates per 1,000 children between the ages of 0 – 18 years-old in Cumberland county, Health ENC counties, and North Carolina between 2014 – 2017. *Health ENC counties is a regional program that comprises 33 counties in eastern North Carolina (ENC), including Cumberland county. Adopted from the 2019 Cumberland County Health Needs Assessment (Cumberland County Public Health Department, 2019).*

Child Maltreatment Rates in Cumberland County and North Carolina, 2017

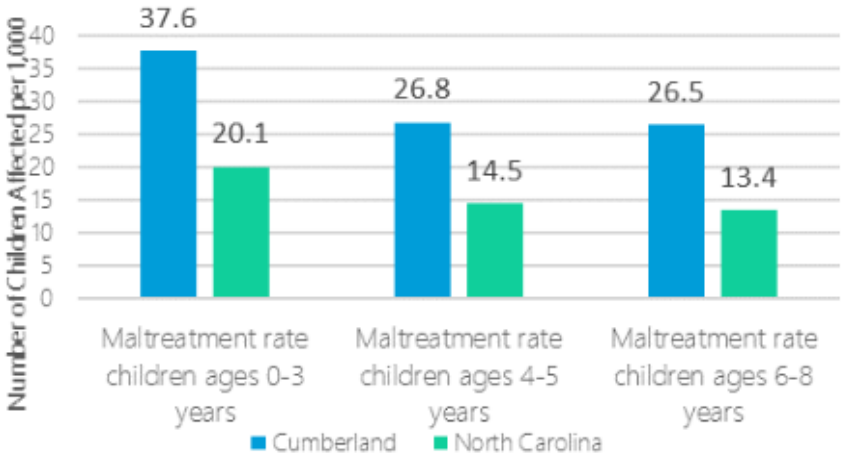


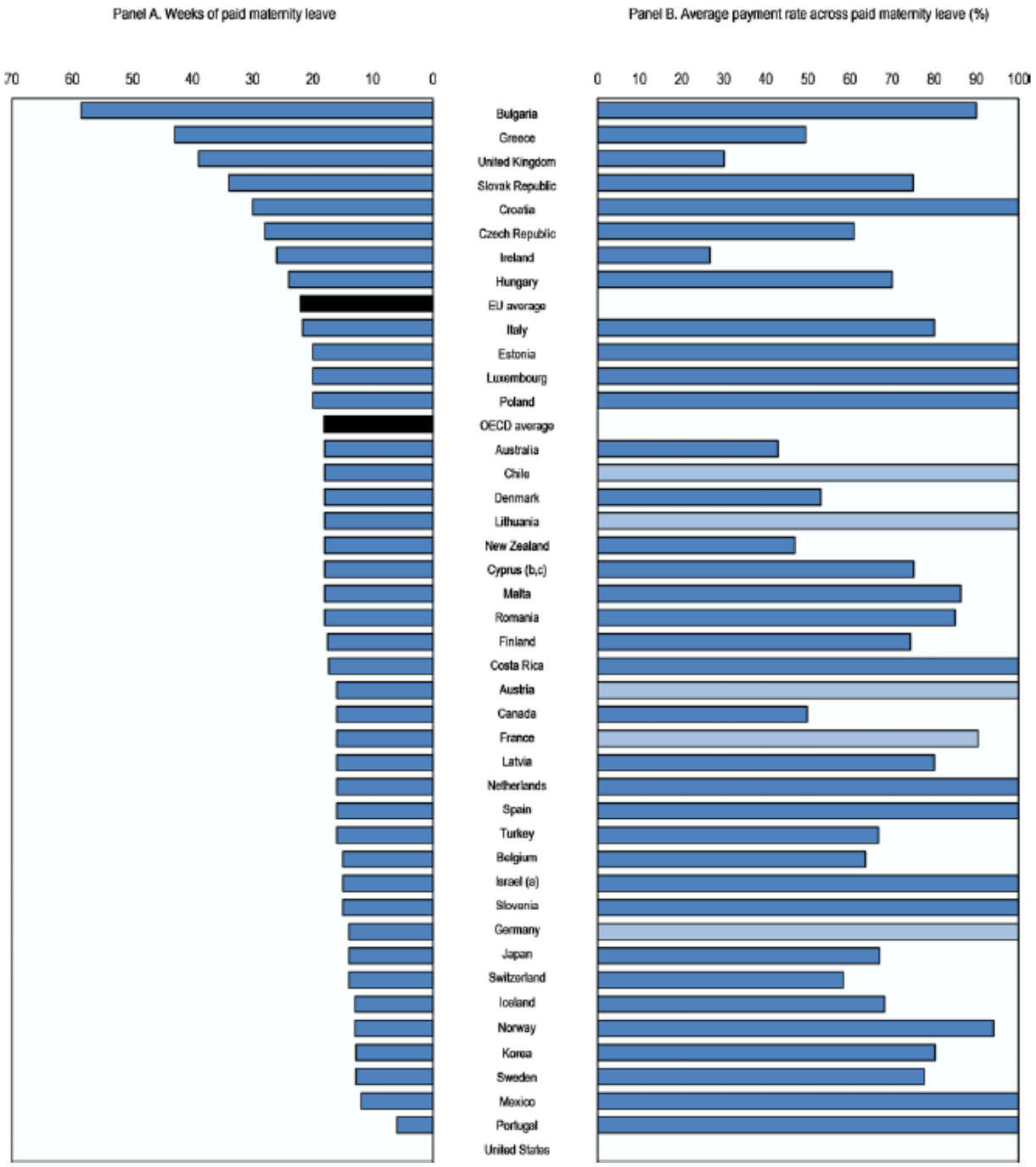
Figure 4. *Child maltreatment rates by age per 1,000 children in North Carolina and Cumberland county. Adopted from the 2019 State of the County Health Report (Green, 2020).*

Frequency of adverse childhood experiences (ACEs) stratified by race, (%)

	Hispanic	**Non-Hispanic Black**	**Non-Hispanic White**
Victim/witness of violence	0.74	1.63	0.94
Domestic Violence	1.13	0.66	0.23
Parent served time in jail	1.09	0.75	0.22
2+ ACES reported	1.52	1.06	0.39

Table 3. *ACEs among children by race. Data obtained from Slopen, et al (2016) which summarized responses of 84,837 children who responded to the National Survey of Child Health. Data is statistically significant at the $p < 0.05$ level.*

Appendix 2- Duration of Paid Maternity Leave and the Average Payment Rate Across Paid Maternity Leave for an Individual on National Average Earnings, 2018

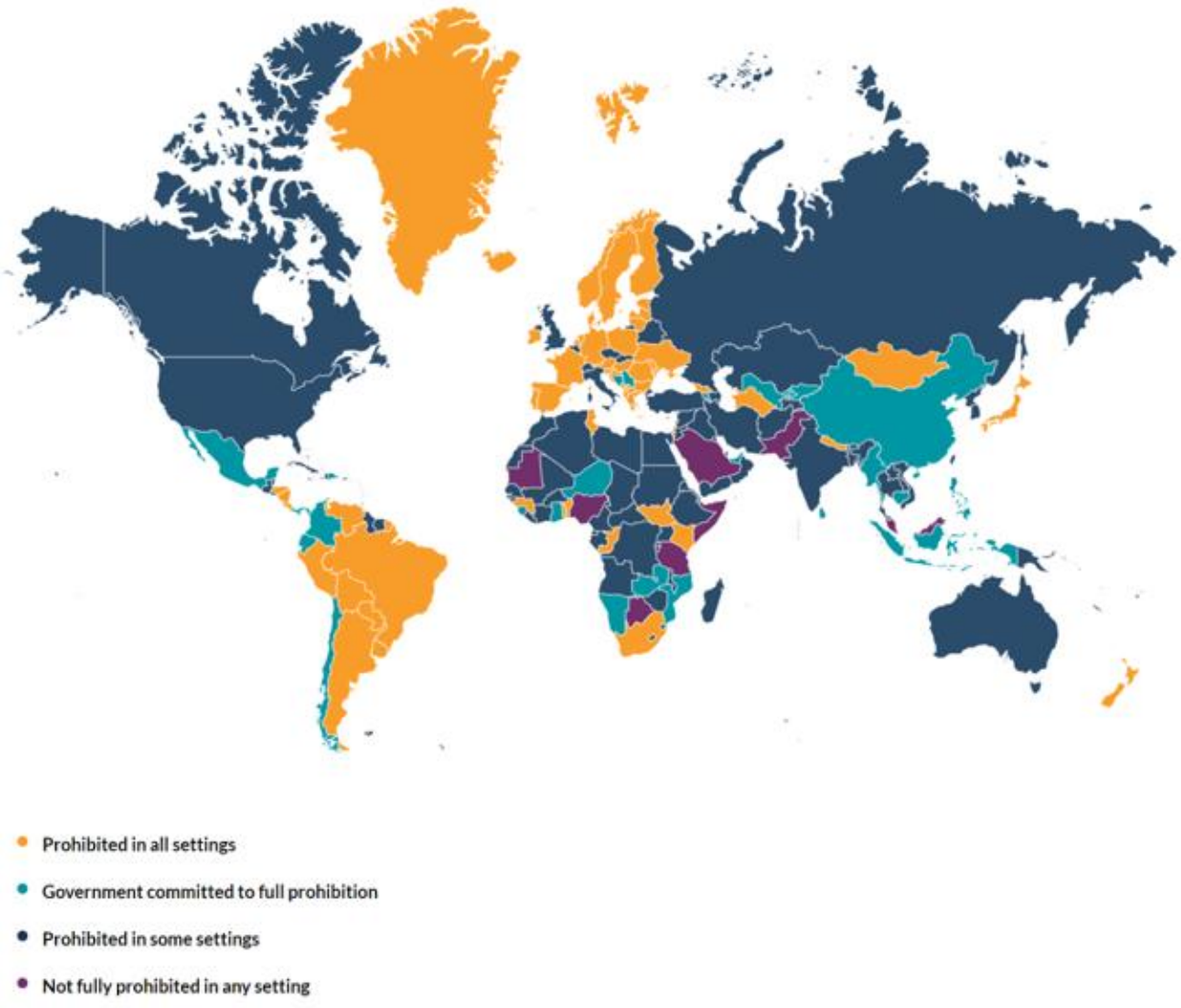


Adapted from OECD (2019), OECD Family Database, www.oecd.org/els/family/database.htm. Light blue bars indicate that payment rates are based on net earnings (post income tax and social security contributions). In some countries, parental benefits may be subject to taxation and may count towards the income base for social security contributions.

APPENDIX 3- POLICY OPTIONS EVALUATION MATRIX

Policy Option	Cost to the federal government	Impact	Political Feasibility	Acceptability to constituents	Score *(out of 20 possible points)*
Federal policy requiring paid parental leave at 100% equivalence for a duration of 12 weeks	2	4	2	4	12
Federal ban on the use of corporal punishment at home, daycares, and alternative care settings	**5**	**5**	**3**	**4**	**17**

APPENDIX 4- GLOBAL STATUS OF CORPORAL PUNISHMENT



Adapted from End Violence Against Children (https://endcorporalpunishment.org/global-progress)

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