Georgia Action Plan for Child Injury Prevention

An Agenda to Prevent Injuries and Injury-related Fatalities among Children in Georgia

The Georgia Action Plan for Child Injury Prevention is developed by the Child Injury Prevention Plan Workgroup, and supported and monitored by the Georgia Child Fatality Review Panel.

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May 2015

May 11, 2015

Honorable Nathan Deal and Members of the Georgia General Assembly:

It is my sincere honor to present to you the 2015 Georgia Action Plan for Child Injury Prevention. This plan summarizes and provides the framework for reducing the number of unintentional injuries, the leading cause of death among children ages 1 to 19 years.

In 2006, a subcommittee of the Child Fatality Review Panel, the Child Injury Prevention Planning (CIPP) workgroup, was tasked with developing the Framework for Child Injury Prevention. Members of the CIPP worked with key agencies and organizations that provided services to children, and in 2008, the first Framework was published and disseminated throughout the state. Georgia's was the first Framework for Child Injury Prevention in the nation, and has been used as a model by other states.

The 2015 Action Plan is an updated, comprehensive plan which reflects new and emerging trends in injury prevention and evidence-based best practices to aid state and local agencies, organizations, community groups and policymakers in educating families and caregivers.

The Panel and I appreciate your time in reviewing this Plan and for the support you have provided to us as we continue our efforts to protect the lives of Georgia's children.

Sincerely,

Judge C. LaTain Kell, Chair
Georgia Child Fatality Review Panel

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EXECUTIVE SUMMARY

Introduction

Injuries and violence affect everyone, regardless of age, race, or economic status. For Americans 1 to 44 years of age, injuries are the number-one killer. In fact, people in that age group are more likely to die from an injury—such as a motor vehicle crash, fall, or homicide—than from any other cause, including cancer, HIV, or the flu. The consequences of injuries can be extensive and wide ranging. Injuries have physical, emotional, and financial consequences that can impact the lives of individuals, their families, and society. Some injuries can result in temporary or long-term disability. Injuries also place an enormous burden on hospital emergency departments and trauma care systems, accounting for approximately one third of all emergency department visits and 8% of all hospital stays.

Childhood unintentional injuries are the leading cause of death among children ages 1 to 19 years in the United States, representing nearly 40 percent of all deaths in this age group. Each year, an estimated 8.7 million children and teens from birth to age 19 are treated in emergency departments for unintentional injuries and more than 9,000 die as a result of their injuries—one every hour. Common causes of fatal and nonfatal unintentional childhood injuries include: drowning, falls, fires or burns, poisoning, suffocation, and transportation-related injuries. Injuries claim the lives of 25 children every day. While tragic, many of these injuries are predictable and preventable. Diverse segments of society are involved in addressing preventable injuries to children; with this Action Plan, Georgia is providing a unified set of goals, strategies, and actions to help guide a coordinated statewide effort.

Burden

Injuries are the leading cause of death among children in Georgia. An average of 3,311 children is treated in hospitals each year in Georgia, and an average of 420 die from sleep-related circumstances and injuries. This is equivalent to losing 23 kindergarten classrooms of children each year! Like diseases, injuries do not strike randomly. Males are at higher risk than females. Infants are injured most often by suffocation. Toddlers most frequently drown. As children age, they become more vulnerable to traffic injuries. Motor vehicle injuries dominate among teens. Poverty, crowding, young maternal age, single parent households, and low maternal educational status all increase risk and make children more vulnerable to injury. Nationally, death rates are highest for American Indians and Alaska Natives and

lowest for Asians or Pacific Islanders. States with the lowest injury rates are in the northeastern part of the United States.

In Georgia, the average child death rate due to injuries between 2009 and 2013 is 12.5. The death rate due to injuries is higher among African-Americans (rate: 15.3) compared to White non-Hispanics (rate: 13.0) and Hispanics (rate: 6.6). Among rural counties, the average injury death rate is 16.6, and the highest child injury death rates are in Brantley (rate: 33.3), Emanuel (rate: 38.4), Heard (rate: 48.0), McIntosh (rate: 34.2), Pierce (rate: 45.2), and Wilcox (rate: 56.6). Among non-rural counties, the average injury death rate is 11.7, and the highest rates are in Coffee (rate: 25.5), Effingham (rate: 25.7), and Jackson (rate: 24.0).

Framework

One framework for reducing childhood injuries is based on the public health model – a model that is used for preventing many other diseases. The public health approach includes identifying the magnitude of the problem through surveillance and data collection, identifying risk and protective factors, and, on the basis of this information, developing, implementing, and evaluating interventions, and promoting widespread adoption of evidence-based practices and policies. Interventions can be implemented during various time frames before, during, or after an adverse event. For example, safety latches on medicine cabinets provide protection before an injury event, child safety seats minimize injury during the injury-causing event, and effective emergency response speeds treatment and improves outcomes after an injury event has occurred.

The Georgia Action Plan for Child Injury Prevention provides a full framework for each of the most significant injury issues affecting Georgia's children.

- o The background of the problem
- o Risk factors and vulnerable populations
- o Benchmarks and Healthy People 2020 goals, if available
- o Relevant data and surveillance findings
- o Opportunities for policy and prevention at the local and statewide level

Improvements within each domain are also recommended. In particular, improvements to surveillance and data collection will lead to more accurate needs assessments, enhanced data quality (that is

reliable and believable), better decision making, increased effectiveness (doing what works), and efficiency (avoiding waste). Information systems and surveillance programs should make existing data available to those who can use it and share it to support interventions.

The framework of the Action Plan allows for all interested parties – state and local agencies, philanthropies, businesses, schools, educators, health care providers, and policymakers – to align priorities, capitalize on existing strengths, address needs and gaps, and coordinate resources to the ultimate goal of reducing injuries and injury-related deaths to children. Prevention opportunities presented within the Action Plan reference feasible evidence-based strategies and best practices when possible. A coordinated, consistent message is desirable for ensuring all of Georgia's families receive the information that will help them choose safety for their children and loved ones.

GOALS

For Researchers and University Partners

For more than four decades, the scientific study of childhood injuries has paid rich dividends. Effective interventions such as bike helmets, four-sided pool fencing, booster seats, smoke alarms, concussion guidelines, and teen driving policies have already saved many lives. Additional research to improve our prevention efforts will be required to further drive down child injury rates and is needed at three different levels: 1) foundational research (how injuries occur), 2) evaluative research (what works and what doesn't work to prevent injuries), and 3) translational research (how to put proven injury prevention strategies into action throughout the nation). Because research is a shared public, academic, and private endeavor, better coordination of research efforts will minimize waste and maximize return. Research can also help reduce health disparities through better understanding of the relationship between injuries and factors such as socioeconomic status, demographics, race and ethnicity.

For Communities, Agencies, and Organizations

Raising awareness about childhood injuries is important at multiple levels. It can often trigger action, or support policies intended to reduce injuries. Better communication will better inform the actions by policy makers (enacting legislation to protect children), organizations (approaching injury prevention in a coordinated way), and by families (implementing evidence-based injury prevention strategies at home, on the road, on the playground, and in the community). A balanced, coordinated communication strategy must be audience-specific and culturally appropriate, and use both traditional and innovative channels ranging from public relations campaigns to social media. Today more than ever, messages must be concise and relevant, and the messengers must be knowledgeable, credible, and relatable. Various strategies can be used to deliver health messages to specific audiences, utilizing the talents of various injury partners. Some of the actions include:

- o Creating and implementing local and national campaigns on child safety
- o Establishing web-based communications tool kits
- o Finding local young people to be spokespersons for prevention
- o Using local businesses to support communication efforts to employees and their families

For Health Care Providers

Health care providers treat injuries, but they are also partners in prevention through health care systems. While responding to and treating trauma, health care providers are critical for accurately documenting external causes of injuries and circumstances. Beyond the clinical setting, health care providers are credible advocates for child safety and can facilitate change in communities and families. Health care systems can address child injury by providing anticipatory guidance to health care providers and collecting clinical data. Trends and changes to health care delivery models, including adoption of electronic medical records, the medical home model, and quality improvement efforts should all be utilized to augment injury reduction goals and objectives by improving data collection while also ensuring quality and continuity of medical care for children. Best practices for delivery of preventive services should be identified and disseminated. Furthermore, opportunities exist for new technologies and information systems to improve injury outcomes. Information systems can equip providers with evidence-based data and protocols to strengthen the quality of clinical decision-making and improve trauma care. Some of the actions suggested include incorporating child injury risk assessment into home visitation programs, creating injury prevention quality measures that apply to the medical home, and using linked data systems to improve treatment decisions.

For Policymakers

The policy arena is important because it is system-based, affecting populations by changing the context in which individuals take actions and make decisions. Historically, policies regarding safe environments and products (swimming pool fences and safe cribs) and safe behaviors (sober driving and bike helmets) have changed norms in communities and nationally, leading to a reduction in injuries and injury-related deaths. Policy includes aspects of law, regulation, or administrative action and can be an effective tool for governments and nongovernmental organizations to change systems with the goal of improving child safety. The Georgia Action Plan informs policymakers about the value of adopting and implementing evidence-based policies. It calls for better compliance and enforcement of existing policies to protect children, such as car seats or four-sided pool fencing where these policies exist. The Georgia Action Plan underscores the importance of documenting and disseminating the effective and cost-saving policies at the broadest level. Some of the actions include developing statewide leadership training in policy analysis for child injury prevention, documenting successful policies that save lives and prevent injuries to

children, and supporting state capacity building for implementing policy-oriented solutions that reduce childhood injuries.

Conclusion

The successful implementation of the Georgia Action Plan will require bold actions, effective leadership, and strong partnerships. We cannot afford to wait any longer. Child injuries are preventable, and improvements in the safety of children and adolescents can be achieved if there is an effort by various stakeholders to adopt and promote known, effective interventions—strategies that can save lives and money.

BACKGROUND AND HISTORY

The mission of the Georgia Child Fatality Review Panel is to provide the highest quality child fatality data, training, technical assistance, investigative support services, and resources to any entity dedicated to the well-being and safety of children in order to prevent and reduce incidents of child abuse and fatality in the state. This mission is accomplished by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse and child fatalities, and developing and monitoring the statewide child injury prevention plan.

In 2006, the Child Fatality Review panel partnered with the Injury Prevention Section of the Georgia Division of Public Health to lead the process of developing the Framework for Child Injury Prevention. Development of the Framework fell under the direction of the Child Injury Prevention Planning workgroup (CIPP), a subcommittee of the Child Fatality Review Panel. Members of the CIPP represented key agencies and organizations that provided services to children. The first Framework was published in 2008, and disseminated throughout the state. It became the first Framework for Child Injury Prevention in the nation, and has been used as a model by other states. This is the revision document, updated to reflect new and emerging trends in injury and evidence-based best practices for prevention. Again, the members of the CIPP led the effort and worked diligently for more than a year to research, develop, and review the content for this Action Plan. Through their efforts, the state of Georgia now has a comprehensive Action Plan for state and local agencies, organizations, community groups, and policymakers to use in reducing injuries – the leading cause of death for children.

SLEEP RELATED INFANT DEATHS

DEFINITIONS:

- **SUID:** Sudden unexplained infant death: cases for which, after investigation, risk factors are identified that *could have* contributed to the death, but are not conclusive to have *caused* the death
- **Sleep-related Asphyxia:** Infant death with forensic evidence of:
  - Suffocation
  - Overlaying (rolling on top of or against baby while sleeping)
  - Wedging or entrapment between mattress, wall, bed frame or furniture
  - Positional asphyxia
- **SIDS:** Sudden Infant Death Syndrome: after a thorough case investigation – including a death scene investigation, complete autopsy, and review of medical history – the cause of death remains unknown
- **Sleep-related Medical Death:** When an infant has a serious medical condition but was also placed in an unsafe environment, which exacerbated the medical issues and contributed to the death.

RISK FACTORS

Infant Risk Factors

- Prematurity
- Prone or side sleeping position
- Recent febrile illness
- Exposure to tobacco smoke
- Soft sleeping surface, soft bedding
- Thermal stress/overheating
- Sharing bed with parents or siblings

Maternal Risk Factors

- Smoking
- Alcohol use
- Illegal drug use
- Inadequate prenatal care
- Younger maternal age
- Low socioeconomic status
- Short interval between pregnancies

Each year in the United States, about 4,000 infants die suddenly due to no immediately obvious cause. Among infants one to twelve months old, the leading causes for death are sleep-related.

According to the Georgia Pregnancy Risk Assessment and Monitoring System (PRAMS) survey, which is a state-wide survey of mothers with young infants, from 2006 to 2011, 80.9% of African-American mothers and 53.6% of White mothers reported sharing a bed with their infants. Regarding sleep position, 51.9% of African-American mothers and 36.3% of White mothers reported placing their infants non-supine to sleep (Salm Ward, n.d). Both of these behaviors place infants at a much higher risk of sleep-related infant death. It is clear that prevention efforts are needed to decrease infant deaths.

Figure 1: Sleep Related Deaths with Reported Bed Sharing, by Position when Found, GA, 2013 (n=72)
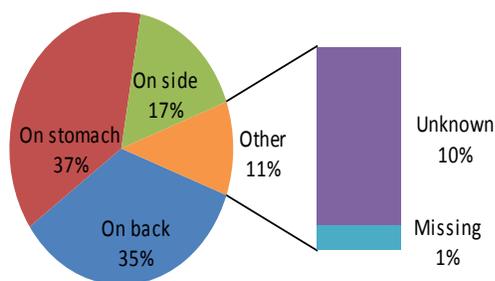
Of all 2013 Sleep-related Deaths reviewed by the Georgia Child Fatality Review Panel, it was found that approximately 59% were reported as sleeping in an unsafe position, whether on the side or on the stomach.

Number of Deaths by position

- On Back: 42
- On Stomach: 66
- On Side: 16
- Unknown: 14
- Missing: 1

SAFE SLEEP RESOURCES

National Action Partnership to Promote Safe Sleep, http://www.nappss.org/ includes safe sleep resources as well as information about promising practices and evidence-based interventions to increase infant sleep safety.

Safe to Sleep Campaign, National Institute for Child Health and Human Development, www.nichd.nih.gov/sts/ maintains free materials to launch a local safe sleep education campaign, including informational materials for health care providers regarding how to answer parents' questions about infant sleep, a safe sleep curriculum for nurses, parent materials such as culturally-tailored brochures, door hangers, and posters, and videos.

HEALTHY PEOPLE 2020 TARGET

- Increase the proportion of infants who are put to sleep on their backs in a safe sleep environment
- Baseline: 69.0% of infants were put to sleep on their backs in 2007
- Target: 75.9%

Top Five Locations for Sleep Related Deaths, GA, 2011-2013

■ Adult Bed   ■ Crib   ■ Couch   ■ Bassinette   ■ Carseat

2011: 80, 25, 19, 14, 2
2012: 85, 23, 16, 7, 2
2013: 65, 26, 14, 13, 6
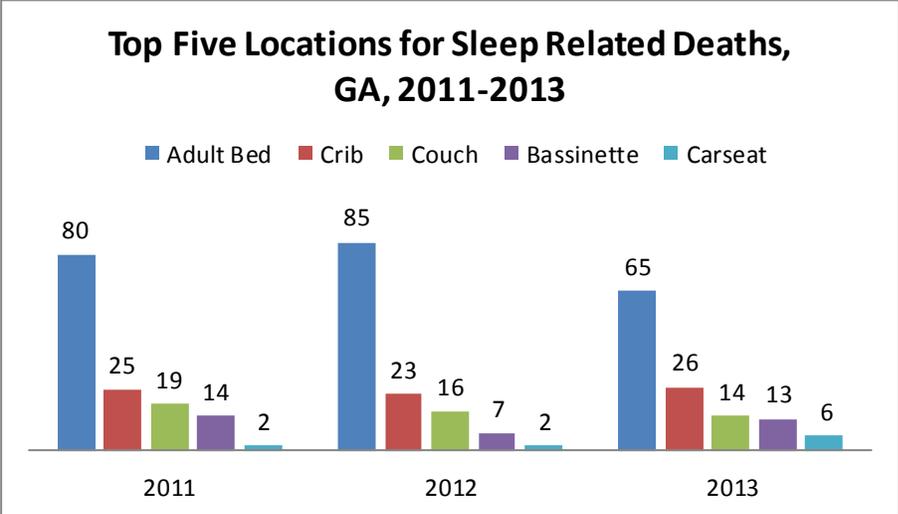
Sleep environment remains an issue in reviewed fatalities in Georgia. From 155 in 2011 to 139 in 2013, sleep related infant deaths have not shown a significant decrease and adult beds remain the top locations for those deaths in Georgia.

The most commonly identified themes on the barriers for following safe sleep recommendations against bed sharing and stomach sleeping, in peer reviewed literature are:

- **Better caregiver and infant sleep**

- **Convenience/comfort**

- **Familial tradition**

- **Perceived child safety/concerns of choking and,**

- **Parent and child emotional needs**

ORIENTATION OF THE TRACHEA TO THE ESOPHAGUS
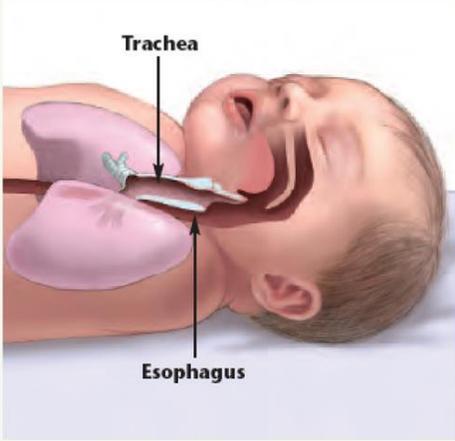
Figure 3.
Upper-Respiratory Anatomy: Baby in the Back Sleeping Position
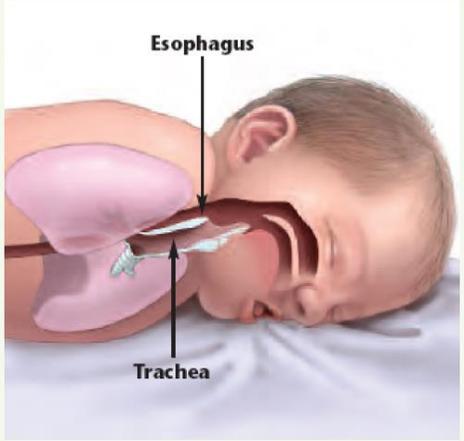
Figure 4.
Upper-Respiratory Anatomy: Baby in the Stomach Sleeping Position

Figure 3: Orientation of the Trachea to the Esophagus

Healthy babies naturally cough up or swallow fluids to make sure their airway is kept clear. In the back sleep position, the trachea is on top of the esophagus and babies may clear such fluids better when on their backs. When the baby is sleeping on its stomach, such fluids will exit the esophagus and pool at the opening for the trachea, making choking more likely.

Action Plan and Recommendations

FOR PARENTS

Sleep Position
- <u>Always</u> put the baby on his or her back for sleep time.
- Studies have shown that babies who sleep on their stomach are at a higher risk for sleep-related infant deaths than babies who sleep on their backs.

Sleep Environment
- Avoid placing soft materials in the infant's sleep environment, over, under or near the infant. This includes pillows, bumper pads, comforters, quilts, and stuffed animals. These items may increase the risk of suffocation or strangulation.
- Why not bumper pads? Because they may cause serious injury and death. Keeping them out of the baby's sleep area is the best way to avoid these dangers.
- Always use a firm sleep surface. Car seats and other sitting devices are not recommended for routine sleep; children who sleep on a soft surface, such as a quilt, or a soft blanket are at a greater risk of dying of sleep-related causes.
- Avoid overheating or over bundling. A one-piece sleeper or sleep sack can be used for sleep clothing. If you notice baby sweating or breathing rapidly, he or she may be too warm.

Room Sharing without Bed Sharing

The baby should sleep in the same room as the parents – this helps to reduce the risk of sleep-related causes of infant deaths. However, the baby should not sleep in the same bed as the caregivers.

Pregnant Women

Pregnant women should receive preconception and interconception care and should begin prenatal care within the first trimester and regularly throughout the pregnancy.
- Women should not drink alcohol or smoke during pregnancy and infants should not be exposed to secondhand smoke.
- Breastfeed your baby; breastfeeding has many health benefits for both mother and child.

Tummy Time
- Supervised awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (head flattening).
- Tummy time also helps the baby's neck, shoulder and arm muscles get stronger.

Other Recommendations for Parents

- Talk about safe sleep practices with everyone who cares for your baby.
- Do not use home cardiorespiratory monitors as a strategy for reducing the risk of sleep-related infant deaths; there is no evidence that these monitors decrease the incidence sleep-related infant deaths.
- Follow health care provider guidance on your baby's vaccines and regular health checkups.

Action Plan and Recommendations

Statewide

Expand the state campaign to include a major focus on the safe sleep environment and ways to reduce the risks of all related infant deaths, including sleep-related infant death, suffocation, and other accidental deaths

Regulation of the advertisement and sales of sleep devices and bedding for infant cribs to meet safety requirements.

Continue research and surveillance on the risk factors, causes, and pathophysiological mechanism of sleep-related infant death and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths entirely.

Childcare Providers and Media

There are many misconceptions about proper sleep environment for infants. Practitioners should address the concerns of parents and common myths; for example, it is important to warn caregivers about the use of commercial devices such as co-sleepers which are marketed to reduce the risk of sleep-related death.

Health care professionals, staff in newborn nurseries and NICUs, DFCS workers, first responders, law enforcement, school social workers, CASA, Atty GAL, and other child care providers should endorse the sleep-related infant death risk-reduction recommendations from birth.

Appropriate infant sleep environments must also be enforced in the hospital if the infant is physically able to follow safe sleep guidelines.

Media and manufacturers should follow safe sleep guidelines in their messaging and advertising

Continue research and surveillance on the risk factors, causes, and pathophysiological mechanism of sleep-related infant death and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths entirely.

Model evidence-based practices

Action Plan and Recommendations

What Does a Safe Sleep Environment Look Like?

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby's sleep area is next to where parents sleep.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

Action Plan and Recommendations

Adopt a "No Missed Opportunity" Infant Safe Sleep Education Campaign

- Local and State Agencies that work with children and families:
- Implement and maintain funding for a coordinated and consistent infant safe sleep education campaign, including multiple strategies to inform and influence the behavior of all persons who care for infants, as well as their support persons
- Implement agency policy to standardize safe infant sleep training for all staff that work with children and families.
- Address the barriers to maintaining a safe infant sleep environment, such as the impact of poverty, affordable housing, and access to resources when designing services for high-risk families and infants
- Use presentations and other materials that are relevant and accessible to all cultures and populations with emphasis on the racial and income disparities that put infants at greater risk for sleep related deaths

Develop Enhanced Provider Outreach and Education

- Agencies that provide licensing and accreditation to health and human service providers:
- Require demonstrated core competencies in infant safe sleep for professionals who work in health care and other human service delivery fields, including:
  - Hospital personnel such as nurses, doctors, patient care assistants, midwives lactation consultants and all other personnel who interact with new parents
  - Home visiting program workers and prevention services personnel
  - Preconception care, prenatal care, pediatric and family care providers
  - Federally Qualified Health Centers and Primary Care Associations personnel
  - Post-secondary schools of medicine, nursing, social work, psychology, health education and health communication

Provide Support to Parents and Caregivers

- Policymakers should consider funding a 24-hour hotline for parents and caregivers to access when in need of information relating to safe infant sleeping. Parents who are frustrated with an infant's lack of sleep may resort to bed-sharing, physical violence or shaking; having a hotline readily available to support parents in soothing a crying, wakeful infant could reduce bed-sharing suffocations and injuries.
- Have emergency bassinets or cribs available for families that do not have the means of providing a safe sleep environment for their infant during the first critical months.

MALTREATMENT

Definition: Any act or series of acts of commission or omission by a parent, other caregiver, or another person in a custodial role that results in harm, potential for harm, or threat of harm to a child under the age of 18

According to Georgia law, child maltreatment includes the following acts:

🔶 Physical abuse or death
🔶 Sexual abuse or sexual exploitation
🔶 Neglect

RISK FACTORS

Victim

- Children under 4 years of age
- Special needs of the child that may increase burden on caregiver

Perpetrator

- Parent history of child maltreatment
- Substance abuse and/or mental health issues including depression in the family
- Unemployment and poverty
- Community and family violence
- Social isolation and lack of caregiver support
- Parent characteristics: young age, low education, single parenthood, large number of dependents in the family.

National Annual Costs Consequences of Child Abuse and Neglect, in Billions

Category	Costs in Billions
Mental health care	1.1
Hospitalization for serious injuries	6.6
Juvenile delinquency costs for abused offenders	7.2
Child welfare services	25
Law enforcement costs	33
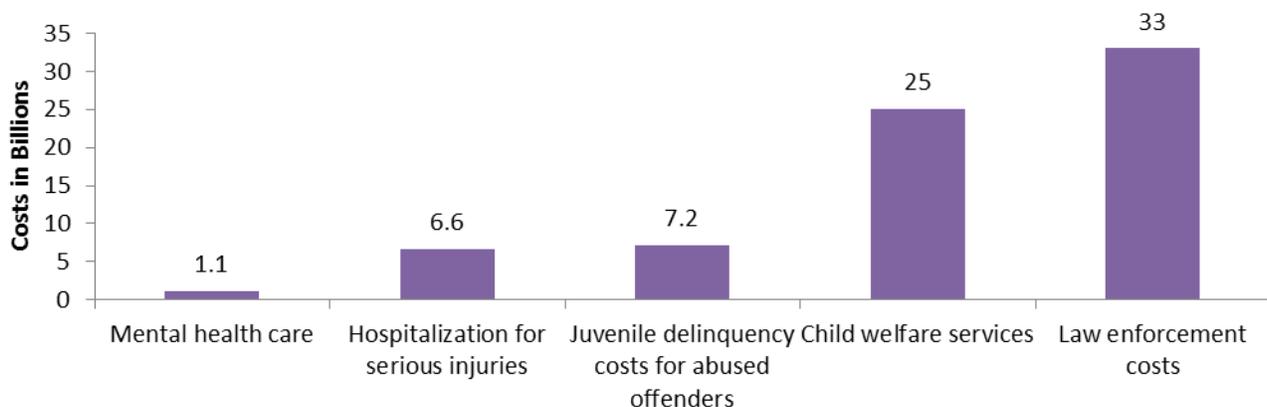
Long-Term Consequences of Child Maltreatment

The adverse consequences of child maltreatment affect all aspects of life, including physical and emotional health as well as social and economic wellbeing, and continue well after the maltreatment ends. The Adverse Childhood Experiences (ACE) Study links ACE to various risk factors that may lead to social and individual health consequences from conception to death. An ACE score is used to assess the total number of stresses a child experiences including child maltreatment; an increase in a child's ACE score is associated with a strong and graded increase in the following health behaviors/conditions: depression, elevated risk of intimate partner violence, chronic health problems, and suicide attempts.

The diagram below represents the conceptual framework for the study:
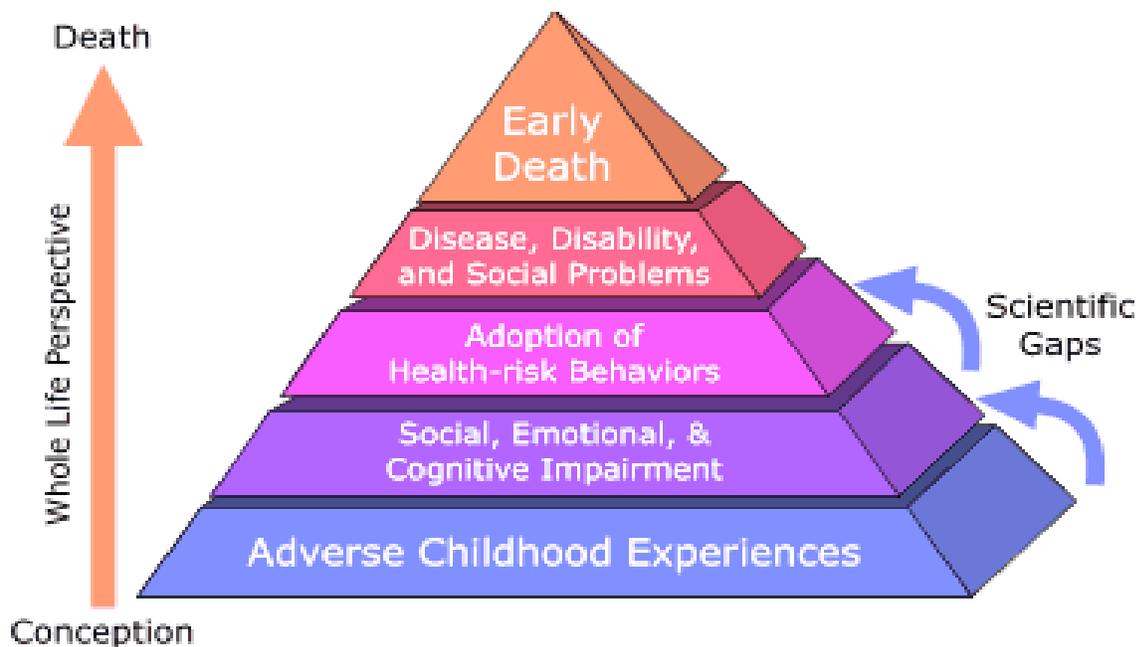
CDC Childhood Experiences (ACE) Study 2013

ACE in the form of abuse and neglect are linked to various outcomes, including:

- Mental health problems
- Early sexual activity
- Intimate partner violence
- Delinquency
- Chronic health problems - heart disease, diabetes, lung disease, hernias, ulcers, kidney and liver disease, as well as neurological disorders
- Substance Abuse
- Suicide Risks

Child Maltreatment Data and Statistics

Georgia Child Victim Rates from 2008 to 2012

	2008	2009	2010	2011	2012
Georgia Victimization Rates	10	9	8	7.5	7.5
National Victimization Rates	9.5	9.3	9.3	9.2	9.2

Healthy People 2020 Target: 8.5

Rate per 1000 Children
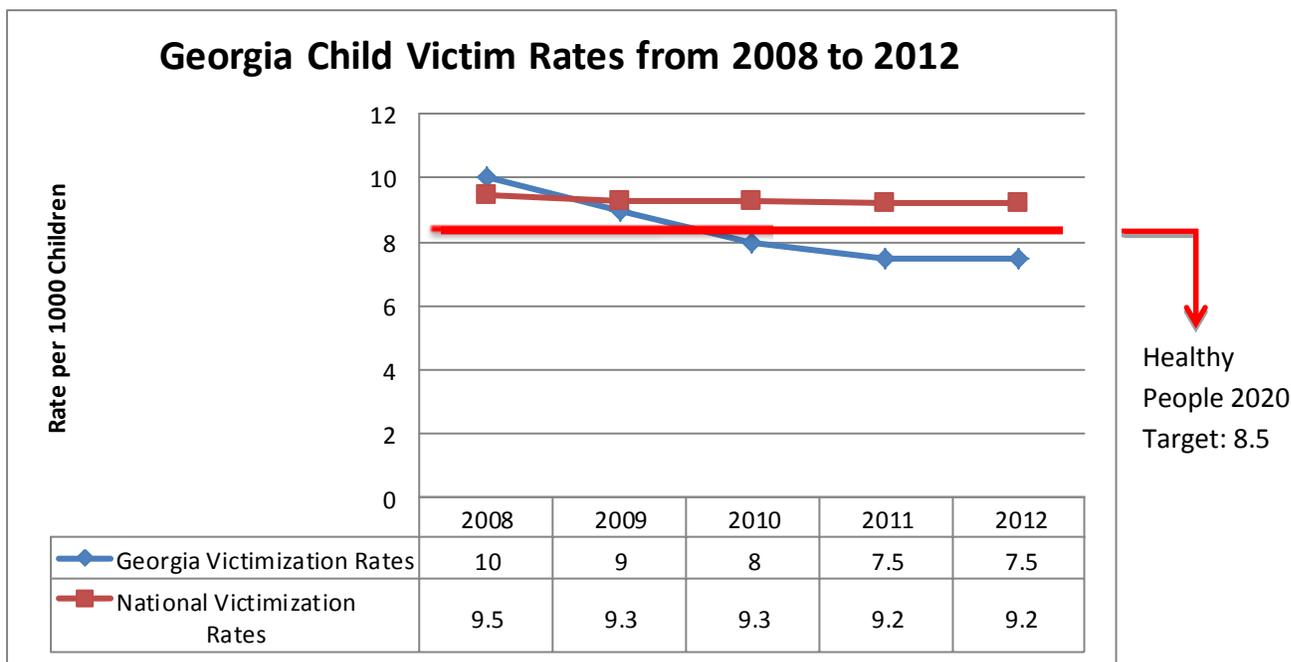
Georgia Child Victims, 2008-2012				
2008	2009	2010	2011	2012
25,716	23,249	19,976	18,541	18,572

The Healthy People 2020 target is to reduce nonfatal child maltreatment from 9.4 victims per 1,000 children under 18 (2008) to 8.5 victims per 1,000 children age 17 and under by 2012. According to the DHHS 2013 Maltreatment Report, Georgia victimization rates have decreased from 10 child victims per 1,000 children in 2008 to 7.5 per 1000 children in 2012. Therefore, Georgia child victimization rates have decreased, achieving the Healthy People 2020 target. The 2012 National rates are higher than the rates in Georgia, at 9.2 victims per 1000, but also show a decline from 2008.

While the Georgia rate of child victims from 2011 to 2012 stayed the same, at 7.5 per 1,000 children, there were fluctuations in fatality and type of abuse. From 2011 to 2012, there was a 7% increase in physical abuse, a 4% decrease in neglect, and 9% increase in fatality. While neglect decreased from 2011, it remains the most prevalent type of maltreatment in Georgia. In 2012, neglect represented 68.3% of all forms of maltreatment in Georgia, followed by psychological maltreatment (23.3%), physical abuse (13.6%), sexual abuse (5%), and medical neglect (4.5%). Additionally, the greatest numbers of victims in 2012 were under the age of 4 years old.

Georgia Risk Factors

Domestic violence, alcohol abuse, and drug abuse were risk factors associated with over half of the victimization cases reported for Georgia in 2012. The majority of reported victims were under the age of four (7,548 victims) and neglect was the top form of abuse in Georgia (68.3% of all reported cases).

Georgia's Victims According to Caregiver Risk Factors, 2012		
Risk Factor	**Number**	**Percent**
Domestic Violence	**6,814**	**36.3**
Alcohol Abuse	**598**	**3.2**
Drug Abuse	**3855**	**20.6**
This table shows the unique victims with a domestic violence, alcohol abuse, or drug abuse caregiver risk factors, as reported in the NCANDS 2012 maltreatment report. The percentages are calculated against the number of unique victims in Georgia (N = 18,752).		

THE COST OF CHILD MALTREATMENT IS ESTIMATED TO BE ABOUT $124 BILLION EACH YEAR IN THE UNITED STATES

Georgia Victims by Age, 2012

Age	Number
13 to 17	3391
9 to 12	3295
5 to 8	4489
Under 4	7548

Georgia Victims by Age, 2012

Types of Maltreatment in Georgia, 2012

Type	Percent
Sexual Abuse	5
Psychological Maltreatment	23.3
Physical Abuse	13.6
Neglect	68.3
Medical Neglect	4.5

Types of Maltreatment in Georgia, 2012 (Percents)
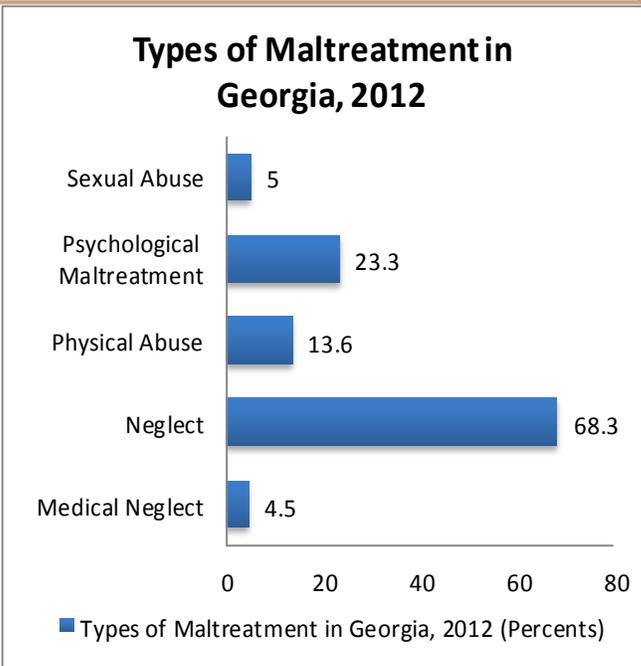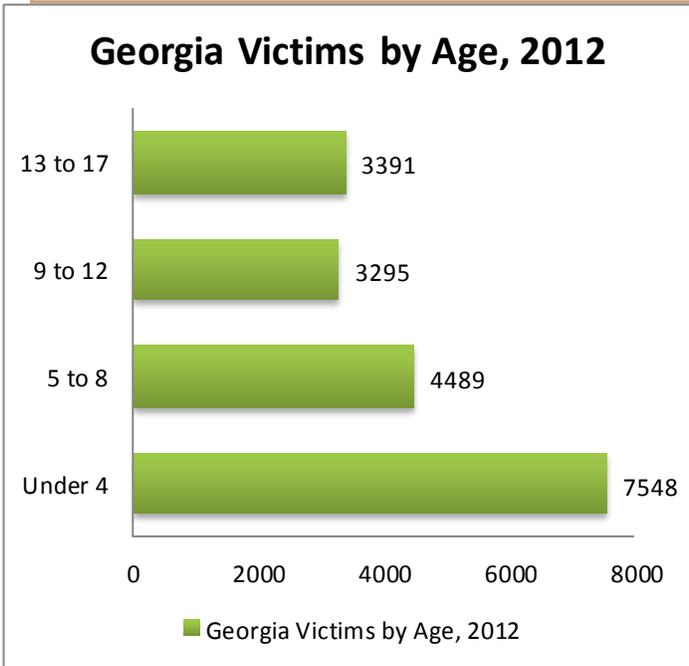
TOP STRATEGIES FOR CHILD MALTREATMENT PREVENTION

Early Intervention (Part C under IDEA)

System of services that helps babies and toddlers with developmental delays or disabilities. They focus on helping eligible babies and toddlers learn the basic and brand-new skills that typically develop during the first three years life. These services may include medical services, counseling and training for the child and family, psychological services, occupational therapy, speech therapy, and nutrition services (CPIR, 2014).

Evidence-Based Home Visitation Program

Evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to target the participant outcomes which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits. Home visitation services may also target other outcomes such as improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

Parent Education Programs

Programs focused on enhancing parenting practices and behaviors, such as developing and practicing positive discipline techniques, learning age-appropriate child development skills and milestones, promoting positive play and interaction between parents and children, and locating and accessing community services and support. The parent education programs are typically delivered in the home by trained progressions coaching parents on meeting the needs of their children through observation, instruction and demonstration of mastery of skills.

Family Support Services

Community-based services that promote the well-being of children and families; they often aim to reduce caregiver and family sense of isolation, stress or self-blame, provide education or information, teach skills, and empower and activate them so they can more effectively address the needs of their families.

These prevention strategies are interventions that can guide child maltreatment prevention through the following Healthy People 2020 objectives:

EMC-2.1 (Developmental) Increase the proportion of parents who report a close relationship with their child

EMC-2.2 Increase the proportion of parents who use positive communication with their child

EMC -2.3 Increase the proportion of parents who read to their young child

EMERGING AND PROMISING PRACTICES

SAFECARE
- Home visitation program proven to reduce child maltreatment, particularly neglect, among families at risk
- Provides parents with concrete skills in three areas: health, home safety, and parent-child/-infant interactions
- Target Age: 0-5yrs
- Target Population: Parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse

Parents as Teachers (PAT)
- Early childhood parent education, family support, and school readiness home visitation model based on the premise that "all children will learn, grow, and develop to realize their full potential"
- Target Age: Pregnancy-5yrs
- Target Population: Families with an expectant mother or parents of children up to Kindergarten entry (usually 5 years)

Nurse-Family Partnership
- Community health program that provides home visits by registered nurses to first-time, low income mothers, beginning during pregnancy and continuing through the child's second birthday.
- Target Age: Pregnancy-5yrs
- Target Population: First-time, low income mothers (no previous live births)

Healthy Families Georgia
- Aims to build and sustain community partnerships to systematically engage overburdened families in home visitation services prenatally or at birth, cultivate and strengthen nurturing parent-child relationships, enhance family functioning by reducing risk and building protective factors, and promote healthy childhood growth and development.
- Target Age: pregnancy - 5yrs
- Target Population: prenatal parents and new parents.

Early Head Start - Home Based
- Home-based program that aims to enhance the development of infants and toddlers while strengthening families; it provides child development and parent support services, emphasizing the role of the parent-child relationship
- Target Age: Pregnancy-3yrs
- Target Population: Families at or below the federal poverty line.

Triple P Positive Parenting Program
- Parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to equip parents with the skills and confidence needed to be self-sufficient and to be able to manage family issues.
- Target Age: 0-16yrs
- Target Population: parents with children 0-16 with specialist programs for parents with children with disabilities, parents going through separation or divorce, parents of children who are overweight, and indigenous parents.

ABUSIVE HEAD TRAUMA: SHAKEN BABY SYNDROME

Definition:

Shaken Baby Syndrome (SBS): A form of Abusive Head Trauma (AHT) and Inflicted Brain Injury (ITBI) that is a preventable and severe form of physical child abuse. It results from violently shaking an infant by the shoulders, arms, or legs.

RISK FACTORS

Victim

- Less than one year of age
- Inconsolable and/or frequent crying
- Infant prematurity or disability
- Prior physical abuse or prior shaking
- Being one of a multiple birth
- Most SBS victims are male

Perpetrator

- Frustration and anger from infant's crying
- Limited social support
- Young parental age
- Feelings of inadequacy, isolation or depression
- Unstable family environment
- Unrealistic expectations about child development and child-rearing
- Low socioeconomic status
- Rigid attitides and impulsivity
- Limited anger management or coping skills
- Negative childhood experiences, including neglect and abuse
- Working mother without child care using unrelated adult male as caretaker for infant

Mechanism of SBS

When a baby is shaken, the brain rotates within the skull cavity, injuring or destroying brain tissue. Blood vessels feeding the brain can be torn, leading to bleeding around the brain. Blood pools within the skull, sometimes creating more pressure in the skull; this may cause additional brain damage and bleeding in the retina (back of the eye).

Why is SBS so damaging?

1. Babies' heads are relatively large and heavy, making up about 25% of their total body weight. Their neck muscles are too weak to support a disproportionately large head
2. Babies' brains are immature and easily injured by shaking
3. Babies' blood vessels around the brain are more susceptible to tearing than older children or adults

Immediate & Long-Term Consequences on Overall Well-being

Immediate Consequences	Long Term Consequences
• **Breathing may stop or be compromised** • **Extreme irritability** • **Seizures** • **Limp arms and legs or rigidity/posturing** • **Decreased level of consciousness** • **Vomiting; poor feeding** • **Inability to suck or swallow** • **Heart may stop** • **Death**	• **Learning disabilities** • **Physical disabilities** • **Visual disabilities or blindness** • **Hearing impairment** • **Speech disabilities** • **Cerebral Palsy** • **Seizures** • **Behavior disorders** • **Cognitive impairment** • **Death**

Did you know?

SBS is a leading cause of child abuse deaths in the United States; at least one of every four infants who are violently shaken dies as a result

Inconsolable crying is a primary trigger for shaking an infant

Very young infants (newborn to 4 months) are at greatest risk of injury from shaking

In the United States, care for SBS victims and their families averages **1.2 billion to 16 million dollars** each year.

PREVENTING SBS

Individual-level Strategies	Strategies aimed at changing parents' or caregivers' knowledge and skills
Relationship-level Strategies	Strategies aimed at trying to change the interactions between people – parents and children, parents and other caregivers, parents and health care providers, bystanders and parents
Community-level Strategies	Strategies aimed at modifying characteristics of settings that give rise to violence or that protect against violence (e.g., access to quality child care for working mothers, access to and availability of parental support programs, early child care, social and economic factors, and respite care centers).
Societal-level Strategies	Strategies aimed at changing cultural norms surrounding parenting as well as laws and policies aimed at supporting parents

PROMISING PRACTICE – PERIOD OF PURPLE CRYING

The Period of PURPLE Crying is the phrase used to describe the period in a baby's life when crying occurs more often than in any other time. It is a way to help parents understand this time in their baby's life as a normal part of every infant's development.

PURPLE STANDS FOR:

Peak pattern: crying peaks around 2 months, then decreases

Unpredictable: crying for long periods can come and go for no reason

Resistant to soothing: the baby may keep crying for long periods

Pain-like look on Face

Long bouts of crying: crying can go on for hours

Evening crying: baby cries more in the afternoon and evening

Prevent Child Abuse Georgia Helpline: 1-800-CHILDREN

Call for parenting support, family violence concerns, concerns about the well-being of a child or family member, counseling and support needs and more.
Open Monday to Friday, from 8am. – 7p.m

Various ways to calm a crying baby include:

Rubbing his or her back

Gently rocking

Offering a pacifier

(CDC, 2004b)

Singing or talking

Taking a walk using a stroller or going for a drive with the baby in a properly-secured car seat

PURPLE Crying Framework

- Intervention
  - o Exposure 1: Education by RNs through nursery video and take-home booklet
  - o Exposure 2: Education by other healthcare providers during prenatal visits and checkups
  - o Exposure 3: Media Campaign
    - The general public understands the commonality of PURPLE crying and the dangers of shaking
    - Social norms: PURPLE crying is normal and shaking is unacceptable
      - Alternative caregivers able and willing to help
- Impacts
  - o Knowledge Changes: parent understands
    - Normalcy of PURPLE crying
    - The dangers of shaking
    - Alternatives to addressing PURPLE crying
    - How to identify other 'safe' caretakers
  - o Attitude and Belief Changes: parent believes
    - Crying is normal
    - Shaking is preventable
    - She can educate and train other caregivers in PURPLE crying concepts
    - She can identify good caregivers
    - She prioritizes child's safety from shaking
  - o Skills Change
    - Recognizes frustration and need to approach other coping strategies
    - Parent can identify and apply coping strategies
    - Parent can train other caregivers in PURPLE principles
- Outcomes
  - o Outcome 1: Parent displays the following coping behaviors
    - Provides comfort to baby and/or
    - Leaves baby in a safe place to cry (when she feels pushed to the limit, being sure to check on child every 5-10mins.) and/or
    - Chooses quality alternative caregivers and
    - Trains alternative caregivers
  - o Outcome 2: Reduction in shaking incidence

  - o **Ultimate Outcome:** Reduction in abusive head trauma

Action Plan and Recommendations

PARENTS AND CAREGIVERS

- Remember that babies cry a lot in the first few months of life and this can be frustrating but it will get better.
- Remember, you are not a bad parent or caregiver if your baby continues to cry after you have done all you can do to calm him/her.
- If you have tried various ways to calm your baby and he/she won't stop crying, do the following:
    - ❖ Check for signs of illness or discomfort like diaper rash, teething, or tight clothing
    - ❖ Call the doctor if you suspect your child is injured or ill
    - ❖ Assess whether he/she is hungry or needs to be burped

If you find yourself pushed to the limit by a crying baby, you may need to focus on calming yourself. Put your baby in a crib on his/her back, make sure he/she is safe, then walk away for a bit and call a friend, relative, neighbor, or parent helpline for support. Be sure to check on him/her every 5-10 minutes

FRIENDS, FAMILY MEMBERS, HEALTH CARE PROFESSIONALS AND OBSERVERS OF A PARENT OR OTHER CAREGIVER

- Be aware of new parents in your family and community who may need help or support.
- Provide support by offering to give them a break, sharing a parent helpline number, or simply being a friend.
- Let the parent know that the crying can be frustrating, especially when they're tired and stressed. Reinforce that crying is normal and that it will get better.
- Tell the parent how to leave his or her baby in a safe place while he or she takes a break.
- Be sensitive and supportive in situations when parents are trying to calm a crying baby.
- Think about policies or services that could be resources for new parents in your community and advocate for those that do not exist.

Action Plan and Recommendations

EDUCATION

- School prevention programs for junior high and high school students providing students with an understanding of child maltreatment issues, anger management techniques, teen dating violence prevention programs, and child care skills
- Babysitting courses as a skill builder for future parents. These are often part of community education offered as local hospitals
- Educational print and video materials provided at the time of delivery as well as at pediatric offices and prenatal classes

AGENCY

- Coordinated hospital-based primary-prevention programs targeting parents of newborns
- Home visitation programs for new parents; expand the reach of various home visitation programs and additional services to at-risk families. For example, since neglect represents the number one form of maltreatment in Georgia, greater number and dissemination of programs proven to decrease neglect, such as SafeCare may reduce the number of neglect cases
- In responding to CPS referrals, child welfare agencies should focus on non-serious allegations of abuse and neglect for children 0-5, as well as cases with clear safety threats, and continue implementing early intervention in families where multiple risk factors are present
- Pay more attention to emotionally detached and disengaged parenting during risk assessments – practitioners should focus on the quality of parent-child interactions and pregnant women's hostile attributions about infants during risk assessments
- Promote partnerships with local community-based organizations (CBOs) that can provide education, training, message dissemination, and follow-up support to parents identified as needing additional resources or information

LAW

- Broaden the public policy focus and education on families with or without prior contact with CPS who have children ages 0-3, caretakers with serious substance abuse or mental health problems, domestic violence present during or after pregnancy, or living in impoverished homes

ENFORCEMENT

- Enforce the use of evidence-based practices as the foundation for any intervention; conduct more research on effective interventions and gain a better understanding of the fatality and incidence trends in Georgia and the fluctuations in forms of maltreatment over time.
- Ensure the availability and provision of mandated reporter trainings
- Persons employed by or volunteering at a business or an organization, whether public, private, for profit, not for profit, or voluntary, that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children should be educated in Georgia child abuse laws, detecting abuse, and reporting procedures

BULLYING

Definition: An act which occurs on school property, on school vehicles, at designated school bus stops, or at school related functions or activities, or by use of data or software that is accessed through a computer, computer system, computer network, or other electronic technology of a local school system, that is:
(O.C.G.A. 20-2-751.4):

- Any willful attempt or threat to inflict injury on another person, when accompanied by an apparent present ability to do so;

- Any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm; or

- Any intentional written, verbal, or physical act, which a reasonable person would perceive as being intended to threaten, harass, or intimidate, that:
  - Causes another person substantial physical harm or visible bodily harm
  - Has the effect of substantially interfering with a student's education
  - Is so severe, persistent, or persuasive that it creates an intimidating or threatening educational environment; or
  - Has the effect of substantially disrupting the orderly operation of the school

The Healthy People 2020 Goal
IVP-35: Reduce bullying among adolescents
Baseline: 19.9% of students in grades 9 through 12 reported that they were bullied on school property in the previous 12 months in 2009.
Target: Decrease to 17.9%; at least a 10% improvement by 2020

WHAT IS NOT BULLYING

- Mutual Conflict – a disagreement rather than an imbalance of power. Unresolved mutual conflict may escalate into bullying if one of the parties is repeatedly targeted in retaliation
- Single-episode acts
- Social rejection or dislike – this is not considered bullying unless it involves repeated and deliberate attempts to exclude and create dislike by others or to cause distress
- Accidently bumping into someone

RISK FACTORS

Some risk factors for engaging in bullying and being a victim of bullying are presented below. However, it is important to recognize that bullies come in all shapes and sizes. Additionally, depending on the environment, some groups including youth with disabilities, socially isolated youth, and lesbian, gay, bisexual, or transgendered (LGBT) youth may be at increased risk of being bullied.

Victimization

- Friendship difficulties
- Social isolation
- Poor self-esteem
- Quiet, passive manner with lack of assertiveness
- Children perceived as different from their peers
- Suffer from intellectual or developmental disability

Engaging in Bullying

- Impulsivity
- Harsh parenting by caregivers or less parental involvement
- Bullying/abuse in the home

Warning signs of victims

- Comes home with torn, missing, or damaged belongings
- Few, if any, friends
- Trouble sleeping or frequent bad dreams
- Seems afraid of going to school, riding the school bus, walking to and from school, or engaging in organized activities with peers
- Returns from school saddened, depressed, or moody
- Frequently complains of physical ailments
- Takes long, unexplained routes to and from school
- Has unexplained injuries
- Appears anxious or shows low self-esteem
- Has little or no appetite
- Many medical excuses for not going to school (headache, stomach ache, etc.) without any real medical issues other than psychological distress

CYBERBULLYING

Definition: Bullying that takes place using electronic technology such as cell phones, computers, and tablets as well as communication tools (social media sites, text messages, chat, and websites).

"What makes cyber bullying so dangerous…is that anyone can practice it without having to confront the victim. You don't have to be strong or fast, simply equipped with a cell phone or computer and a willingness to terrorize" (King, 2006)

Warning signs a child may be a victim of cyberbullying

Upset after being online
Upset after viewing a text message
Withdrawn from social interaction with peers
Possible drop in academic performance
Targeted by on-campus bullying

NATIONALLY

Percentage of students age 12-18 who reported being cyber-bullied during the school year, NCES 2011

■ Male ■ Female

Category	Male	Female
Total cyber bullying	6.9	11.2
Hurtful information on internet	1.7	5.7
Private information purposefully shared on internet	0.7	1.5
Subject of harassing instant messages	1.5	4
Subject of harassing text messages	2.4	6.5
Subject of harassing e-mails	1.1	2.7
Subject of harassment while gaming	2.7	0.2
Excluded online	1	4
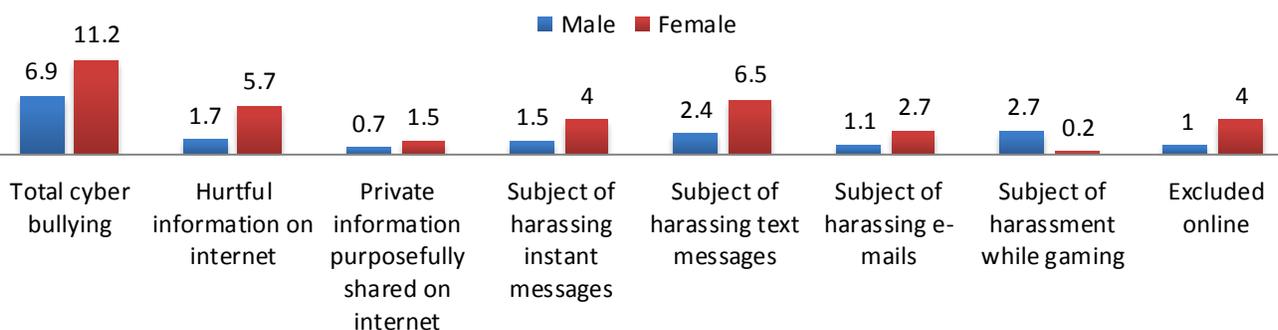
The numbers above represent the percentage of students from ages 12 to 18 who reported being victims of cyberbullying anywhere during the 2010-2011 school year. The data above is collected a male student population of 12,857,000 and a female population of 11,824,000.

According to the CDC 2013 Youth Risk Survey, 14.8% of students, nationwide had been electronically bullied during the 12 months before the survey; forms of bullying include instant messaging, e-mail, websites, chat rooms, and texting. Overall, the prevalence rate was higher among females (21.0%) than males (8.5%), with the highest prevalence in non-Hispanic white (25.2%) and 9th grade (22.8%) females.

BULLYING ON SCHOOL PROPERTY

Percentage of High School Students who bullied on school property - United States, Youth Risk Behavior Survey, 2013

■ Male ■ Female

|	Male	Female
NonHispanic White	16.2	27.3
NonHispanic Black	10.2	15.1
Hispanic	14.8	20.7
Grade 9	20.8	29.2
Grade 10	15.8	28.8
Grade 11	13.1	20.3
Grade 12	11.2	15.5
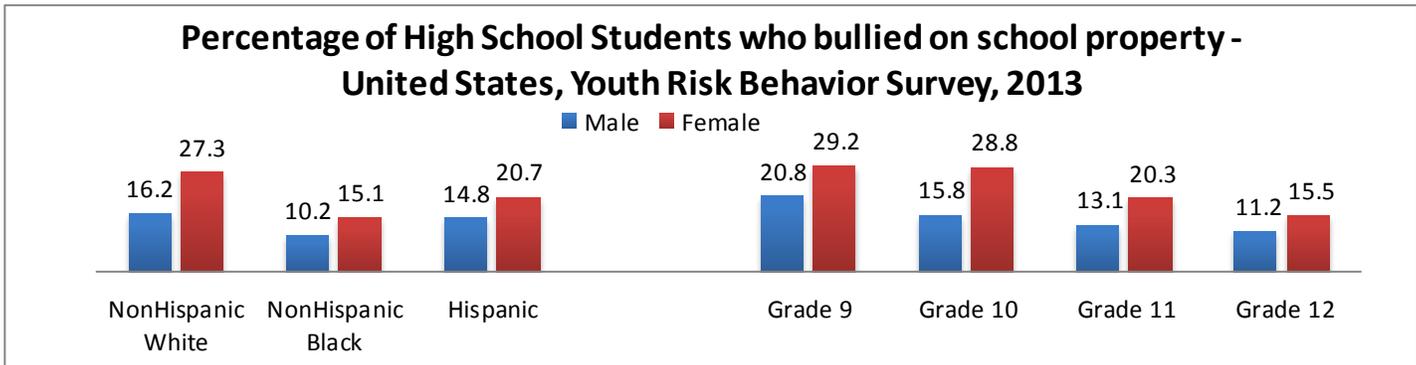
Nationwide, 20.1% of high school students reported that they were bullied on school property during the 12 months before the Youth Risk Behavior Survey (CDC, 2014). The prevalence rate was higher among female students (22.0%) than male students (18.2%), with 25.2% prevalence in non-Hispanic white females compared to 20.7% in non-Hispanic white males, 12.2% in non-Hispanic African-American females compared to 11.1% in non-Hispanic African-American males, and 19.3% in Hispanic females compared to 16% in Hispanic males. A similar pattern is seen across grade levels; in each grade level, the prevalence is higher in females than in males. Overall, a higher prevalence is seen in Grades 9 and 10, than in Grades 11 and 12. The most common location of school bullying is in the hallway or stairwell (45.6%) followed by the classroom (32.8%) and then outside on school grounds (22.1%).

STUDENT SAFETY CONCERNS

High schools students who did not go to school because they felt unsafe - United States, Youth Risk Behavior Survey, 2013

■ Female ■ Male

	Female	Male
Grade 12	5.9	5
Grade 11	8.1	5.8
Grade 10	10.7	5.3
Grade 9	9.9	5.5
Hispanic	12.6	6.9
NonHispanic Black	8	7.8
NonHispanic White	7.4	3.8
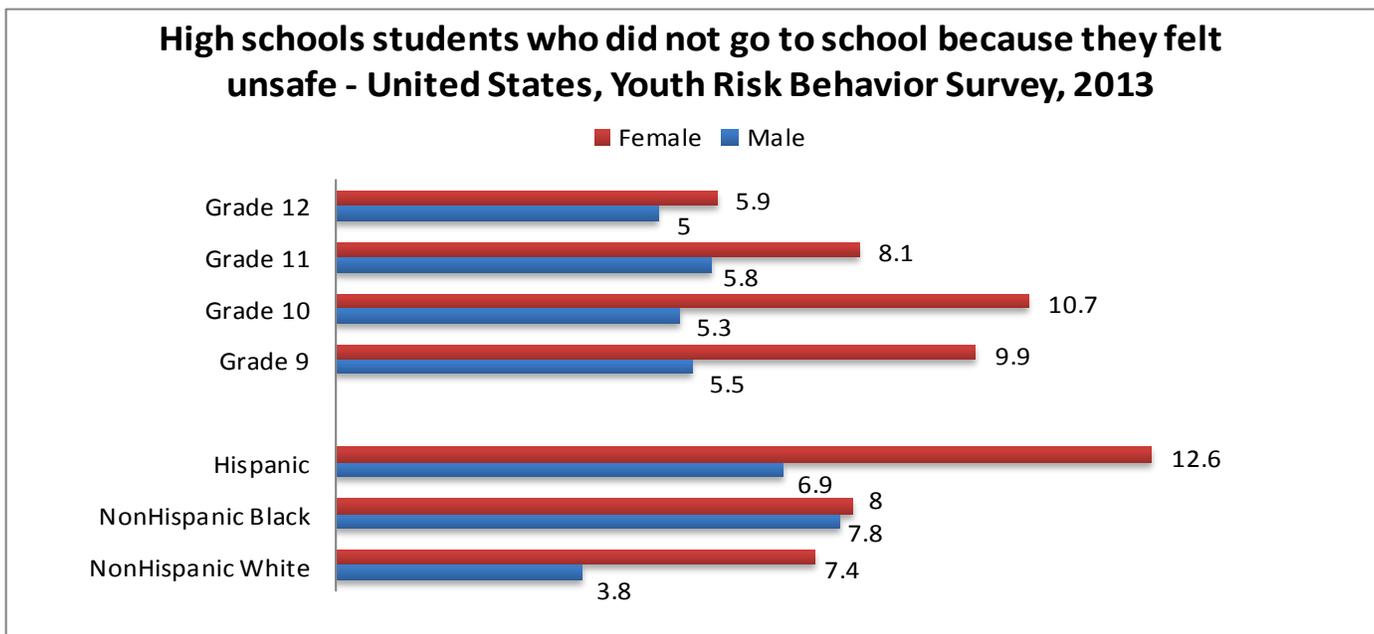
## GEORGIA STUDENT HEALTH SURVEY DATA

In the 2012-2013 Georgia Student Health Survey **37,529** students reported that they had bullied others within 30 days of taking the survey while **75,201** students reported being victims of bullying within 30 days. When comparing grades 6 to 12, the prevalence rate of bullying was highest in the 6th, 7th, and 8th grades, above all other grades.

Percentage of students in Georgia who reported being bullied, 2013

22.05	18.95	15.8	12.52	10.83	9.33	8.26
Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12

Georgia Students reporting being picked on or teased at school, 2012-2013

- Grade 6 — 23%
- Grade 7 — 20%
- Grade 8 — 17%
- Grade 9 — 13%
- Grade 10 — 11%
- Grade 11 — 9%
- Grade 12 — 7%
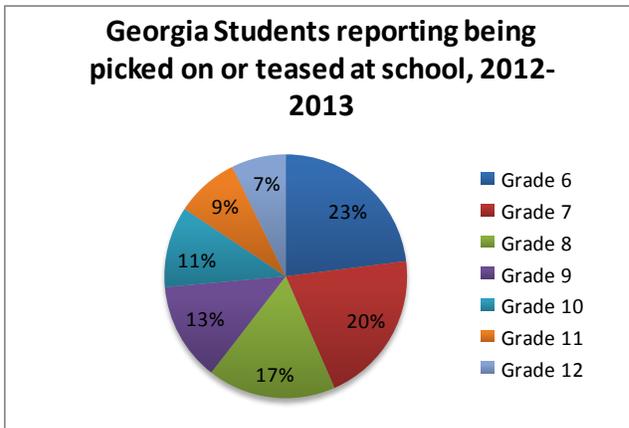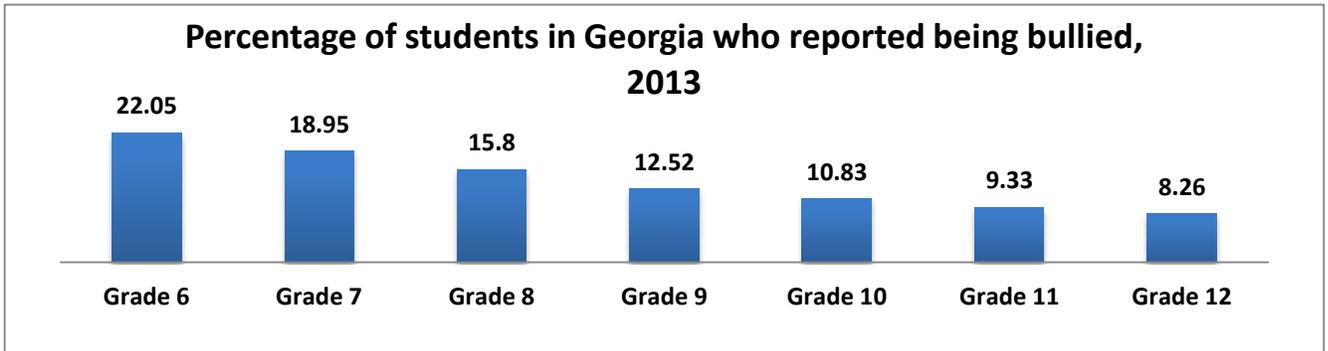
In the Georgia 2012-2013 Student Health Survey, a total of 62,804 students strongly agreed that they had been picked on or teased at school in the past 30 days prior to taking the survey. More students in 6th and 7th grade (23% and 20% respectively) reported being picked on or teased compared to other grade levels surveyed. Similarly to reports of bulling victimization, reports of experiencing teasing or being picked on decreased as grade level increased.

Percentage of Georgia High School Students who were electronically bullied, bullied on school property, and who did not go to school because of safety concerns - Youth Risk Behavior Survey, 2013

■ Male   ■ Female

	Male	Female
Electronically Bullied	11.2	16.4
Bullied on school property	17.9	21.1
Did not go to school because of safety concerns	7.4	6.7
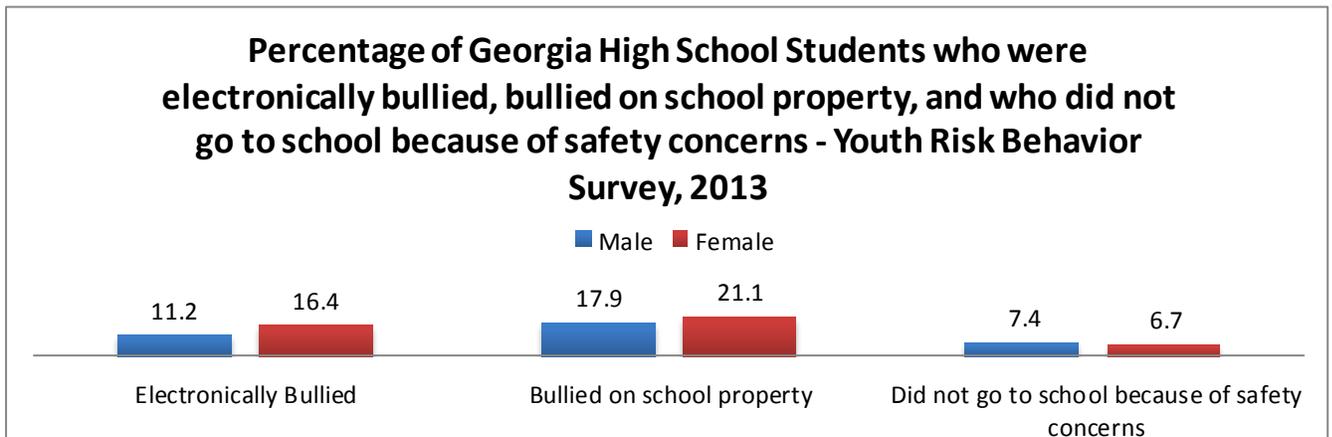
According to the Youth Risk Behavior Survey (2013), among middle-school students, 18.4% reported being electronically bullied and 41% reported being bullied on school property.

GEORGIA POLICIES ON BULLYING

- **Local Board of Education**
  - **Each local board of education is expected to:**
    1. Adopt a policy that prohibits bullying between students; this prohibition is required to be included in the student code of conduct for schools in that school system.
    2. When a disciplinary hearing officer, panel, or tribunal of school officials finds that a student in grades 6 through 12 has bullied another student for the third time in a school year, require that the student will be assigned to an alternative school.
    3. Ensure that parents and students are informed of the prohibition against bullying and the associated penalties, by posting such information at each school and including the information in parent and student handbooks.
    4. Establish and publish an approach for notifying the parent, guardian, or other person who has charge or control of a student when such student has committed an offense of bullying or is a victim of bullying.

- **Department of Education must develop a model policy on bullying that may be revised periodically. This policy shall be posted on its website and will include:**
    1. A statement prohibiting bullying.
    2. A requirement that teachers or other school employees report cases of bullying.
    3. A requirement that each school have a procedure for the school administration to promptly investigate in a timely manner and determine whether bullying has occurred.
    4. An age appropriate range of consequences for bullying which shall include, at a minimum and without limitation, disciplinary counseling or action as appropriate under the circumstances.
    5. A statement prohibiting retaliation following a bullying report
    6. A procedure for reporting or providing information on bullying activity.

Action Plan and Recommendations

PARENTS

- Make sure your child feels (and is) safe and secure, and convey unconditional support. It is important to maintain and cultivate open lines of communication
- Be aware of what your kids are doing online
  - Educate your children about appropriate behaviors online; teach and reinforce positive values and morals about how others should be treated with dignity and respect
  - Establish rules for technology use and inform your kids that you may review their online communications
  - Use blocking and filtering software as part of a *comprehensive* approach to online safety, not as the sole protection option
- Understand school rules and bullying policies and meet with school administrators, a counselor or trusted teacher as needed
- When appropriate, contact the police. Law enforcement should be contacted for the following crimes:
  - Threats of violence
  - Child pornography or sending sexually explicit messages or photos
  - Stalking and hate crimes
  - Taking a photo or video of someone in a place where he or she would expect privacy
- Talk to other parents through community organizations and through the school. This can be a way to raise awareness, to determine the extent of the problem, and to gain support

Action Plan and Recommendations

SCHOOLS

- Thoroughly investigate all incidents – intervene consistently and appropriately in bullying situations
- Focus on the school environment
- Enlist the support of a school liaison officer
- Establish and enforce all school rules and policies related to bullying
- Increase adult supervision in places where bullying occurs
- Focus some class time on bullying prevention
- Form a group to coordinate the school's bullying activities
- Work with parents to convey to the student that bullying behaviors are taken seriously and not to be tolerated
- Train school staff in bullying prevention
  Incorporate anti-bullying school assembly programs
- Prove newsletters or letters to parents about cyberbullying. Newsletters may include:
  - Definition and examples of cyberbullying
  - Tips on responding to cyberbullying
  - Reporting cyberbullying at school
  - Safe use of social networking sites and social media
  - How to report abusive behavior and when to notify the police

Action Plan and Recommendations

FOR TEENS

I'm Being Bullied

You Are NOT Alone!
It's NOT Your Fault!
You CAN DO Something about It

Talk to Someone

- Remember that you are not on your own and there is always someone who can help.
- Talk to a teacher or someone at your school.
- Talk to your mom or dad, a family member, a grandparent, friend or someone else you trust and ask them to help you address the situation.

Keep a Record

- If bullying is happening over the internet or on your phone, keep a record of messages or posts and show a trusted adult.
- Take screenshots of your phone, latptop or computer when you receive a threatening message, photo, video, etc.

If bullying happens on the phone or internet

- Don't respond to the message
- Tell a trusted adult or friend
- Block the person's phone number on your mobile device and social media sites so that you no longer receive the bullying posts or texts.

Other Recommendations

- Hang around people that will help you feel good about yourself. Friends do not bully you - they care about you and are fun to be around.
- **Don't try to get back at the person who bullies you. You may end up in trouble too and it usually doesn't work.**

RECOMMENDATIONS FOR TEENS TO EDUCATE THEIR COMMUNITY

- Teach your younger friends and relatives on safe and responsible online practices
- Become a mentor
- Create informative posters
- Review your school bullying and cyber bullying policies

SUBSTANCE ABUSE

Definition: pattern of harmful use of any substance exhibited by persistent and significant adverse consequences related to the repeated use of those substances. Consequences may include social and interpersonal conflicts, legal problems,

Risk Factors	Protective Factors
• Chaotic home environment • Perceived parental approval • Peers engaging in problem behvior • Early and persistent problem behaviors, risk-taking, and high sensation-seeking • Low parental monitoring (or perception of monitoring) • Parental or older sibling drug use (or perception of use) • Low perception of harm • Easy access and availability • Poor schoool achievement and low social bonding	• Strong and positive family bonds • Parental engagement in child's life • Clear parental expectations and consequences that are consistently enforced within the family • Academic success • Strong bonds and pro-social institutions (school, religious organizations, community) • Conventional norms about alcohol and drugs

RISKS ASSOCIATED WITH SUBSTANCE ABUSE

- High-risk behaviors (sexual activity; driving/passenger while intoxicated; failure to wear a seatbelt; self-injurious behaviors)
- Acute medical complications
- Social and Interpersonal Conflicts
- Involvement with the legal system
- Poor education outcomes
- Substance dependence

WHY SUBSTANCES ARE ABUSED

- Lack of parental supervision
- Peer pressure
- Drug availability
- Poverty
- Major transitions in a person's life

Prevention Programs

1. National Substance Abuse Prevention Month – a month-long observance in October focused on the role substance abuse prevention plays in promoting safe and healthy communities. Access substance abuse prevention resources and materials for individuals and prevention professionals.

2. Stop Underage Drinking --- a comprehensive portal of Federal resources for information on underage drinking and ideas for combating this issue.

3. The Strategic Prevention Framework (SPF) uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span.

4. Find Youth Info --- promotes the goal of positive, healthy outcomes for youth.

5. Safe Schools/Healthy Students --- a grant program designed to prevent violence and substance abuse among our Nation's youth, schools, and communities.

6. Too Smart to Start --- helps youth, families, educators, and communities prevent underage alcohol use and its related problems.

7. Building Blocks for a Healthy Future --- provides parents, caregivers, and teachers of children aged 3 to 6 the opportunity to find lots of great tips, materials, and ideas for spending time with their children and learning together.

8. National Registry of Effective Programs and Practices --- a searchable online registry of more than 160 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.

9. Communities That Care (CTC) -- a coalition-based community prevention operating system that uses a public health approach to prevent youth problem behaviors including underage drinking, tobacco use, violence, delinquency, school dropout and substance abuse.

10. Prevention Management Reporting and Training System --- provides substance abuse prevention resources, data collection, and reporting services.

11. Center for the Application of Prevention Technologies -- provides responsive, tailored, and outcomes-focused training and technical assistance to prevent and reduce substance abuse and associated public health issues across the lifespan.

12. Fetal Alcohol Spectrum Disorders (FASD) – information and resources about the prevention and treatment of FASD.

13. Drug-Free Workplace -- addressing substance abuse prevention in the workplace through comprehensive drug-free and health/wellness workplace programs.

14. Native American Center for Excellence -- a national resource center for up-to-date information on American Indian and Alaska Native (AI/AN) substance abuse prevention programs, practices, and policies.

15. Medication Assisted Treatment -- the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

16. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital

17. Georgia Council on Substance Abuse Alcohol Prevention efforts: Be the Wall

Substance Abuse in Georgia

+ For youth ages 12 to 18, in any given year: (2002-2008)

SUBSTANCES EXAMINED

+ Alcohol
+ Binge drinking
+ Marijuana
+ Cocaine (all forms)
+ Crack Cocaine
+ Heroine
+ Hallucinogens
+ Inhalants
+ Pain relievers
+ Tranquilizers
+ Stimulants
+ Sedatives
+ "Special Drugs" GBH, Adderall, non-prescription cold and cough medicines, ketamine, DMT, AMT or Foxy, and Salvia divinorum
+ "Illicit drugs" – marijuana/hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically
+ "Illicit drugs" (aggregated) – include illicit drugs and special drugs
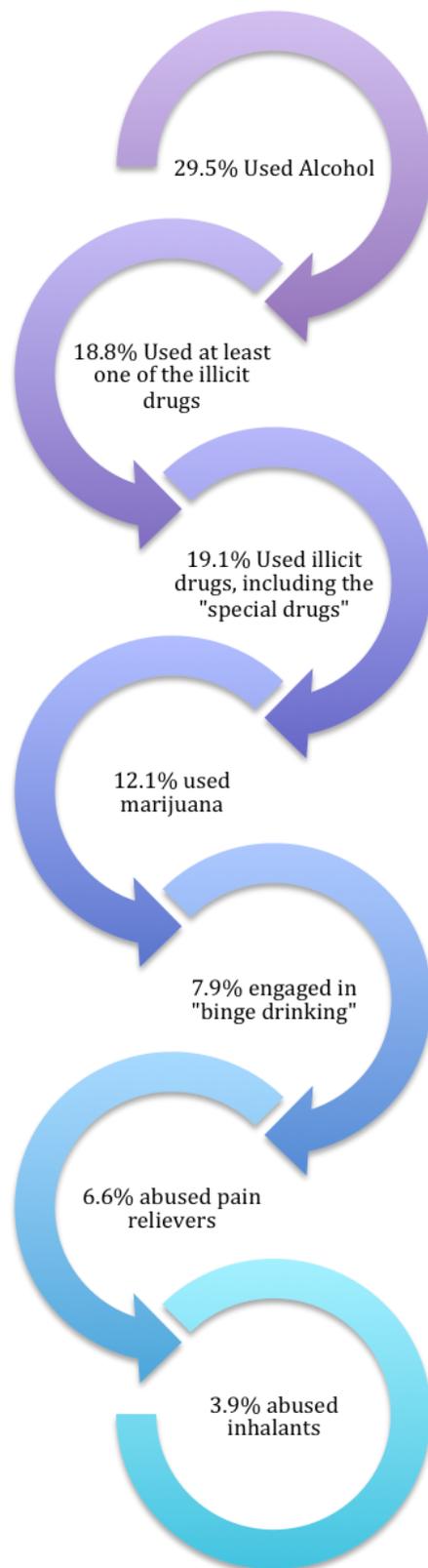
The Healthy People 2020 Goal

In 2008, over 41,000 people died as a result of poisoning. One of the objectives in Healthy People 2020 is to reduce fatal poisonings in the United States. Poisoning mortality increased during the tracking periods of Healthy People 2010 and drugs (legal and illegal) cause the vast majority of poisoning deaths. Much of the increase in drug poisoning deaths is due to misuse or abuse of prescription drugs (opioid analgesic pain relievers)

The highest risk periods for drug abuse among youth appear during major transitions (elementary to middle school, middle school to high school, and high school to college or work). Strengthening protective factors at these stages of life are important steps towards prevention.

29.5% Used Alcohol

18.8% Used at least one of the illicit drugs

19.1% Used illicit drugs, including the "special drugs"

12.1% used marijuana

7.9% engaged in "binge drinking"

6.6% abused pain relievers

3.9% abused inhalants

SUBSTANCE USE AMONG MIDDLE AND HIGH SCHOOL STUDENTS IN GEORGIA, YOUTH BEHAVIORS SURVEY, 2013

Substance	% Middle School Students	% High School Students
Tobacco	19.9%	40.4%
Alcohol (any)	24.7%	59.2%
Marijuana	10%	35.9%
Cocaine	3.2%	7%
Inhalants	9.2%	9.9%
Prescription drugs (Oxycotin, Percocet, Vicodin, codeine, Adderall, Ritalin, Xanax) without a prescription	6.7%	17.7%
Ecstasy (MDMA)		7.1%

COSTS

- **National Institute on Drug Abuse**
  - Abuse of tobacco, alcohol, and illicit drugs cost over $600 billion annually to the United States in costs related to crime, healthcare, and lost work productivity.

	Healthcare	Overall
Tobacco	$96 billion	$193 billion
Alcohol	$30 billion	$235 billion
Illicit Drugs	$11 billion	$193 billion

MONITORING THE FUTURE SURVEY (8th, 10th, and 12th GRADERS)

- Cigarette smoking continues to fall to the lowest rate in the survey's history
- Five-year trends showed significant decreases in alcohol use among all grades and across nearly all prevalence periods
- The use of Ecstasy showed a significant drop in the past year from 2011 to 2012
- Overall, the use of most illicit drugs has either declined or remained steady from 2011 to 2012
- Significant increases in marijuana use among 10th and 12th graders.
- New synthetic marijuana (K2 or Spice) among 8th and 10th graders. Use of bath salts reported by 0.8% of 8th graders, 0.6% of 10th graders, and 1.3% of 12th graders
- Many drugs used by 12th graders are prescription or over-the-counter medications
- The percent of 12th graders reporting the nonmedical use of Adderall has increased from 5.4% in 2009 to 7.6% in 2012

Action Plan and Recommendations

Restrictions on location and density of alcohol and drug outlets	Utilize evidence-based home visitation programs for early intervention to strengthen families	Restrictions on marketing and advertising of additive substances in ways that appeal to youth
Increased taxes on tobacco and alcohol products to reduce use	Combined school and community programing for a comprehensive, cross-sector effort to change the environment in which students make choices about alcohol and other drugs.	Community-level interventions such as neighborhood watches, undercover buying operations and nuisance abatement programs.
	Ongoing evaluation of the effectiveness of federal, state, local and organizational policies	Collaboration of law enforcement, businesses, and criminal justice system to ensure enforcement of youth tobacco, alcohol, and drug use policies

- Establish school and community-based prevention programs that help children, teens, and adolescents:

  - Strengthen their self-esteem and academic skills
  - Resist social pressures to engage in substance abuse
  - Improve decision-making and communication skills
  - Manage stress and anxiety

PRESCRIPTION DRUG ABUSE

Definition: Taking prescription meds in a way that wasn't prescribed to create an altered sate

Most Abused Prescription Drugs:
1. Opioids – narcotic painkillers
   a. Morphine, Codeine, Oxycodone, Vicodin®
   b. Symptoms of Abuse – drowsiness, nausea, constipation, slowed breathing
2. Stimulants – treat narcolepsy and attention deficit disorder
   a. Adderall®, Ritalin®, Concerta®
   b. Symptoms of Abuse – paranoia, increased body temperature, irregular heartbeat
3. CNS depressants – treat anxiety and sleep disorders
   a. Xanax® & Valium®
   b. Slowed speech, shallow breathing, fatigue, disorientation, lack of coordination, seizures (with withdrawal of chronic use)

Risks Associated with Prescription Drug Abuse:

1. Immediate effects on your body
2. Could be fatal
3. Can become addictive
4. Gateway to other drugs
5. Wreaks havoc on "brain chemistry" especially in the developing brain (humans 0 to 30 years).
6. Costly monetarily. The cost to the individual, community, and society.

Why Prescription Drugs are Abused?

1. Attitude: a false sense of security; believing prescription drugs aren't as dangerous as illegal drugs
2. Availability: number of prescription drugs on the market and increased prescribing
3. Access: internet; medicine cabinets; receiving from family and friends
4. Awareness: more advertising over the internet, TV, billboards, and radio
5. Peer Pressure
6. Need additional energy or ability to focus (Ritalin® and Adderall®)
7. Need to cope with academic, social & emotion stress / "manage/regulate" their lives (Oxycotin® and Xanax®)
8. To help with weight loss or to gain muscle mass (Amphetamines)
9. Humans insatiable need to experience ever increasing amounts of instant pleasure and avoid or attempt to minimize all emotional and physical pain. We have a "Demand Problem" not a "Supply Problem".
10. Coping skills to deal with pain and the need for pleasure are not keeping up with the advertising promises of "easy fixes" with this drug or that drug.
11. Pharm parties (fishbowl parties)

PATS KEY FINDINGS: Release April 23, 2013. 2012 Partnership Attitude Tracking Study, sponsored by MetLife Foundation

1 in 4 teens (24%) report having misused or abused a prescription drug at least once in their lifetime (up from 18% in 2008 to 24% in 2012), which translates to about 5 million teens. This is a 33% increase over a 5-year period
-   Of those kids who said they abused Rx medications, 1 in 5 (20%) has done so before age 14
More than a quarter of teens (27%) mistakenly believe that misusing and abusing prescription drugs is safer than using street drugs
33% of teens say they believe "it's okay to use prescription drugs that were not prescribed to them to deal with an injury, illness or physical pain."
Almost 1 in 4 (23%) of teens say their parents don't care as much if they are caught using Rx drugs without a doctor's prescription, compared to getting caught with illegal drugs.
1/8 of teens (about 2.7 million) now report having misused or abused the Rx stimulants Ritalin® or Adderall® at least once in their lifetime.
9% of teens (about 1.9million) report having misused or abused the Rx stimulants Ritalin® or Adderall® in the past year (up to 6% in 2008) and 6% of teens (1.3million) report abuse of Ritalin or Adderall in the past month (up to 4% in 2008)
1 in 4 teens (26%) believe that prescription drugs can be used as a study aid.

NATIONALLY

- Among persons aged 12 or older in 2009-2010 who used pain relievers non-medically in the past year, 55% reported obtaining the pain relievers they most recently used through a friend or relative for free, 11.4% reported purchasing them from a friend or relative, and 4.8% reporting taking them from a friend or relative without asking.
- Among 12th graders nationally, prescription and over-the-counter (OTC) medications are the most commonly abused drugs after nicotine, alcohol, and marijuana.
- Females aged 12-17 were more likely than males aged 12-17 to be current nonmedical users of physiotherapeutic drugs and current nonmedical users of pain relievers.
- Among 12th graders, whites tend to have the highest rates of use of a number of drugs, including OxyContin®, Vicodin®, amphetamines, Ritalin®, Adderall® sedatives and tranquilizers.
- Among 8th graders, Hispanics had the highest rate of illicit drug use overall and the highest rates for most drugs (though not for amphetamines, Ritalin® or Adderall® specifically

Georgia

In 2008-2009, an estimated 360,000 (4.62%) of Georgians aged 12 and older reported using pain relievers non-medically. Of the 360,000, 51,000 (14%) were 12 to 17 years old.

Ages 12-17, nearly 1 out of every 5 (18.8%) used at least one illicit drug (includes marijuana, cocaine/crack, heroin, hallucinogens, and inhalants, as well as 62 psychotherapeutics used nonmedically) and slightly more (19.1%) used illicit drugs including "special drugs" (includes both prescription and nonprescription drugs including: GBH, Adderall, Ambien, non-prescription cold and cough medicines, ketamine, DMT, AMT (Foxy), and Salvia divinorum).

Nearly 7% (6.6%) of those 12-17 used pain relievers non medically

Overall, illicit drug use in Georgia was slightly high among African-Americans (17%) than whites (13.9%) or Hispanics (12.4%). Hispanics were significantly more likely to have abused pain relievers than Africa-Americans (7.9% vs. 3.5%)

2012 - The State of Prescription Drug Use in Georgia: A Needs Assessment

According to GSHS about 1,020 6th graders, 1,859 8th graders, 1,832 9th graders, 2,330 10th graders, 2,164 11th graders, and 2,402 12th graders reported having used prescription drugs not prescribed to them at least once during the past 30 days

Students in higher grades tended to report a high prevalence of prescription drug use, as well as higher frequencies of use.

Ease of access to prescription drugs increased according to students' grade level and nearly 40% (36.9%) of 12th graders reported that they strongly agreed it was easy to obtain prescription drugs not prescribed to them. Similar percentages were found among 10th graders (32%) and 11th graders (34.7%), while over a quarter of 9th graders (26.9%) strongly agreed it was easy to obtain prescription medicines not prescribed to them

Morbidity and Mortality Weekly Report, Surveillance Summaries, Vol. 61, No. 4. *Youth Risk Behavior Surveillance – United States, 2011.* June 8, 2012

The prevalence of having ever taken prescription drugs without a doctor's prescription was higher among African-American male (17.5%) than African-American female (11.9%) students and higher among 12th-grade male (27.9%) than 12th-grade female (23.2%) students. Overall, the prevalence of having ever taken prescription drugs without a doctor's prescription was higher among white (22.9%) than African-American (14.7%) and Hispanic (19.4%) students; higher among Hispanic (19.4%) than African-American (14.7%) students; higher among white female (22.2%) and Hispanic female (19.0%) than African-American female (11.9%) students; and higher among white male (23.6%) than African-American male (17.5%) students.

Overall, the prevalence of having ever taken prescription drugs without a doctor's prescription was higher among 11th-grade (23.3%) and 12th-grade (25.6%) than 9th-grade (16.5%) and 10th-grade (18.2%) students; higher among 11th-grade female (22.2%) and 12th-grade female (23.2%) than 9th-grade female (16.2%) students; higher among 12th-grade female (23.2%) than 10th-grade female (18.1%) students; and higher among 11th-grade male (24.5%) and 12th-grade male (27.9%) than 9th-grade male (16.7%) and 10th-grade male (18.3%) students.

DID YOU KNOW

An estimated $213 billion in 2012 healthcare spending in the United States was due to improper and unnecessary use of medicines, equivalent to 8% of the nation's total healthcare spending in 2012 according to the Burrill Report from IMS Institute for Healthcare informatics.

According to the Morbidity and Mortality Weekly Report, Surveillance Summaries, Vol 61, No 4 (Youth Risk Behavior Surveillance – United States, 2011, June 8, 2012)

a. The prevalence of having ever taken prescription drugs without a doctor's prescription ranged from 12.4% to 22.1% across state surveys (median: 17.6%) and from 7.3% to 18.3% across large urban school district surveys (median: 12.6%)

b. Among students nationwide, the prevalence of having ever taken prescription drugs without a doctor's prescription did not change significantly from 2009 (20.2%) to 2011 (20.7%).

GA State Policies:

1. Georgia Pain Management Clinic Act (Formerly House Bill 178) for the purpose of closing down pill mills in Georgia: requires all pain management clinics to be licensed and regulated by the Georgia Composite Medical Board. Additionally, all pain management clinics opened after June 30, 2013 must be owned by a licensed physician in Georgia.
2. Prescription Drug Monitoring Programs (PDMP), which are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients and identify problem prescribers and individuals misusing drugs, require mandatory utilization by prescribers
3. ID required: pharmacies are required to request identification prior to dispensing a controlled substance
4. Doctor Shopping Laws: laws to deter and prosecute people obtaining multiple prescriptions for controlled substances from different health care practitioners without their knowledge
5. Physical Exam: healthcare providers have to perform a physical exam of the patient before prescribing a controlled substance
6. Prescriber Education
7. Lock in programs: individuals suspected of misusing controlled substances must use a single prescriber and pharmacy
8. "Think About It" Program offered by the Medical Association of Georgia Foundation is a campaign for the education about and prevention of prescription drug abuse composed of the following comprehensive initiatives:
   • Development of a Statewide Comprehensive Drug Policy
   • Safe storage and disposal of prescription drugs
   • Education of both the public and professionals about the dangers of and prevention of prescription drug abuse
   • Website: www.rxdrugabuse.org
9. Georgia Prescription Drug Abuse Prevention Initiative (GPDAPI) of The Council on Alcohol and Drugs (TCAD) focuses on education, monitoring, proper medical disposal and enforcement to prevent and reduce prescription drug abuse in Georgia (www.stoprxabuseinga.org)
10. House Bill 965 – provides immunities from certain arrests, charges of persecutions of persons seeking medical assistance for a drug overdose

The Healthy People 2020 Goal

In 2008, over 41,000 people died as a result of poisoning. One of the objectives in Healthy People 2020 is to reduce fatal poisonings in the United States. Poisoning mortality increased during the tracking periods of Healthy People 2010 and drugs (legal and illegal) cause the vast majority of poisoning deaths. Much of the increase in drug poisoning deaths is due to misuse or abuse of prescription drugs (opioid analgesic pain relievers)

Prevention

- Educating the public, parents, and caregivers
  - community leaders can assess community risk and protective factors associated with prescriptions deug abuse to best target prevention services
  - Parents can use information and resources on protection and risk to develop positive prevention strategies such as establishing clear rules, expectations and consequences
  - Educators can strengthen learning and school social bonding by addressing problem behaviors and risks associated with later onset of prescritptioon drug abuse
- Educating healthcare providers
- Safe storage of medication
- Safe disposal of medication
- Connecting patients to the right care
- Developing coping skills, to deal with emotional and physical pain as well as pleasure bumps daily, early in life and within Family Systems that are "drug free".

Action Plan and Recommendations

Increase continuing education for healthcare providers on proper prescribing and disposal of prescription drugs

Expand Medicaid which would expand coverage of substance abuse treatment

Work with relevant dental, nursing, pharmacy, and medical student groups, local anti-drug coalitions, and other organizations to disseminate public educational materials and raise awareness of prescription drug abuse and misuse and appropriate use and disposal of precription and over-the-counter medicine.

Expand use of, or access to Naloxone for overdosing individuals given by lay administrators

Expand partnerships across the state to include Parent Teacher Associations and Georgia schools to guide parent and child education

Use Medicaid, PDMP, or worker's compensation data to identify improper prescribing of painkillers

Recommendations for Individuals

- Utilize Drug Drop Boxes to properly dispose medications (local drug dropbox locations can be found online at: www.stroprxabuseinga.org/prescription-drug-disposal)
  - o Mark out information on the bottle – only leaving the name of the medication
  - o Take them to the Sheriff's Office
  - o Drop them in the Drug Drop Box
  - o What to Drop: Expired and unused prescriptions or ORC medications, medication samples, pet medications, inhalers, medicated ointment/lotion/drops and unopened epi-pens.
- Store all prescription and over-the-counter prescription medications in a secure place where children cannot acquire them
  - o A "Medicine Safe" may be used to store prescription and over-the counter drugs (www.medicinesafe.com)
- If possible, lock away prescription medications
- Keep a running count of how many pills are in each bottle or packet and keep track of refill dates and amounts
- Get help for substance abuse problems (1-800-622-HELP)

INTIMATE PARTNER VIOLENCE

Definition: A *pattern* of abusive behavior or coercive control in any relationship that is used by one person to *gain or maintain power and control* over another (GCADV, 2014b

Emotional Abuse	Psychological Abuse	Economic Abuse	Sexual Abuse	Physical Abuse
Calling their partner names	Brainwashing their partner or trying to make them confused about reality	Controlling the family money	Causing their partner to be hurt during sex	Pinching, poking, slapping, biting, pushing, punching, strangling, burning or cutting their partner
Controlling of their partner	Secretly monitoring their partner through technology or other means	Forcing their partner to give paychecks to the abuser	Forcing their partner to perform sexual acts	Forcing their partner to take drugs
Blaming their partner when things go wrong		Not allowing their partner to work, go to school or attend other activities that would promote economic independence	Having affairs outside of the intimate relationship	
Preventing their partner from talking to people that can help	Forcing their partner to stay awake for long hours leading to chronic exhaustion			Hurting their partner's pet
	Using religion or other belief system to promote or defend their abusive behavior	Depriving their partner of money to pay for basic expenses	Forcing their partner to have sex for money	Taking away their partner's assistance devices, such as TTY, glasses, medicine or ramp
Humiliating their partner in public or with friends and family			Purposely infecting their partner with HIV/AIDS or a sexually transmitted illness (STI)	
Manipulating their partner	Forcing children to engage in verbal or physical abuse of their partner	Trying to get their partner fired from work by calling repeatedly, showing up or starting conflict with their partner's co-workers		Forcing partner to obtain an abortion or trying to force a miscarriage
Acting jealous and isolating their partner from friends and family	Threatening to have their partner deported if they are undocumented		Sabotaging birth control	
Acting in ways that make their partner feel afraid	Switching from violent behavior to kind behavior in order to regain partner's trust	Taking away their partner/s passport, social security card, or other documents so they are unable to establish independence, financial or otherwise		

Common Risk Factors:

Risk factors are associated with a greater likelihood of intimate partner violence (IPV) victimization or perpetration. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

A combination of individual, relational, community and societal factors contribute to the risk of becoming a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various opportunities for prevention. Factors may include the following:

RISK FACTORS

Individual Risk Factors

- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Low Income
- Anger and hostility
- Isolation
- Being a victim of physical or psychological abuse
- Belief in strict gender roles
- History of experiencing poor parenting as a child
- Borderline personality traits
- Prior history of being physically abusive

Relationship Factors

- Marital conflict-fights, tension, and other struggles
- Marital instability - divorces or seperation
- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

Community Factors

- Poverty and associated factors
- Low social capital
- Weak community sanctions against intimate partner violence
- Exposure to violence and poverty

Societal Factors

- Traditional gender norms
- Films, music, and advertising images that allow for domestic and intimate partner violence

ELEVATED HEALTH CARE COSTS FOR VICTIMS OF IPV CAN PERSIST UP TO 15 YEARS AFTER ABUSE HAS ENDED

Some Possible Consequences	
Depression	Traumatic brain injury
Anxiety	Cardiovascular Disease
Insomnia	Bladder/kidney infections
Posttraumatic stress disorder	Digestive Problems
Suicidal behavior	Severe menstrual problems
Sexually transmitted infections	Chronic pain syndromes
Unintended pregnancy	Central nervous system
Death	disorders

IPV NATIONALLY

Nationally, 1 in 4 American women will experience domestic violence at some point in their lifetime.

Most female and male victims of rape, physical violence, and/or stalking by an intimate partner (69% of female victims; 53% of male victims) experienced some form of intimate partner violence for the first time before 25 years of age.

On average, 24 people per minute are victims of physical violence, rape, or stalking by an intimate partner in the United States.

IPV can occur in same-sex and in opposite-sex couples; it can also range from one incident to an ongoing pattern of violence.

Nearly 1 in 10 women in the United States (9.4%) has been raped by an intimate partner in her lifetime and an estimated 16.9% of women and 8.0% of men have experienced sexual violence other than rape by an intimate partner at some point in their lifetime.

According to the U.S. Department of Justice, about 4 in 5 victims of intimate partner violence were female from 1994 to 2010. Most intimate partner violence was perpetrated against females

.
IPV resulted in 2,340 deaths in 2007 nationally; of these IPV victims, 70% were females

Women aged 20-24 years of age are at greatest risk for domestic violence by an intimate partner. Although estimates vary greatly, research indicates that as many as seven million children are exposed to domestic violence each year in the U.S. This is approximately one out of every ten children based on the U.S. Census Data.

IPV IN GEORGIA

Georgia in comparison to the U.S:

In 2012 Georgia was ranked 6th in the nation for rate of men killing women.

Intimate Partner Violence is a leading cause of injury for girls and women between the ages of 15 and 44. According to the National Domestic Violence Hotline, 57% of reported victims of dating abuse range from age 13-19 in Georgia.

According to the latest Center for Disease Control and Prevention, Youth Risk Behavior Surveillance (YRBS), Georgia ranks as the worst state in the nation for teens experiencing dating violence: One in six teen respondents to the YRBS (16%) indicates he or she has experienced some form of this abuse.6 Teen dating violence can also have long term consequences. Georgia's most recent Domestic Violence Fatality Review Report7 indicates that over one quarter (30%) of adult DV fatality victims were 15 to 24 years old when they began their relationship with the person who eventually killed them.

According to the National Domestic Violence Hotline, in Georgia, 40% of calls requesting domestic violence services are from victims between the ages of 25-35.

69% of victims reported emotional abuse as the primary type of abuse.

In 2013, Georgia had 116 domestic violence related deaths. Georgia is seeing increasing numbers of Domestic Violence fatalities since 2008.

From 2003-2013, the counties with the leading number of domestic violence related deaths per 100,000 residents were: Clay, Calhoun and Telfair. By numbers the leading counties were Fulton, Cobb and Gwinnett.

DID YOU KNOW?

The costs of IPV against women exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical care and mental health care and nearly $1.8 billion in the indirect costs of lost productivity. Statistically, the overall total cost estimate of $5.8 billion varies from more than $3.9 billion to more than $7.6 billion, as indicated by the 95% confidence interval for the total costs

The largest proportion of the costs is derived from physical assault victimizations because that type of IPV is the most prevalent. The largest component of IPV costs is health care, accounting for nearly $4.1 billion—more than two-thirds of the total costs

Georgia is ranked 10th in the nation for the rate that men kill women in single-victim homicides, most of which are domestic violence-related murders.

Domestic violence fatality rates in Georgia have fluctuated from 2006 to 2013 with overall little change; however, there was a decrease from 2012 where there were 131 deaths caused by domestic violence in Georgia to 118 deaths in 2013 (Georgia Commission on Family Violence, 2013). By far, the largest percent of deaths were caused by firearms, followed by stabbing and strangulation.

In 2013:
58,955 crisis calls were made to Georgia's certified domestic violence agencies

7,807 victims and children were provided refuge in a Georgia domestic violence shelter

Firearms were the cause of death in 72% of the recorded domestic violence fatalities

DOMESTIC VIOLENCE AND CHILDREN

Children are exposed to domestic violence in many ways such as witnessing homicides, being forced to participate in the abuse, overhearing the abuse, witnessing or being forced to watch the abuse, or being harmed in the course of a domestic violence assault (GCADV, 2013). Children exposed to domestic violence are at a higher risk of being victims of child maltreatment (Holt et al., 2008). Nearly 30% of domestic violence fatality cases included child maltreatment as reviewed by the Georgia Commission on Family Violence and the Georgia Coalition Against Domestic Violence. However the child is exposed to the violence, there are various implications on the child's behavioral, social, emotional, and cognitive health. The chart below presents some of the lifespan implications of exposure to domestic violence from infancy to adolescence.

	INFANTS	PRESCHOOL AGE	SCHOOL AGE	ADOLESCENTS
BEHAVIORAL	Fussiness Decreased responsiveness Trouble sleeping Trouble eating	Aggression Behavior problems Regressive behavior Yelling, irritability Trouble Sleeping	Extreme and persistent: Aggression Conduct problems Disobedience Regressive behavior	Dating violence Delinquency Running away Truancy Early Sexual Activity
SOCIAL		Trouble interacting with peers Stranger anxiety	Fewer and low quality peer relations	Dating violence (victim or perpetrator) Increased risk for ten pregnancy
EMOTIONAL/ PSYCHOLOGICAL	Attachment needs not met	Fear/anxiety, sadness, worry PTSD Negative affect Feeling unsafe Separation anxiety	Somatic complaints Fear and anxiety, depression, low self-esteem, shame PTSD Limited emotional response	Substance abuse Depression Suicidal ideation PTSD Feeling rage, shame Unresponsive
COGNITIVE	Becomes learned behavior	Self-blame	Self-blame Distracted, inattentive Academic problems Pro-violent attitude	Short attention span Pro-violent attitude Defensiveness
PHYSICAL	Smaller in size, smaller head circumference, impairment of cognitive development			

CHILDREN ARE OFTEN THE SILENT VICTIMS OF DOMESTIC VIOLENCE. AS MANY AS 275 MILLION CHILDREN WORLDWIDE ARE EXPOSED TO VIOLENCE IN THE HOME

Percentage of DV fatality cases where others witnessed the homicide, GA 2004-2013

Co-workers	New intimate partners	Friends	Family Members	Strangers	Acquaintances or neighbors	Children
1	2	4	6	10	11	18
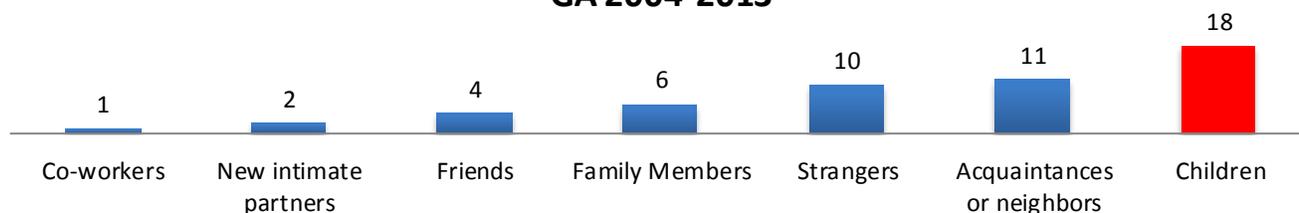
The Healthy People 2020 target to reduce children's exposure to violence from a baseline of 58.8% of children exposed to any form of violence, crime, and abuse in 2008, to 52.9% by 2020 (8% improvement).

The frequent exposure to domestic violence, whether hearing, experiencing, or seeing the violence, normalizes violence for children and increases their risk of becoming family violence victims and abusers.

Domestic violence can happen to anyone regardless of race, age, gender, sexual orientation, religion, of all socioeconomic backgrounds and education levels. Domestic violence not only affects those who are abused, but also has a substantial effect on family members, friends, co-workers, other witnesses, and the community at large. Children who grow up witnessing domestic violence are among those seriously affected by this crime. Frequent exposure to violence in the home not only predisposes children to numerous social and physical problems, but also teaches them that violence is a normal way of life - therefore, increasing their risk of becoming society's next generation of victims and abusers.

Children Exposed to Domestic Violence:

Often, children exposed to domestic violence are the unseen victims of domestic violence because they are not always direct victims. Children are exposed to domestic violence in many ways, including the following:
- overhearing the abuse
- witnessing or being forced to watch the abuse;
- observing injuries and bruises on a parent;
- being held hostage in order to force their partner's return home;
- being forced to participate in the abuse;
- being interrogated by the abuser about the victim's activities
- intervening in an assault to protect a parent;
- intentionally or unintentionally harmed in the course of a domestic violence assault;
- witnessing homicides, attempted homicides and/or sexual assaults.

Witnessing domestic violence and experiencing child abuse can have devastating effects on children.

Research indicates children exposed to domestic violence are at an increased risk of being abused or neglected. A majority of studies reveal there are adult and child victims in 30 to 60 percent of families experiencing domestic violence. Children who are exposed to violence undergo lasting physical, mental, and emotional harm. They suffer from difficulties with attachment, regressive behavior, anxiety and depression, and aggression and conduct problems. They may be more prone to dating violence, delinquency, mental illness, further victimization or perpetration of violence, and involvement with the child welfare and juvenile justice systems. Moreover, being exposed to violence may impair a child's capacity for partnering and parenting later in life, continuing the cycle of violence into the next generation.

In 2013, children were in the vicinity and actually witnessed the homicide in 18% of Georgia's domestic violence fatality cases reviewed and in 40% of reviewed cases they were in the vicinity of the homicide but did not witness it.

Action Plan and Recommendations

Prevention and Primary Intervention in Georgia:

Focus Area: Children Exposed to DV

Increase collaboration and trust between domestic violence and child welfare communities.

Create opportunities for youth to influence policy and practice related to IPV

The Division of Family and Children Services (DFCS), GCADV, the Barton Law Clinic, and The Georgia Commission on Family Violence will partner to successfully implement the new DFCS Domestic Violence protocol in 5 pilot locations and then statewide.

DFCS will collaborate with Domestic Violence partners on child death prevention initiatives related to domestic violence.

Intiatives

Georgia Family Connection Partnership and GCFV will foster connections between the local Domestic Violence Task Forces and local Family Connection Collaborative's to leverage resources and coordinate responses to Georgia's families.

GCFV and the Georgia Family Connection Partnership will collaborate to present domestic violence information to the Partnership's regional peer to peer groups.

Action Plan and Recommendations

For Children:

FAMILY VIOLENCE TASK FORCES AND DOMESTIC VIOLENCE PROGRAMS

- Evaluate available community resources and the process for making families aware of them.
- Develop relationships with and build capacity of local school boards, teachers, faith agencies with youth groups, after-school program, camp counselors, coaches, and teen parent program staff to provide resources and programs on children witnessing abuse at home.
- Coordinate efforts and build rapport between law enforcement and service providers to serve children exposed to domestic violence.

THE DIVISION OF FAMILY AND CHILDREN SERVICES

- Prioritize the emotional and mental health of survivng children following homicide cases. All surviving children should receive professional counseling with therapists who specialize in grief and trauma.
- Regularly update DFCS Child Abuse Protocol in collaboration with domestic violence advocates.

PROSECUTION-BASED ADVOCATES AND LAW ENFORCEMENT AGENCIES

- Implement partnerships so that prosecution-based advocates are notified when there is a domestic violence murder-suicide in your community.
- Reach out to family members to provide them with information on the Georgia Crime Victims Compensation Program and other services available to them.
- Partner with child advocacy centers to provide forensic interviewing to greatly reduce the level of trauma experienced by children during interviews.

STATEWIDE

- Develop a statewide policy for law enforcement response to children at the scene of domestic violence incidents.
- Dedicate resources to effectively serve children exposed to domestic violence.

TEEN DATING VIOLENCE

Teen Dating Violence or TDV is a pattern of abuse or the threat of abuse against teenaged dating partners. TDV is the physical, sexual, or psychological/emotional violence within a dating relationship, which includes stalking. It can occur in person or electronically and may occur between a current or former dating partner. TDV occurs across diverse groups and cultures. It takes different forms, including verbal, emotional, physical, sexual, and digital abuse. The experience of being a victim of TDV has both immediate and long term effects on young people. Although the dynamics of TDV are similar to domestic violence among adults, the experiences of teen dating violence – as well as the challenges in seeking and providing services – make the problem of TDV unique.

RISK FACTORS

Individual

- Relationship based on power and control
- Child Maltreatment history
- Substance abuse
- Exposure to family violence
- Low self-esteem
- Justification of violence
- Early sexual activity and having multiple sexual partners

Peer Group

- Social isolation
- Cultural norms and beliefs justifying violence
- Friends in abusive relationships

School

- High prevalence of dating violence, bullying, and sexual harrasment
- Weak sanctions, acceptance of violence in relationships

Community

- Poverty and stress
- Culture of oppression
- Rigid gender sterotypes
- High levels of violence
- Social influences in the media and music

AGE WHEN ABUSIVE RELATIONSHIP BEGINS - Georgia

■ Victim ■ Abuser

Age Group	Victim	Abuser
13-24	51	36
25-34	26	31
35-44	16	25
45-54	6	6
55-64	1	2
65+	0	0
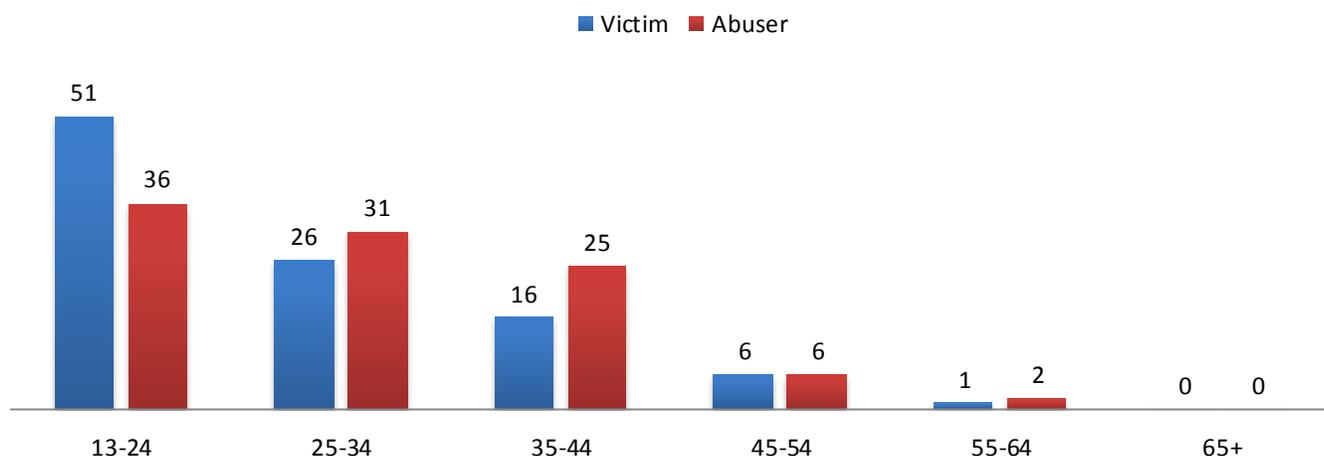
Georgia has higher rates of teen dating violence compared to the national average for both males and females. National rates of teen dating violence are similar between African-American non-Hispanics and Hispanics, and slightly lower in Whites (Youth Risk Behavior Survey, 2011). In reviewed cases, a large number of abusive relationships start when the victim is young between the ages of 13 and 24 years old (Georgia Domestic Violence Fatality Review Project, 2013). Adolescent girls in abusive relationships are approximately six times more likely to become pregnant than girls in non-abusive relationships (Decker, Silverman & Raj, 2005).

Percentage of high school students who experienced dating violence - Georgia vs. National Data

■ Georgia ■ National

	Georgia	National
Male - Dating Violence	15.4	9.5
Female - Dating Violence	16.6	9.3
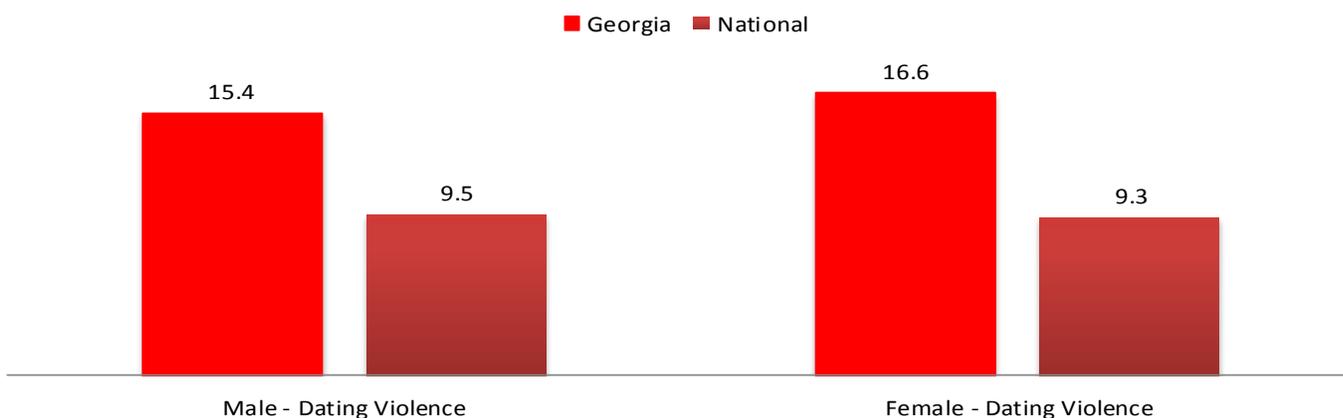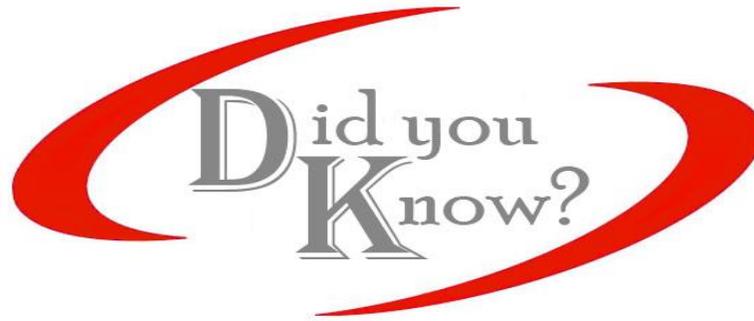
In a one-day survey held on September 17, 2013, 35 out of 50 (70%) local domestic violence programs in Georgia were surveyed. These programs reported seeing 1,975 victims on that day.

The services provided by these local programs include:
Advocacy related to disability issues
Bilingual advocacy
Emergency shelter
Children's support or advocacy
Advocacy related to mental health
Advocacy related to housing office/landlord
Transitional housing
Advocacy related to teen victims of dating violence

In that one day, there were 248 unmet requests for services; 185 (65%) of those unmet requests were for housing. As a result, many victims either
1. Return to their abuser,
2. Become homeless, or
3. Live in their cars

Causes of Unmet Requests for Help?

37% reported reduced government funding
14% reported reduced individual donations
14% reported cuts from private funding sources
14% reported not enough staff
(nnedv 2014)

Action Plan and Recommendations

Prevention and Primary Intervention in Georgia:

Focus Area: Teen Dating Violence (TDV)
1. Increased awareness of TDV and the need for prevention.
2. Increase education for adolescents about healthy relationships and how to recognize and prevent adolescent relationship abuse.
3. Increase school-based opportunities for adolescents to practice healthy relationship and peer behavior.

GCADV will coordinate with the Department of Education (DOE), the Legislature, GOCF, GCFV and the Governor's Office to promote Teen Dating Violence Prevention.

GCADV will partner with DOE to integrate TDV information into existing bullying, health curriculum and school climate initiatives.

Initiatives

DOE and GCADV will collaborate to provide TDV training to Regional Education Services Agencies, educational associations, and System of Care conferences.

DOE, GCADV, Start Strong partner will review various TDV curriculum options and to expand the use of evidence-informed TDV curriculum in middle schools.

Recommendations for In-School Dating Violence Prevention

- Involve teens in program development
- Implement programs in middle school and in the early high school years
- Utilize a comprehensive, ecologically informed approach, engaging all members of the school community
- Provide programming for the general student population and support for students who have experienced violence
- Reinforce positive messages and focus on healthy relationship education and skills
- Address affective, cognitive and behavioral domains and offer various teaching methods that stimulate and involve the active learning process
- Provide opportunities to teens to develop strong and positive relationships through leadership opportunities and mentoring

Action Plan and Recommendations

Prevention and Primary Intervention in Georgia:

Focus Area: Public Awareness Campaign

1. Change public beliefs and attitudes about violence and abuse.
2. Increase public knowledge of risks factors, incidence of DV, and available resources.
3. Change public behaviors on disclosure, reporting, and responding to abuse.

Initiatives:
Georgia Coalition Against Domestic Violence (GCADV) will obtain funding to pull together partners and experts to design and implement a comprehensive, integrated media campaign, with well promoted community events, seminars and trainings.

Healthcare Providers (ACOG, 2012; Lockhart & Danis, 2010)

- Screen for IPV in private, safe settings with individuals and not with partners, friends, family or caregivers in the room.
  - In case of language barriers, use professional interpreters rather than family members
- During screenings, offer a framing statement to indicate that screening is done universally and in acknowledgement of the prevalence of the problem, and not because IPV is suspected
- Incorporate IPV screening into routine medical history by incorporating questions into intake forms
  - Sample Questions:
    - Has your current parner ever hit, kicked, slapped, pushed, punched, or shoved you?
    - Do you feel afraid of your partner?
    - Do you feel isolated?
    - Has your partner ever forced you to have sex when you do not want to?
    - Has your partner prevented you from using a wheelchair, respirator, cane, or other assistive devices?
    - Has your partner tampered with your birth control or tried to get you pregnant when you didn't want to be?
- Train staff about IPV
- Keep printed take-home resource materials that include hotline numbers, safety procdures, and referral information in privately accessible areas such as examination rooms and restrooms.
- Establish and maintain relationships with community resources for women affeted by IPV.

Organizations

- Develop and maintain policies that require screening and create tracking systems to maintain consistent data
- Regularly train employees on domestic violence issues
- Establish workplace policies to address the needs of workers personally affected by IPV
- Establish an atmosphere that welcomes individuals from diverse cultural backgrounds

Action Plan and Recommendations

Policy Goals for legislators and partners:

Develop additional resources in South Georgia, including advocacy/safety services, Task Forces, and Family Violence Intervention Programs

Enhance access to needed services in Georgia, including child care, legal services, housing, language interpretation and transportation, where these are hard to find.

Develop and improve access to services for underserved populations, including children exposed to IPV and teen dating violence.

Develop resources that strengthen collaboration, including cross-training and coordinated protocols among law enforcement, prosecutors, judges, advocates, and DFCS workers.

Promote approaches that encourage community connections for families at risk (or victims) of family violence (e.g., support for faith-based services, alternatives to removal).

Develop a strategic statewide approach for enhancing public awareness and promoting social norms that insist on safety, equality and respect for all people in Georgia.

Improve collaboration and develop practices, protocols and tools for gathering and using Family Violence data to assist with future state planning in Georgia.

Improve access to coordinated, trauma-informed mental health, substance abuse, and domestic violence services statewide (e.g., partnership with accountability courts, criminal justice reform).

Enhance existing resources for people who are abusive, and develop new resources where family violence is high but services for offenders are scarce.

Develop a strategic statewide approach for educating the public about the risks and warning signs of IPV, and what to do about it.

MOTOR VEHICLE RELATED INJURIES

Under the authority and approval of Governor Nathan Deal, the Governor's Office of Highway Safety (GOHS) produces the annual Highway Safety Plan (HSP), which serves as Georgia's programmatic guide for the implementation of highway safety initiatives and an application for federal grant funding from the National Highway Traffic Safety Administration (NHTSA).

Georgia's Highway Safety Plan is directly aligned with the priorities and strategies in the Georgia Strategic Highway Safety Plan (SHSP) and includes a wide variety of proven strategies and new and innovative countermeasures. The Highway Safety Plan is used to justify, develop, implement, monitor, and evaluate traffic safety activities for improvements throughout the federal fiscal year. National, state and county level crash data along with other information, such as safety belt use rates, are used to ensure that the planned projects are data driven with focus on areas of greatest need. All goals and objectives of the Governor's Office of Highway Safety are driven by the agency's mission statement.

In 2011, there were 1,223 motor vehicle fatalities in the State of Georgia. This is a 2% decline in roadway fatalities in comparison to the previous year and a 26% decline from 2007 roadway fatalities. Nine (9) counties in Georgia had no roadway fatalities in 2011. This same year (2011), there were 104,524 motor vehicle injuries and 296,349 motor vehicle crashes in Georgia. In 2010, the national average roadway fatality rate was 1.11 fatalities per 100 million vehicle miles traveled (VMT).

That same year, Georgia had a fatality crash rate of 1.12 fatalities per 100 million vehicle miles traveled (VMT). Although the Georgia fatality rate is high in comparison to the national average, this is the lowest fatality rate for Georgia in recorded history. The level of roadway exposure among Georgians has increased over time. The number of licensed drivers has steadily increased since 2003. In 2003, there were 5.5 million licensed drivers and 104 billion vehicle miles traveled in comparison to 2010 when there were 5.7 million drivers and 111 billion vehicle miles traveled.

The Highway Safety Plan (HSP)

Contains Education and Enforcement countermeasures for reducing motor vehicle related crashes, injuries and fatalities on Georgia roads. It also documents strategic, comprehensive, and collaborative efforts with the Engineering and Emergency Medical Services components to roadway safety in the State. This "5-E" approach will result in a balanced and effective strategy to saving lives on Georgia's roadways.

Governor's Office of Highway Safety (GOHS) plans to develop, promote, implement and evaluate projects designed to address those identified major contributing injury and fatal highway safety factors with the latest data available.

STATEWIDE TRENDS

Although urban areas, such as Atlanta Metropolitan Counties (Clayton, Cobb, DeKalb, Fulton, and Gwinnet) have a higher number of crashes, rural areas have significantly higher fatality rates than urban areas.

From 2009 to 2010, the fatality rates in rural areas have increased by 4%. In that same time period, overall fatality rates decreased by 5% and urban fatality rates decreased by 13% within the same time period
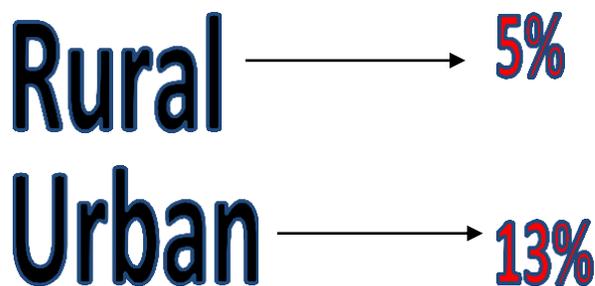
The total fatality 3-year average has declined by 17% in 2010 from the 2009, an average of 1,344 motor vehicle deaths with the last three years. The rural fatality 3-year average has steadily declined over the 5-year period, with an average annual decrease of 6%. On the other hand, the urban fatality 3-year average remained steady of the past five years

Top 10 Counties with the highest motor vehicle fatalities in rank order (2011)

1. **Fulton**
2. **DeKalb**
3. **Gwinnett**
4. **Cobb**
5. **Richmond**
6. **Clayton**
7. **Hall**
8. **Carroll**
9. **Chatham**
10. **Bibb**

In 2011, 19% of all Georgia motor vehicle fatalities occurred in the top five counties. Although five of the ten counties with the highest 2011 fatalities decreased from the previous year, counties like Richmond, Cobb, Clayton, and DeKalb experienced an increase in fatalities.

Driving under the influence of drugs and/or alcohol is a problem in Georgia

Over the past five years (from 2007 to 2011), 352 alcohol impaired fatalities occurred per year, representing on average 26% of all roadway fatalities a year. The lowest percentage of alcohol related fatalities occurred in 2009 with 331 deaths representing 25% of all fatalities in that year. In 2011, Georgia experienced the lowest number (277 counts) of alcohol related fatalities.

In 2011, the number of unrestrained fatalities for persons older than 5 years of age riding in passenger vehicles decreased by 2% from 428 unrestrained fatalities in 2010. The percentage of unrestrained fatalities among passengers in a moving vehicle has decreased from 53% in 2008 to 48% in 2011.

The Governor's Office of Highway Safety continues to address the issue of non- use (or gross misuse) of child passenger restraints in rural areas of Georgia. The Thunder Task Force enforcement campaigns indicate citation numbers for child passenger seats have dramatically increased in recent months. To address this issue, the Governor's Office of Highway Safety is continuing the emphasis on collaborations with rural law enforcement agencies through the expansion of the Highway Enforcement of Aggressive Traffic. (H.E.A.T) program, providing public awareness through the annual Child Passenger Safety Caravan, and encouraging increased rural participation in events including National Child Passenger Safety Week.

The HSP goals will be accomplished through several "countermeasures that work" best practices in programs and partnerships. Some goals are achieved through major enforcement and public awareness campaigns in conjunction with the national high-visibility mobilizations including the GOHS Highway Enforcement of Aggressive Traffic (H.E.A.T.) program, and the GOHS Thunder Task Force. Other goals are achieved through continuing partnerships with the Georgia Department of Public Health, the University of Georgia's Traffic Injury Prevention Institute (GTIPI), the Georgia State Patrol, and the Atlanta Fire Department. GOHS collaborates with these agencies in implementing national high-visibility enforcement campaigns, public awareness campaigns, as well as child passenger safety fitting stations and trainings.

The Georgia Highway Safety Plan core performance measures and priority goals:

The Georgia Highway Safety Plan core performance measures and priority goals include:

- Decrease the number of serious traffic injuries below the 2012 calendar base year average of 115,116 to 112,256 by December 31, 2014.

- Decrease unrestrained passenger vehicle occupant fatalities in all seating positions by four-percent (4%) from the 2011 calendar base year of 421 to 402 by December 31, 2014.

- Decrease drivers age 20 or younger involved in fatal crashes from the 2011calendar base year of 165 to 152 by December 31, 2014.

- Increase the rate of observed safety belt use from baseline 91.5% in 2012 to 92% by the end of FFY 2014 for drivers and front seat outboard passengers.

- Maintain statewide observed safety belt use of front seat outboard in passenger from the 2012 calendar base year average usage rate of 91.5% to 92% by December 31, 2014.

Georgia Restraint Use Observational Survey
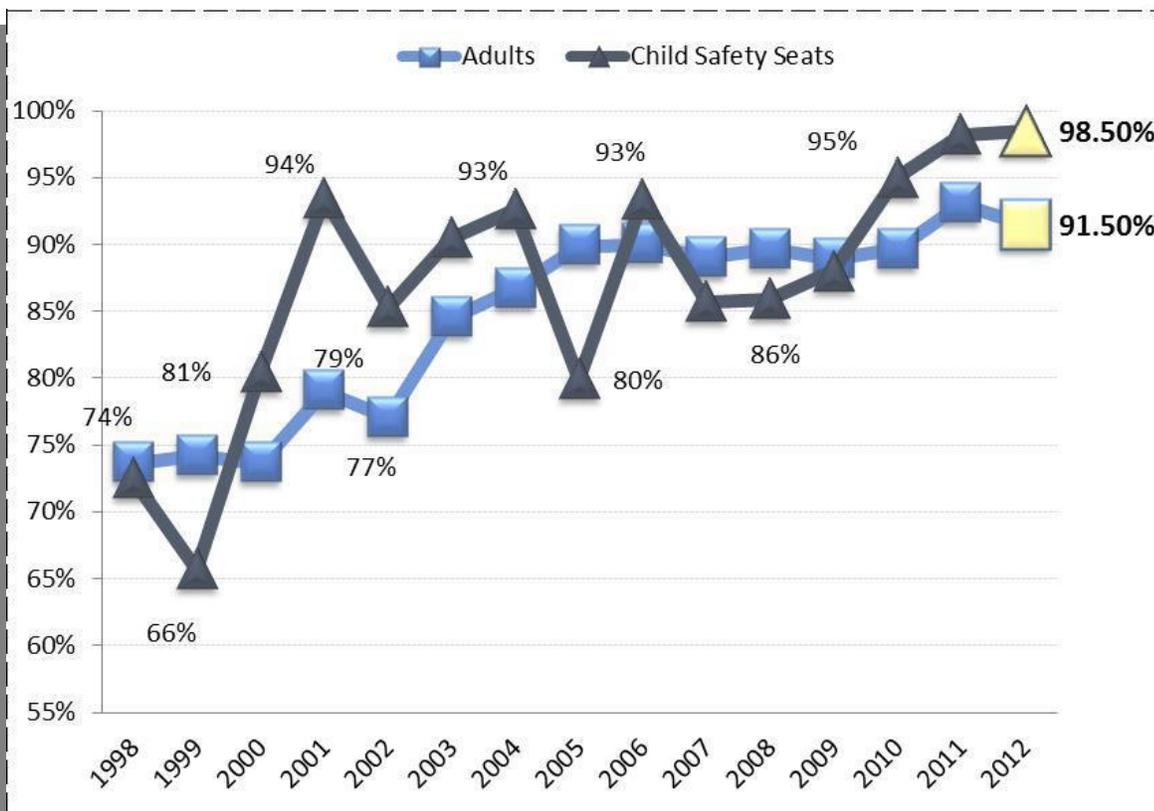
MOTOR VEHICLE RELATED INJURIES – CHILD PASSENGER SAFETY

Georgia Data relating to child passenger safety

	YEAR									
	2009		2010		2011		2012		2013	
	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate
MVC	674	27.1	770	30.9	735	29.5	654	26.2	595	23.9

	YEAR									
	2009		2010		2011		2012		2013	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
MVC	98	3.9	127	5.1	103	4.1	78	3.1	104	4.2

**The above data was retrieved from OASIS for children 0-17 with measures caused by Motor Vehicle Crashes

Motor vehicle injury related deaths are higher in Georgia than the United States, with the U.S. death rates being 0.81 in 2009 and 0.61 in 2010 compared to the rates above.

Common Risk Factors on Child Passenger Safety

- Incorrect installation of a car seat/improper car seat for the child
- Low socioeconomic status, low education level for parents
- Of children that die in a MVC, minority children (African-American and Hispanic) are more likely to be unbuckled than white children
- As children age, it is more likely that they will not be buckled up. The "booster seat stage" is often skipped.

The Healthy People 2020 Goal

IVP-13: "Reduce motor vehicle crash-related deaths"

IVP-13.1: "Reduce motor vehicle crash-related deaths per 100,000 population"

Baseline: 13.8 deaths per 100,000 population
Target: 12.4 deaths per 100,000 population

IVP-13.2: "Reduce motor vehicle crash-related deaths per 100 million vehicle miles traveled"
Baseline: 1.3 deaths per 100 million miles
Target: 1.2 deaths per 100 million miles

IVP-14: "Reduce nonfatal motor vehicle crash-related injuries"

Baseline: 771.4 injuries per 100,000 population
Target: 694.3 injuries per 100,000 population

IVP-15: "Increase use of safety belts"
Baseline: 84% use of seat belts Target:
92% use of seat belts

IVP-16: "Increase age-appropriate vehicle restraint system use in children"

Cost Data

- Annual cost for motor vehicle related injury/death is over $240 billion
- Medical costs amounting to $56 million in 2005
- Work loss costs amounting to $8.2 billion in 2005

Best Practices for Prevention

- Midnight driving curfew for teenagers to limit accidents
- Provisional licensing for teenagers
- Child safety seat distribution + education programs
- Booster seats for children who have outgrown car seats
- Require children 12 years and younger to sit in the backseat as airbags can harm children during an accident
- Increasing the age requirement to 7 or 8 years for car seat/booster seat use.

Education alone without distribution of needed car seats or safety equipment is not as effective as education + distribution programs.

Georgia Efforts toward Prevention

- Road blocks
- Department of Public Health mini grant program
- Car seat education and distribution programs (Safe Kids)
- Booster seat campaigns
- GOHS caravan

MOTOR VEHICLE RELATED INJURIES –   PEDESTRIAN

Common Risk Factors Relating to Pedestrian Safety

- Males continuously represent more of the child pedstrian injuries than females
- Children are most likely to be involved in a pedestrian incident between the hours of 3pm and 6pm
- Teenagers between 16 and 19 years of age are now most at risk for pedestrian related injuries, and the number of injuries has increased by 25% from 2007-2011
- Low socioeconomic status
- Low-income neighborhoods
- Lack of adult supervision for young children, particulary in driveways and parking lots
- Distractions (eating, smoking, listening to music, talking to peers and texting)

Healthy People 2020 Goal

IVP-18: "Reduce pedestrian deaths on public roads" (10 percent improvement) Baseline: 1.5 deaths per 100,000 population

Target: 1.4 deaths per 100,000 population

IVP-19: "Reduce nonfatal pedestrian injuries on public roads" (10 percent improvement) Baseline: 22.6 injuries per 100,000 population

Target: 20.3 injuries per 100,000 population

Cost data relating to pedestrian safety

- $711 million total lifetime cost of motor-vehicle related fatalities for children in 2005
- Medical costs including physical therapy and rehabilitation in the recovery period
- Emotional stress for the child who underwent trauma as well as the parent(s)
- Work loss for parents who must care for injured children
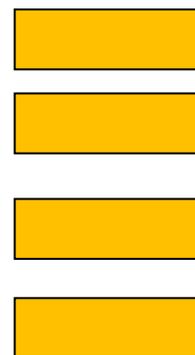
Best practices for prevention

- Provide constant supervision for young children when they are around motor vehicles (parking lots, driveways, neighborhood streets)

- Design safe neighborhoods with sidewalks, crosswalks, and traffic lights Educate older children about safe practices for walking in areas with traffic Education combined with the distribution of safety items

- Educate teens about the risks of distracted driving/walking

Georgia Efforts toward Prevention

- *Safe Routes to School*
- *Safe Kids Walk this Way*
- *PEDS*
- *GOHS Programs*

Action Plan and Recommendations

Using the correct car seat or booster seat can be a lifesaver: make sure your child is always buckled in an age- and size-appropriate car seat or booster seat.

Birth 1 2 3 4 5 6 7 8 9 10 11 12+

Age by Years*

REAR-FACING CAR SEAT

Birth up to Age 2*
Buckle children in a rear-facing seat until age 2 or when they reach the upper weight or height limit of that seat.

FORWARD-FACING CAR SEAT

Age 2 up to at least age 5*
When children outgrow their rear-facing seat, they should be buckled in a forward-facing car seat until at least age 5 or when they reach the upper weight or height limit of that seat.

BOOSTER SEAT

Age 5 up until seat belts fit properly*
Once children outgrow their forward-facing seat, they should be buckled in a booster seat until seat belts fit properly. The recommended height for proper seat belt fit is 57 inches tall.

SEAT BELT

Once seat belts fit properly without a booster seat
Children no longer need to use a booster seat once seat belts fit them properly. Seat belts fit properly when the lap belt lays across the upper thighs (not the stomach) and the shoulder belt lays across the chest (not the neck).

Keep children ages 12 and under in the back seat. Never place a rear-facing car seat in front of an active air bag.

*Recommended age ranges for each seat type vary to account for differences in child growth and height/weight limits of car seats and booster seats. Use the car seat or booster seat owner's manual to check installation and the seat height/weight limits, and proper seat use.

Child safety seat recommendations: American Academy of Pediatrics.
Graphic design: adapted from National Highway Traffic Safety Administration.
www.cdc.gov/motorvehiclesafety/cps

Georgia has a booster seat law until age 8

Conduct statewide campaigns to promote occupant safety (Buckle Up America Month, Child Passenger Safety Month, Hands Across the Border, and Click It or Ticket)	Develop Occupant Protection intiatives within law enforcement and educational grants	Continue building collaborative parnerships with organizations, law enforcement and community groups to addresss highway safety initiatives at the local level
Address occupant safety use among young adults through occupant and child safety seat education	Ensure all agencies responsible for transporting children meet Georgia seatbelt and child restraint laws	Provide training to childcare providers and educational professionals on safe transporation for children

DROWNING

Definition: The process of experiencing respiratory impairment from submersion/immersion in liquid

- Drowning can be classified as either fatal or non-fatal

Risk Factors

Victim

- Children aged 1-4 years
- Children with seizure disorders or hypoglycemia
- Most drowning victims are male
- Lack of prior swimming instruction
- Alcohol use
- Lack of use of Personal Flotation Device (PFD)
- African-American children have a higher risk of drowning than Whites

Supervisor

- Lack of proper supervision
- Lack of knowlege of CPR and other recussitation methods
- Alcohol use

Costs Due to Drowning Deaths in Georgia, All Ages, 2005

Medical Costs	Work Loss Cost	Combined Cost
Average Per Person: $2,207	Average Per Person: $1,128,866	Average Per Person: $1,131,073
Total in 2005: $254,000	Total in 2005: $129,820,000	Total in 2005: $130,074,000
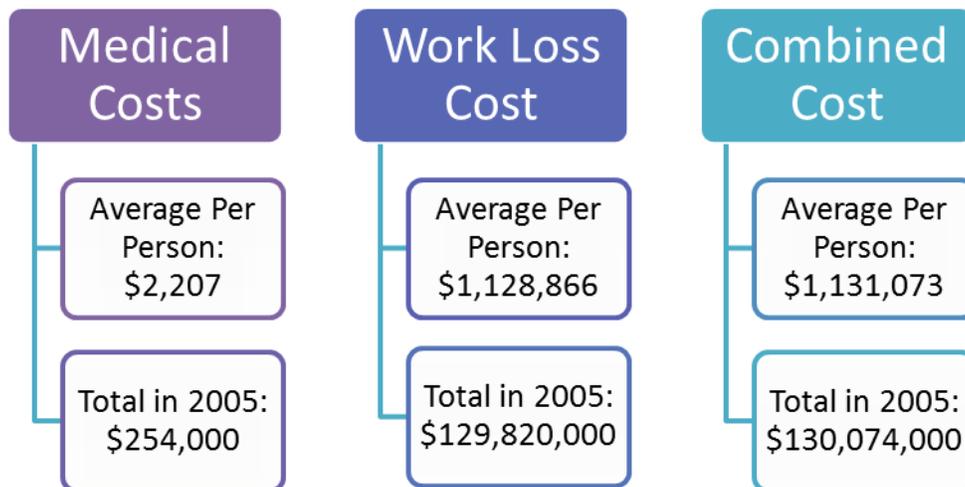
Outcomes of Drowning

- Death
- Brain injury
- Damage to lung tissue
- Hypothermia
- Paralysis
- Decreased motor and coordination skills

Children age 5 and older are most likely to drown in natural bodies of water, while children younger than 5 are most likely to drown in swimming pools or bathtubs

Did you know?

Drowning can occur in as little as one inch of water (Healthy Children, 2013).

There are higher rates of drowning on the weekends than on the weekdays (CDC, 2014).

Drownings can occur in any type of liquid, not just water (Healthy Children, 2013).

Georgia Data for Child Drowning

	YEAR									
	2009		2010		2011		2012		2013	
	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate
Drowning	17	0.7	50	2.0	55	2.2	41	1.6	39	1.6

|	YEAR									
	2009		2010		2011		2012		2013	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Drowning	36	1.4	39	1.6	32	1.3	27	1.1	29	1.2

**The above data was retrieved from OASIS for children 0-17, with measures caused by drowning

- Medical costs amounting to $5.7 million in 2005 (CDC)
- Work loss costs amounting to $1.2 billion in 2005 (CDC)
- Drowning injuries cost over $16 billion in 2000 (PIRE)

WHAT DOES DROWNING LOOK LIKE?

## THE SIGNS OF DROWNING

1. FACING SHORE
2. MOUTH AT WATER LEVEL
3. HEAD TILTED BACK
4. BODY VERTICAL
5. CLIMBING LADDER MOTION

2 MOUTH AT WATER LEVEL

3 HEAD TILTED BACK

1 FACING SHORE

4 BODY VERTICAL

5 CLIMBING LADDER MOTION

SAND BAR

Great Lakes Surf Rescue Project,

Great Lakes
SURF
RESCUE
PROJECT

GLSRP.ORG
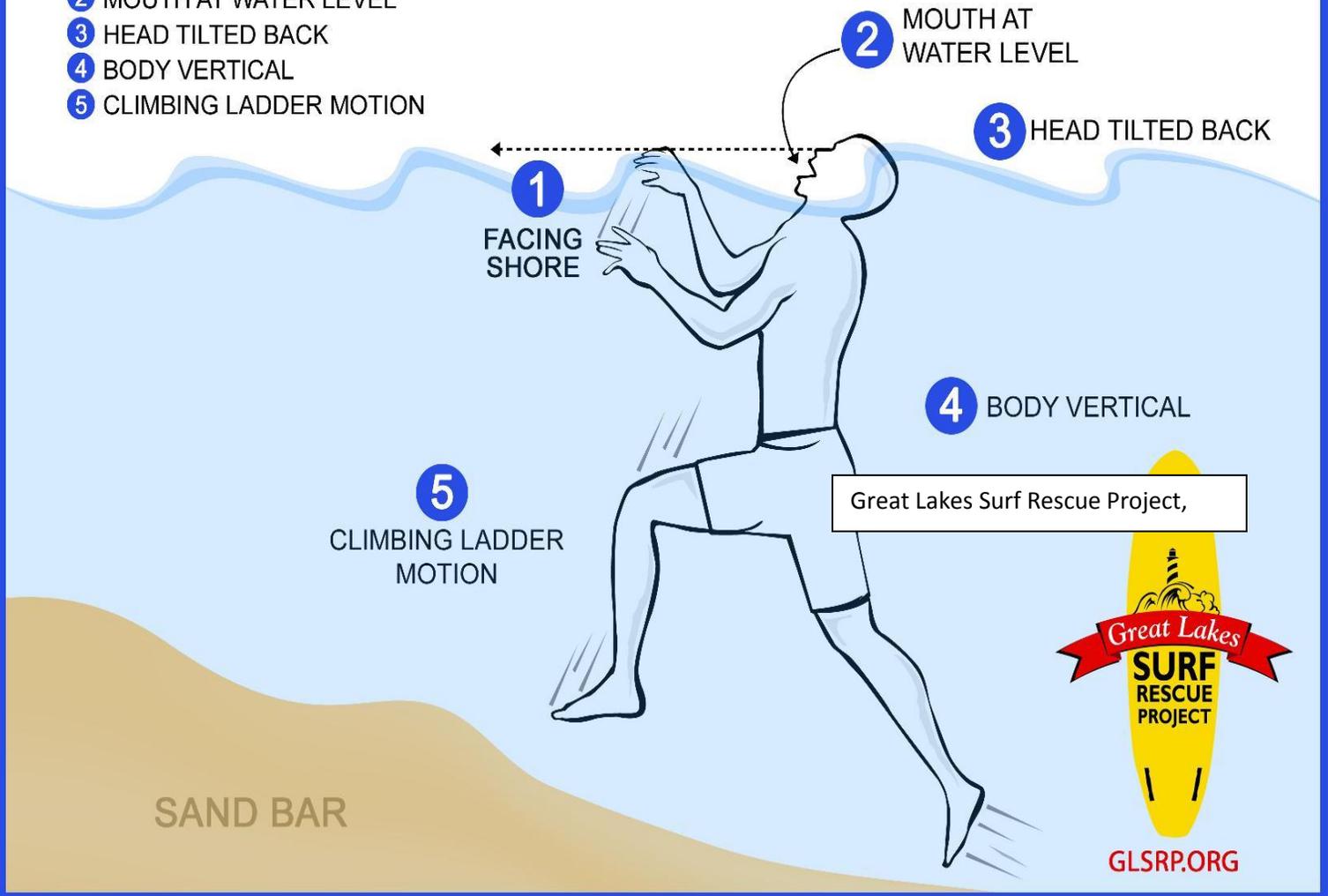
Great Lakes Surf Rescue Project, 2013

Drowning Rates Differ by Age Group and Gender

Average Annual Death Rates from Unintentional Drowning by Gender and Age Group, U.S. 1999-2010
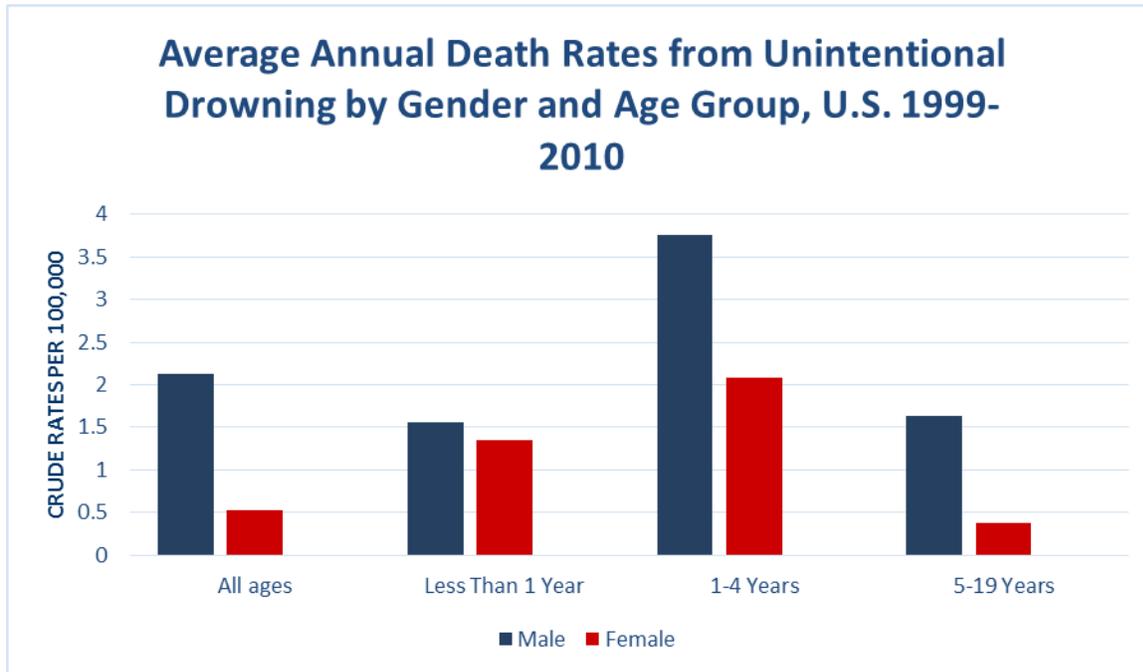
Males have higher rates of drowning than females. In Georgia for the years 2008-2012, the age-adjusted death rate due to drowning for males aged 0-19 was 2.33 per 100,000, while the age-adjusted drowning rate for females was .65 per 100,000, according to the CDC. The difference in drowning rates between males and females is highest in the 5-19 year age group. This difference seems to stem partly from males engaging in more aquatic activity than females in the 5-19 year age group. These males report engaging in more activities with potential for submersion than females, and also report riskier aquatic behavior, such as alcohol use while swimming or boating, swimming alone, swimming at night, or swimming in natural bodies of water at higher rates than females (Howland et al., 1996).

Children aged 1-4 have the highest drowning rate as compared to other age groups. According to the CDC, unintentional drowning accounted for 23.3% of all injury deaths in children aged 1-4 in the United States in 2012. In Georgia for the years 2010-2012, the crude drowning rate for children aged 0-4 was 2.55 per 100,000. This rate was higher than the drowning rates for the age groups 5-9, 10-14, and 15-19, which were 1.29 per 100,000, .72 per 100,000, and 1.51 per 100,000, respectively. This high drowning rate for children aged 1-4 might be due to increased mobility at that age coupled with a lack of adequate supervision, appropriate flotation devices, or proper pool enclosures. Furthermore, children aged 1-4 tend to have decreased swimming ability as compared to older children and adults; this may contribute to the higher drowning rate (CDC WISQARS, 2012).

Drowning Rates by Age Group and Drowning Type

Locations of Unintentional Drowning Deaths by Age, U.S. 1999-2010
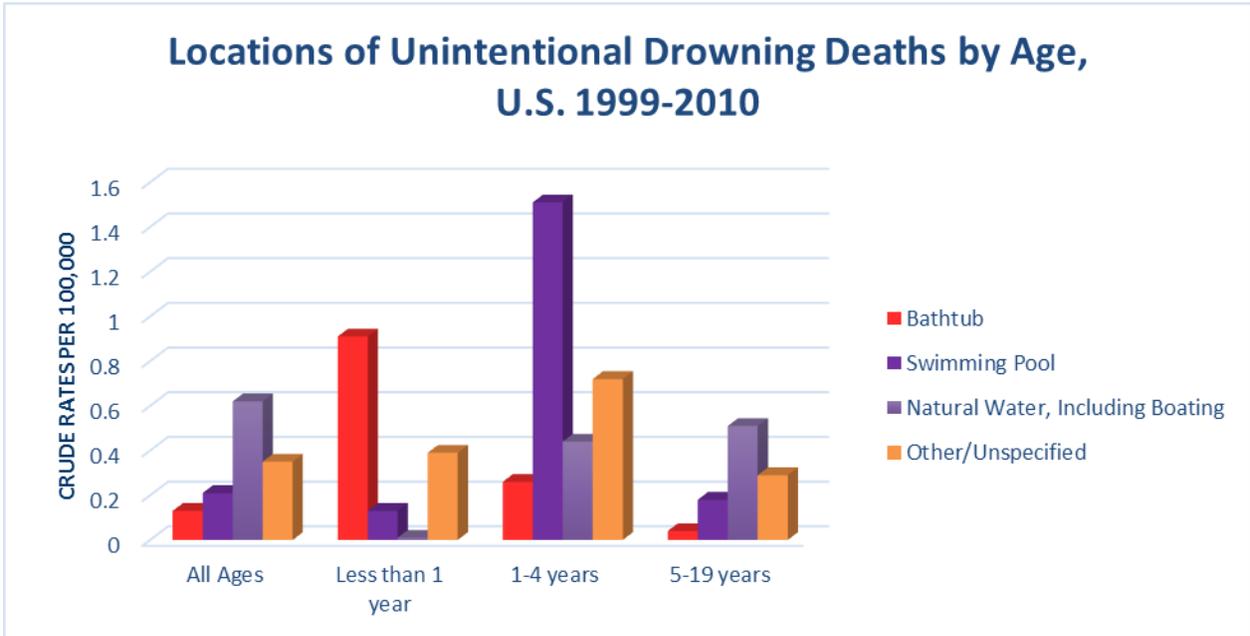
The most common locations of drowning differ by age group. Infants less than one year old are more likely to drown in a bathtub, while children between the ages of 1 and 4 are more likely to drown in swimming pools. Children older than 4 are more likely to drown in natural water, such as rivers or lakes (Xu, 2014).

Drowning Rates over Time

AGE-ADJUSTED DROWNING RATES FOR AGES 0-19, 2008-2012

	2008	2009	2010	2011	2012
Georgia Drowning Rate	1.67	1.38	1.82	1.43	1.26
National Drowning Rate	1.3	1.24	1.31	1.23	1.27

Healthy People 2020 Goal: 1.1 per 100,000
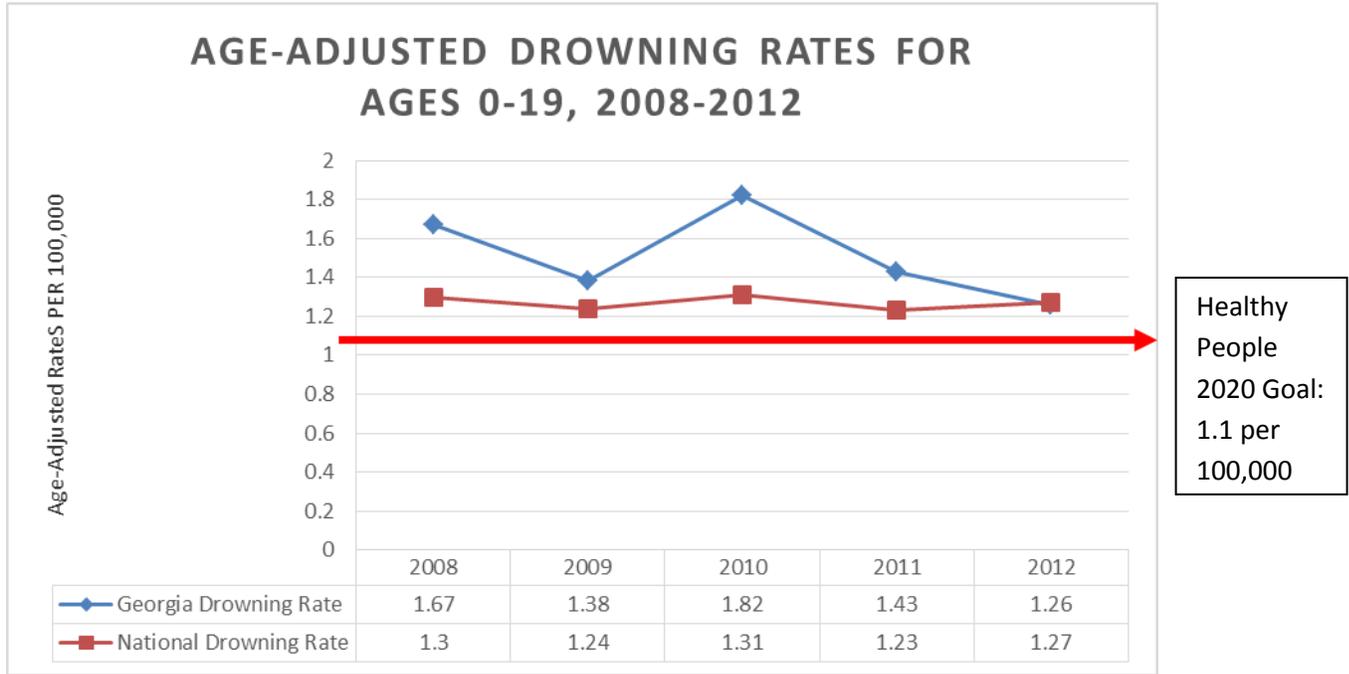
One Healthy People 2020 goal is to reduce the overall national drowning rate to 1.1 per 100,000. This would be a 10% decrease from the national drowning rate in 2007. The aggregate drowning rate in Georgia for the years 2008-2012 was 1.53 per 100,000, while the national rate was 1.28 per 100,000. The national drowning rate did not significantly change from 2008 to 2012.

NONFATAL DROWNING/SUBMERSION INJURIES IN THE U.S., 2009-2013

Age Group	Number of Non-Fatal Drowning/Submersion Injuries	Crude Rate	Age-Adjusted Rate
0-4	18,222	18.14	--
5-9	4,811	4.72	--
10-14	2,469	2.39	--
15-19	1,682	1.55	--
All Ages 0-19	27, 184	6.56	6.57

What is Georgia Doing?

Georgia Policies Aimed at Drowning/Submersion Injury Prevention for Public Swimming Pools

Fencing Regulations

1. The enclosure must be at least 4 feet tall

2. All gates or openings must be self-latching or self-closing

3. There must not be direct access to the pool enclosure from any dwelling

4. Above ground pools must have ladders or steps that can be secured to prevent access

Signage

1. Permanently visible "No Diving" signs for areas that are less than 5 feet deep

2. A "Warning – No Lifeguard on Duty" sign if there is no lifeguard on duty

3. A safety rules sign containing the following, among other instructions:

    a. Children should not use the pool without an adult in attendance

    b. Diving area must be clear of patrons before diving is permitted

    c. No running or rough play allowed

Action Plan and Recommendations

Evidence-Based Prevention Strategies

Prior Swimming Instruction	Four Sided Pool Fencing	Use of Personal Flotation Devices	Lifeguards and Increased Supervision	Resuscitation After Drowning
-In children aged 1-4 years, swimming lessons were associated with an 88% decrease in the risk of drowning (Brenner et al., 2009; Asher et al., 1995).	-Four sided pool fencing decreases the risk of drowning as compared to no pool fencing, as well as three sided pool fencing (Thompson & Rivara, 2000).	-The use of personal flotation devices cuts the risk of drowning approximately in half (Cummings, Mueller, & Quan, 2011).	-75% of drownings on beaches occurred when no lifeguard was present (Branche & Stewart, 2001).	-Drowning outcomes were significantly better for those who received immediate resuscitation (Kyriacou, Arcinue, Peek, & Kraus, 1994).

Free or Low-Cost Prevention Strategies:

- Proper supervision
- Emptying all tubs, buckets, or inflatable pools immediately after use
- Pool alarms/pool covers
- Parental or supervisor knowledge of resuscitation methods, such as CPR
- Limited alcohol use by either the swimmer or supervisor
- Employing lifeguards at community swimming pools or water recreation areas
- Proper signage that includes information on the depth of the water, whether or not a lifeguard is on duty, age restrictions, and other safety regulations
- Adherence by the consumers as well as the manufacturers and owners to any rules, laws or regulations regarding swimming areas

Looking for More Information?

http://oasis.state.ga.us/oasis/
http://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html
http://www.uscg.mil/

Action Plan and Recommendations

Recommendations for a Community Prevention Action Plan

Education

1. Disseminate information to parents to increase awareness of drowning locations, age trends, and other risk factors through posters or pamphlets
2. Encourage parents, pool owners, and other supervisors to learn resuscitation methods, such as CPR
3. Advocate for universal or free swimming lessons or CPR instruction in the community
4. Develop and release water safety checklists for different aquatic areas, including swimming pools, beaches, lakes, and water parks
5. Target high risk groups, such as parents of males or children between ages 1 and 4
6. Create partnerships with other health entities and education groups, such as Safekids, RedCross, or YMCA

Communication

1. Highlight drowning/submersion stories in the news, or create PSAs to illustrate the need to learn CPR, have proper supervision, reduce alcohol use, and other ways to prevent drowning
2. Relay PSAs through several mediums, such as radios, billboards, television, and newspapers.
3. Target summer months and areas that have high recreational aquatic use
4. Put drowning prevention posters or pamphlets in public areas such as schools, libraries, health departments or doctors' offices with water safety information

Policies

- Provide support for laws around evidence-based strategies, such as four sided pool fencing or the use personal flotation devices
- Evaluate existing policies, such as lifeguard requirements, to determine any improvements or changes could be made to increase their effectiveness
- Strengthen enforcement of policies regarding the use of personal flotation devices and boating while intoxicated
- Advocate for swimming ability screening programs at summer camps

Health Care Providers

1. Pediatricians should educate parents and children on drowning prevention strategies
2. Primary care providers and pediatricians should encourage parents and children to learn CPR or engage in swimming lessons
3. Collaborate with other health entities to provide pamphlets or support PSAs on drowning prevention

FIRE/BURNS

Definition: Fatal or non-fatal injury that is a mechanism of fire can include burns or smoke inhalation and is defined as the severe exposure to flames, heat, or chemicals that leads to tissue damage in the skin or places deeper in the body; smoke inhalation to the upper airway, lower airway, or lungs that results in serious injury or death

Burn: An injury to the skin or other organic tissue caused by heat or due to radiation, radioactivity, electricity, friction, or contact with chemicals

Risk Factors

Victim
- Children below the age of 5
- African-American children have higher risk of burns than their white counterparts
- Males have higher risk of burns than females
- Children with disabilities, such as seizure disorders

Parental/Familial
- Young mother
- Low income families
- Poor supervision
- Single-parent families
- Living in rented housing
- Smoking in the home/in bed
- Lack of first aid knowledge

ADVERSE OUTCOMES OF FIRES/BURNS

PHYSICAL	PSYCHOLOGICAL
- Death - Amputation of one or more limbs - Contracture (permanent shortening of a muscle, tendon, ligament, or joint) - Scarring - Disability - Physical outcomes of smoke inhalation: confusion, fainting, seizures, and coma	- PTSD - Anxiety - Phobias - Decreased self-esteem

Georgia Data for Child Hospitalizations due to Fire

	YEAR									
	2009		2010		2011		2012		2013	
	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate	Discharges	Rate
Fire/Smoke Exposure	123	4.9	106	4.2	90	3.6	79	3.2	95	3.8

	YEAR									
	2009		2010		2011		2012		2013	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Fire/Smoke Exposure	22	0.9	9	0.4	13	0.5	7	0.3	24	1.0

**The above data was retrieved from OASIS, for children 0-17 with measures with a cause of fire/smoke exposure

COST OF FIRE/BURN DEATHS IN GEORGIA FOR AGES 0-19, 2005

Medical Cost
- Average per Person: $1,226
- Total: $23,000

Work Loss Cost
- Average per Person: $1,190,824
- Total: $22,626,000

Combined Cost
- Average per Person: $1,192,050
- Total: $22,649,000

Healthy People 2020 Goal

Reduce the national death rate from residential fires to .86 per 100,000. This would be a 10% reduction in the national death rate due to residential fires in 2007, which was .95 per 100,000. The annual death rates due to residential fires in Georgia have consistently been above the national rates since 2008.

Did you know?

Nearly 75% of burns in young children are from hot liquid, tap water, or steam

Mortality from fire can be caused by smoke inhalation as well as a physical burn

Cooking is the leading cause of house fires

Fire/Burns Data and Statistics

Fire/Burn Death Rates Differ by Age Group and Race

Average Annual Death Rates from Fire/Burns by Age Group and Race, U.S., 2008-2012
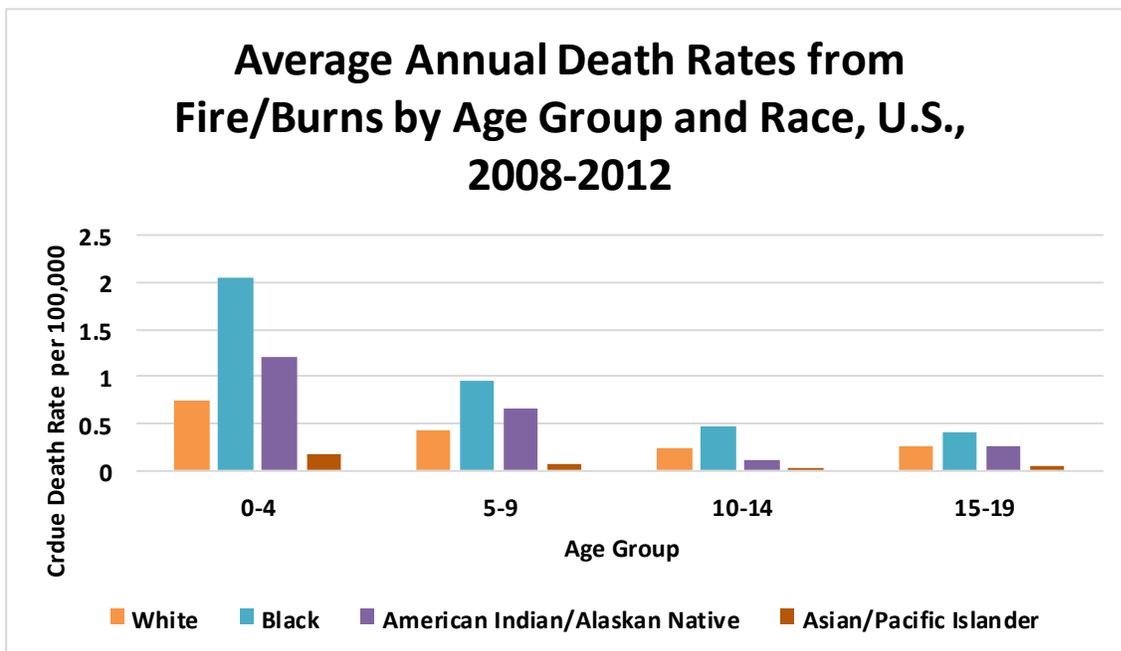
Children between ages 0-4 are at the highest risk for burns. In Georgia in 2008-2012, the crude rate for children ages 0-4 was 1.25 per 100,000. One reason for this increased risk in this age group is that, for children of that age, cognitive development has not yet matched motor development. These children are just becoming able to move around, but do not yet have the mental capacity to know to avoid hot liquids or to escape in the case of a fire. (Warda et al., 1999).

Overall, black children are at higher risk of death from fire/burns than their white counterparts. The age-adjusted death rate for black children in Georgia aged 0-19 is .83 per 100,000 from the years 2008-2012, while the age-adjusted death rate for white children is .44 per 100,000. One factor that might be contributing to this disparity is the lack of the use of smoke alarms in non-white homes (Warda et al., 1999).

Death Rates from Residential Fires over Time

Age-Adjusted Death Rates for All Ages due to Residential Fires, 2008-2011

Crude Rate per 100,000

	2008	2009	2010	2011	2012
Georgia	0.96	1.16	1.08	1.04	0.82
United States	0.83	0.76	0.73	0.68	0.62

Healthy People 2020 Goal: .86 per 100,000
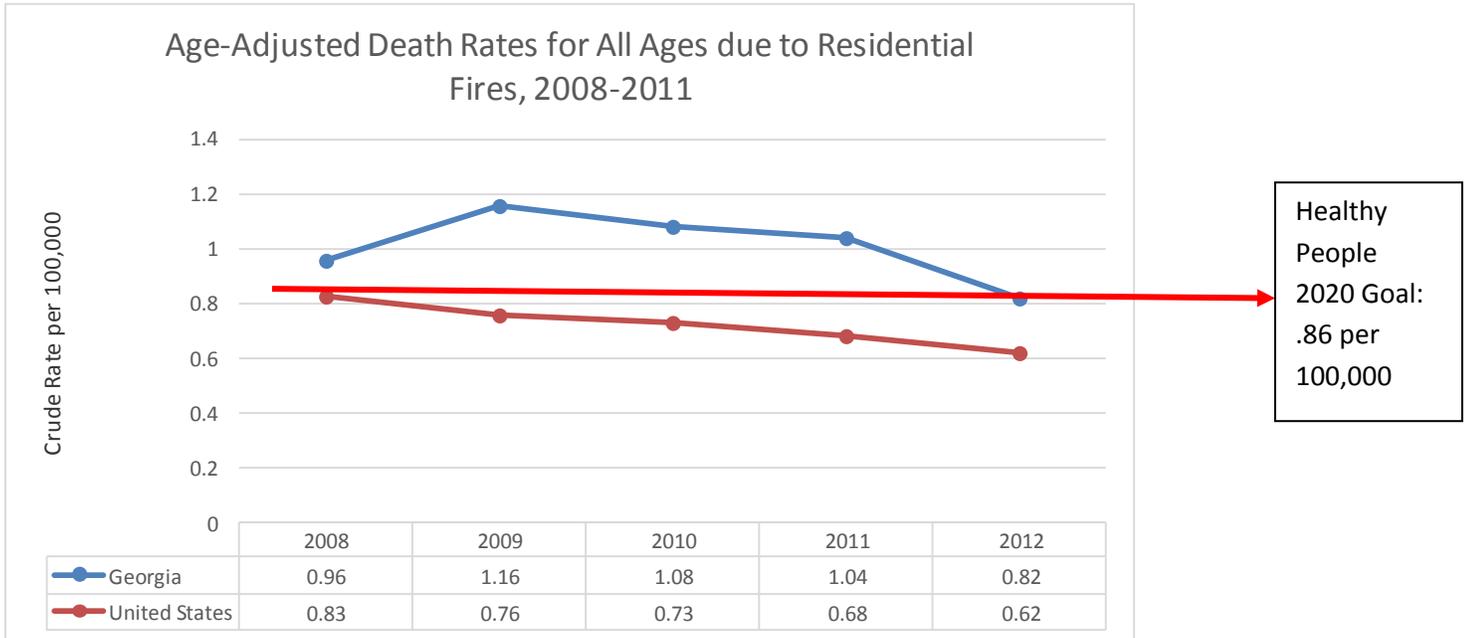
Nonfatal Injuries due to Fire/Burns in Ages 0-19, U.S., 2009-2013

Age Group	Number of Injuries	Crude Rate per 100,000
0-4	63,297	318.59
5-9	21,706	105.52
10-14	15,654	75.81
15-19	28,107	132.84

Locations of Fire Causing Hospitalization in Georgia, 1999-2001

Other, 4%
Private Building, 22%
Unspecified, 21%
Ignition of Inflammable Material, 30%
Not in Building, 10%
Ignition of Clothing, 10%
Other/Unspecified Building, 3%
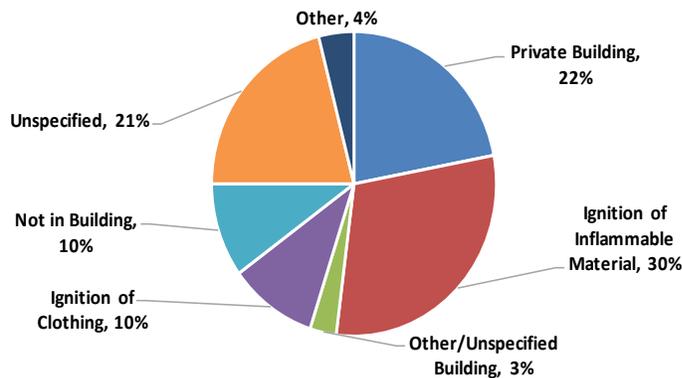
Most fires that led to hospitalization in Georgia from 1999-2001 were caused by ignition of inflammable material. Inflammable material is any material that is capable of catching fire easily and spreading fire quickly. For example, some clothes are made of inflammable fabrics, which can be dangerous if they catch fire. The second leading location was private buildings, which includes homes. Many locations of fires that led to hospitalizations were unspecified (Yeager et al., 2005).

Fire/Burn Prevention

Evidence-Based Intervention Practices

Use of Fire Alarms
- The use of fire alarms reduces the risk of death from fire, especially in children under the age of 5 (DiGuiseppi, Roberts, & Li, 1998).

School-Based Education Programs
- Children who received a school-based education program had improved fire safety behavior that led to improved household fire safety practices (Hwang, Duchossois, Garcia-Espana,, & Durbin 2006).

Mandated Maximum Temperature Setting for Hot Water Heaters
- These regulations decreased the number of hot water scalds (Clouatre, Pinto, Banfield, & Jeschke, 2013).

Free or Low-Cost Interventions:

- Fire extinguishers that are easily accessible
- Creating and practicing evacuation plans
- Keeping lighters/candles/matches/hot water out of reach of children
- Supervise children while they are in the kitchen or bathroom
- Turning off hot surfaces, such as stoves or ovens
- Knowledge of first aid to treat burns
- Stricter building codes and regulations, and enforcement of these regulations
- Mobile demonstration models used to train children on fire safety and escape methods (look at State Farm site regarding provisions of these models for training)

Georgia Regulations to Prevent Fire/Burn

- Requires a minimum of five hours of fire safety training for operators, directors, and staff members of day-care centers (Georgia Department of Community Affairs, 2007).

- Requires apartment buildings to develop and provide residents of the building with a Fire Emergency Guide (Fire Safety Handbook, 2014).

- Requires smoke detectors to be installed in new dwellings, which includes houses, apartment units, motel rooms, and dormitory rooms (Fire Protection and Safety, 2011).

Action Plan and Recommendations

For Parents:

- Have a meeting place identified.
- Do home fire drills.
- Have emergency numbers posted.
- Do regular smoke alarm checks
- Keep it simple. Children learn when the rules are straight forward and easy to remember. If you have preschoolers, you may want to introduce just one or two of the rules at a time.
- Use teachable moments. Reinforce your discussions about fire safety whenever the topic arises -- for example, when there is a fire in the news or in a book, or when you see a fire, ask your children what they would do if they were in that situation.
- Do it. Don't just say it! Children learn by doing and by following your example. Make a game of practicing a fast escape from each room in your house, especially at night when most deadly fires occur.

- Know two ways out. Use a stopwatch and wait until everyone has gathered at your family's designated meeting place before you stop the timer. Work together to set a family record.
- Repeat yourself. Children need to hear and do things over and over before they remember them. Practice your family's escape plan 4 times every year
- Don't scare small children with too much responsibility. In a dangerous situation, it's normal for 3-6 year olds to forget things they've learned. Make a game of practicing fire safety do they become very comfortable with all of the rules. Remind them to never hide. Go outside.

Other Recommendations to Prevent Fire/Burns

Individual
- Education to increase knowledge of fire hazards and risk factors for burns and fires
- Developing and practicing evacuation plans with the family
- Learning first aid to treat burns
- Installing and periodically testing smoke alarms

Community
- Develop PSAs to encourage the use of smoke alarms, to promote the development of evacuation plans, and inform about common fire/burn hazards
- Communicate the PSAs through television or radio
- Dissemenate information using fire safety posters or pamphlets in public areas, such as health departments, doctor's offices, libraries, and schools
- Encourage education programs regarding fire and burn safety in schools
- Support funding for Fire Departments to give out free smoke alarms

Policy
- Adopt regulations regarding maximum limits on hot water heater temperatures
- Support policies regarding firework restrictions
- Advocate for the development of laws regarding child-resistant lighters
- Adhere to regulations aimed at fire safety, such as the installation of smoke alarms in new dwellings

FALLS

- Falls are the leading cause of non-fatal injuries for all children ages 0 to 19. In 2010, 127 youth died from a fall. The unintentional fall-related death rate declined from 2001-2010 (from 0.26 per 100,000 population to 0.15 per 100,000 population).
- Falls are the leading cause of emergency room visits for nonfatal injuries. 2.8 million children visited emergency departments for fall-related injuries in 2010; 40 percent of them were toddlers. On average, over 275,000 children suffer traumatic brain injuries annually from falls. Annually, emergency departments treat more than 200,000 children for playground-related injuries.

According to Childstats.gov, in 2009–2010, there were 65 emergency department visits for falls per 1,000 children ages 1–4 and 31 visits for falls per 1,000 children ages 5–14. Falls accounted for 42 percent of injury visits for children ages 1–4 and 28 percent of injury visits for children ages 5–14. Falls was the leading cause of injury.

According to the CDC, there were 2,634,102 non-fatal fall injuries involving children 0-17 years of age in the US (2012).

Risk Factors

- Household safety hazards
- Mobile child
- Low socioeconomic status
- Poor housing
- Inadequate Supervision
- Parent characteristics: low education, single parenthood, large number of dependents in teh family

According to the American College of Surgeons:

- Falls among children and adolescents account for more than three million emergency department visits each year, and more than 40% occur among infants, toddlers, and preschoolers.
- In contrast to ground-level falls in the elderly, males and children are more susceptible to falls from heights. Black males under age 5 are at particularly high risk.
- Accounting for 5.9% of childhood deaths due to trauma, falls represent the third leading cause of death in children. Death due to falls is generally from a head injury.
- Falls in children tend to be from balconies, windows, and trees and most frequently tend to occur in homes, followed by schoolyards and playgrounds.
- Nearly three-quarters of falls from a height in children are unintentional.
- In children under age 5, falls of less than 2 meters rarely result in death, and the proposed mechanism of injury should be investigated for inflicted trauma.

| Unintentional Fall Nonfatal Injuries and Rates per 100,000 2012, United States, All Races , Both Sexes, Ages 0 to 17 Disposition: All Cases		
Race Ethnicity	**Number of injuries**	**Population**
All Races	2,634,102	73,728,088
White Non-Hispanic	1,520,012	40,300,460
African-American	306,446	12,233,415
Hispanic	322,799	16,534,053
Other Non-Hispanic	81,799	4,660,160
Not Stated	403,047	--

Unintentional Fall Nonfatal Injuries and Rates per 100,000 2012, United States, All Races, Both Sexes, Ages 0 to 17 Disposition: All Cases			
Age (in Years)	**Number of injuries**	**Population**	**Crude Rate**
0	145,406	3,943,077	3,687.62
1	279,750	3,981,523	7,026.21
2	255,324	3,979,957	6,415.25
3	211,832	3,982,440	5,319.15
4	181,786	4,112,347	4,420.50
5	164,397	4,132,747	3,977.90
6	144,149	4,098,714	3,516.92
7	129,045	4,085,964	3,158.26
8	119,073	4,094,174	2,908.36
9	126,308	4,063,937	3,108.02
10	129,004	4,045,719	3,188.67
11	126,918	4,145,034	3,061.92
12	115,553	4,206,939	2,746.71
13	120,876	4,136,252	2,922.35
14	108,053	4,135,274	2,612.95
15	98,785	4,144,014	2,383.80
16	91,412	4,174,274	2,189.89
17	86,432	4,265,702	2,026.20

According to OASIS, there were 69,680 emergency department visits due to fall injuries involving children 0-17 years of age in Georgia in 2012, 70,034 in 2011 and 66,589 in 2010.

Georgia, Falls by County, All Counties, Ages <1 Year-17 Years, 2012
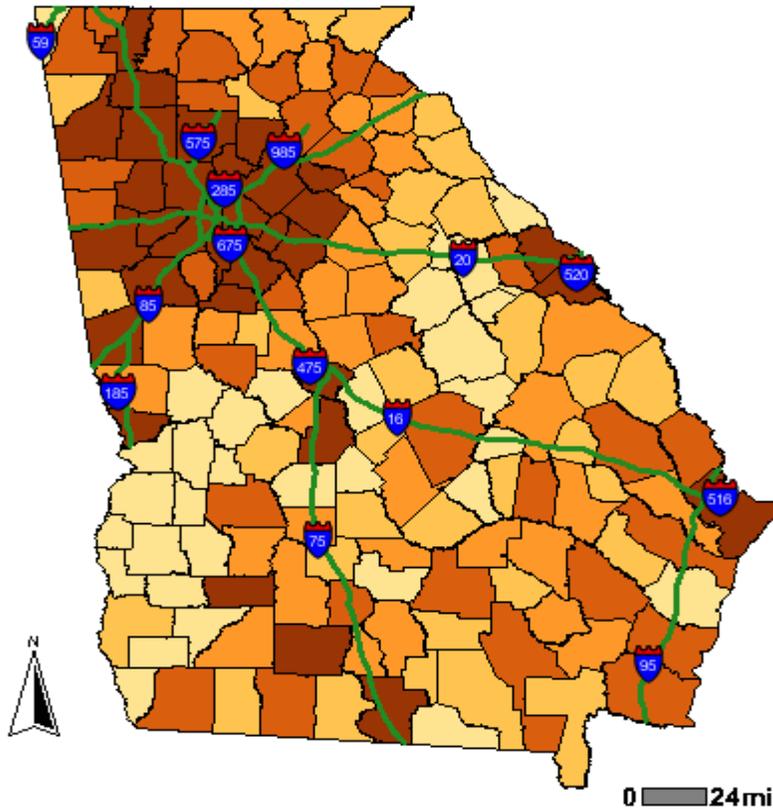
Number

☐	1 - 67
☐	68 - 142
☐	148 - 208
☐	209 - 537
☐	553 - 6,088

Map Legend

Counties

- Highest incidences of fall-related injuries in Northwestern counties to include Floyd, Cherokee, Bartow, Gordon extending across to metro counties, Cobb, Fulton, Gwinnett.
- * This underscores the importance of targeting these areas for localized fall injury prevention outreach.

Action Plan and Recommendations

Play safely

- Falls on the playground are a common cause of injury. Check to make sure that the surfaces under playground equipment are safe, soft, and well- maintained (such as wood chips, rubber, synthetic turf, pea gravel, mulch or sand). If the child falls, the landing will be more cushioned than on concrete, grass, asphalt, or dirt.

Shop safely

- Don't leave your child alone in a shopping cart
- If possible use shopping carts with a wheeled child carrier permanently attached
- If placing the child in a shopping cart seat, use a safety belt or harness. If the belt is broken or missing, select another cart

Keep sports Safe

- Make sure your child wears protective gear during sports and recreation. For example, when in-line skating, use wrist guards, knee and elbow pads, and a helmet.

Supervision is key

- Supervise young children at all times around fall hazards, such as stairs and playground equipment, whether you're at home or out to play.

Make your home safer

- Clean up all spills immediately
- Ensure adequate indoor and outdoor lighting
- Secure electrical and phone cords out of traffic areas
- Remove debris from exterior walkways
- Install approved safety gates at the top and bottoms of stairways or steps; remember to read the manufacturer's warning labels and instructions to ensure you have the right gate for your needs - not all gates are safe for use at the top of stairs
- Secure furniture, TVs, and other crush items to the wall using braces, mounts, brackets, anchors, or wall straps to prevent tip-overs
- Remove tripping hazards (boxes, books, clothes, toys, shoes) from stairs and walkways
- Ensure that all outdoor landing has safety locks, doors, or bars to block access
- Properly install window guards to prevent unintentional window falls; for windows above the first floor, include an emergency release device that adults and older children can easily open in case of emergency
- Keep windows locked and closed when they are not being used
- Periodically check the condition of steps and walkways, and repair damages immediately
- Install handrails on both sides of all staircases
- Adjust gutter downspouts to drive water away from pathways
- Keep babies and young kids strapped in when using infant carrier, high chairs, stroller or swinger. When placing your baby into a carrier, remember to place the carrier on the floor, not on top of a table or other furniture
- Baby walkers can be dangerous, especially around stairs. Try using a stationary activity center to give your baby a chance to practice moving and standing safely. Look for one with a stable non-moveable base and place it away from window cords, hot appliances or stairs

Action Plan and Recommendations

Your child will try to go up or down stairs.
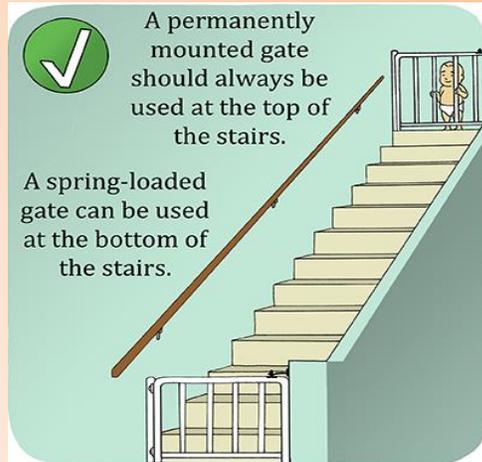
A permanently mounted gate should always be used at the top of the stairs.

A spring-loaded gate can be used at the bottom of the stairs.

Your child could fall out of his high chair if not buckled in.
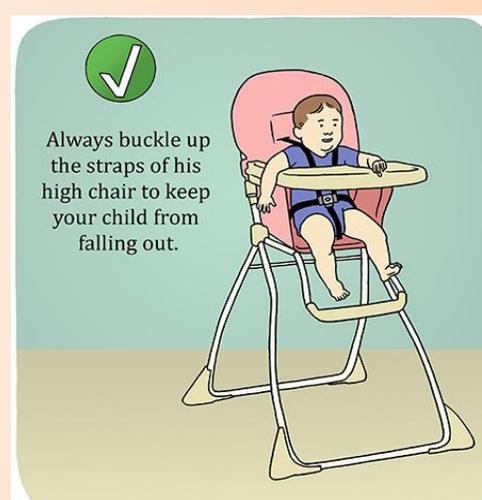
Always buckle up the straps of his high chair to keep your child from falling out.

Your child could hurt his head falling off his bike.

Make sure your child always wears a properly fitting bike helmet when riding.

HOMICIDE AND VIOLENCE

According to the CDC, there were 340,428 violence-related deaths among children ages 0-17 in the US in 2012. The charts below show the number of non-fatal injuries:

Violence-Related All Injury Causes Nonfatal Injuries and Rates per 100,000 2012, United States, All Races [1], Both Sexes, Ages 0 to 17 Disposition: All Cases		
Race/Ethnicity	**Number of injuries**	**Population**
All Races	340,428	73,728,088
White Non-Hispanic	141,497	40,300,460
Black	80,592	12,233,415
Hispanic	58,658[*]	16,534,053
Other Non-Hispanic	8,119	4,660,160
Not Stated	51,562	-

Violence-Related All Injury Causes Nonfatal Injuries and Rates per 100,000
2012, United States, All Races, Both Sexes, Ages 0 to 17
Disposition: All Cases

Age (in Years)	Number of injuries	Population	Crude Rate
0	4,460	3,943,077	113.10
1	4,236	3,981,523	106.40
2	5,208	3,979,957	130.85
3	7,151	3,982,440	179.57
4	6,274	4,112,347	152.56
5	6,553	4,132,747	158.57
6	5,696	4,098,714	138.97
7	3,736	4,085,964	91.42
8	5,963	4,094,174	145.66
9	6,837	4,063,937	168.24
10	6,908	4,045,719	170.74
11	11,227	4,145,034	270.85
12	19,876	4,206,939	472.45
13	30,650	4,136,252	741.00
14	42,679	4,135,274	1,032.08
15	53,748	4,144,014	1,297.01
16	58,202	4,174,274	1,394.30
17	61,025	4,265,702	1,430.60

YOUTH VIOLENCE

Youth violence is a public health crisis in the United States. Based on the most recent data available, approximately 20 percent of high school students report being bullied at school, and more than 30 percent report being in a physical fight. More than 656,000 young people ages 10 to 24 were treated in emergency departments for injuries sustained from violence in 2008. Homicide is the second leading cause of death among young people, with an average of 16 youth murdered every day.

In the state of Georgia, among middle school students, 30.4% reported ever carrying a gun, knife, or club, 55.3% reported being a physical fight in the past year, with 5.3% reporting being treated by a health care professional due to an injury from a physical fight (Youth Behavior Survey, 2013). Among high school students, 18.5% reported ever carrying a gun, knife, or club in the past month, 7.2% reported being threatened or injured with a weapon in the past year, 21.4% reported being in a physical fight in the past year, and 2.3% reported being treated by a health care professional due to an injury from a physical fight (Youth Behavior Survey, 2013).

According to the Johns Hopkins Urban Health Institute, homicide is the leading cause of death for African-American males between the ages of 15 to 34 in the United States. Risk factors such as gang activity, arguments, revenge, self-defense, robbery, and drug disputes contribute to the high numbers of homicides among teens and young adults.

In 2012, CFR committees reviewed 58 homicides reviewed in Georgia. Of those 44 were committed with a weapon and the weapon most frequently used was a firearm (21) and a person's body part (13). In 16 of the 58 reviewed homicides (28%), the perpetrator was the biological parent, step-parent, or adoptive parent. In six cases, the perpetrator was another relative, sibling, or grandparent (10%). In seven homicides, the perpetrator was a friend, acquaintance, or paramour of the victim (12%). In nine homicides, the perpetrator is listed as "Other", which includes law enforcement officers, homeowners defending themselves during a robbery, and rival gang members.

Action Plan and Recommendations

Youth Violence Prevention

Nationally, there are many initiatives in place to address youth violence:

- STRYVE, or Striving To Reduce Youth Violence Everywhere, is a national initiative led by the Centers for Disease Control and Prevention (CDC) to prevent youth violence before it starts. STRYVE emphasizes collaboration among multiple sectors and disciplines, including justice, education, labor, social services, public health and safety, and youth-serving organizations. The participation of community-based organizations, residents, faith-based groups, local businesses, and youth is also important to successfully prevent violence and to promote health and safety

- The National Forum on Youth Violence Prevention is a network of communities and federal agencies that work together, share information and build local capacity to prevent and reduce youth violence. Established at the direction of President Obama in 2010, the Forum brings together people from diverse professions and perspectives to learn from each other about the crisis of youth and gang violence in the U.S and to build comprehensive solutions on the local and national levels

Early Prevention Strategies

- Providing quality prenatal care and reducing prenatal exposure to toxins and drugs among low-income mothers

Health education focused on improving maternal and child health behavior

- Identification and referrals for mothers' mental health and social problems (depression, domestic violence)
- Parent education about child development and parenting skills to improve parent-child interactions
- Provide affordable, accessible childcare to families in need
- Educate parents on choosing the right caregivers for their child(ren) when necessary

SUICIDE

Definition:

- Suicide: death caused by self-directed injurious behavior with any intent to die as a result of the behavior
- Suicide Attempt: non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury
- Suicidal Ideation – thinking about, considering, or planning for suicide

The economic cost of suicide death in the U.S. is estimated to be $34.6 billion annually. With the burden of suicide falling most heavily on adults of working age, the cost to the economy results almost entirely from lost wages and work productivity.

No complete count is kept of suicide attempts in the U.S.; however, the CDC gathers data each year from hospitals on non-fatal injuries resulting from self-harm behavior. In 2013, the most recent year for which data is available, 494,169 people visited a hospital for injuries due to self-harm behavior, suggesting that approximately 12 people harm themselves (not necessarily intending to take their lives) for every reported death by suicide. Together, those harming themselves made an estimated total of more than 650,000 hospital visits related to injuries sustained in one or more separate incidents of self-harm behavior.

Because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. But we know that many suicide attempts go unreported or untreated, and surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm.
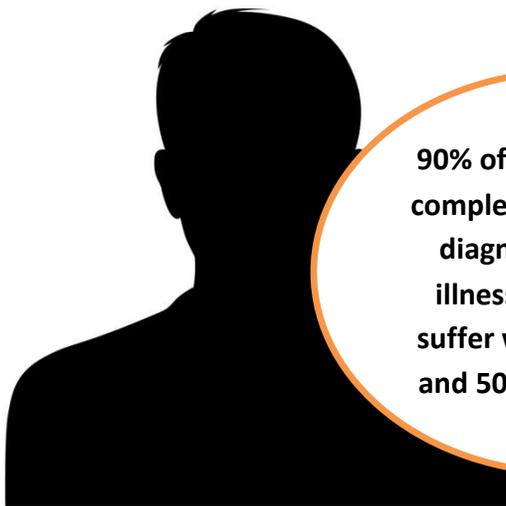
90% of individuals who complete suicide have a diagnosable mental illness, 60% of those suffer with depression, and 50-75% of those in

Suicide Ranks 10th leading cause of death nationally but in our young (15 – 24, it) ranks at 2nd leading cause of death

Our Georgia rate is slightly lower than the national average but relationally our numbers continue to rise.

More than 1 million adults nationally reported attempting suicide in the last year with rates of attempted suicide lowest in Delaware at .1% and highest in Georgia at 1.5%.

> For every one youth suicide there are up to 200 attempts. This is a significant part of the data needed to consider a prevention strategy for youth.

Hospitalizations for suicide attempts from 2002 – 2006, (16,160 attempts) in Georgia resulted in $20 million dollars in hospital charges per year.

Georgia, Middle School Youth Risk Behavior Survey, 2013

Ever seriously thought about killing themselves	18.3 (16.1–20.9) 2,215	23.9 (20.3–27.8) 1,112	13.0 (10.9–15.4) 1,099
Ever made a plan about how they would kill themselves	12.3 (10.4–14.4) 2,241	15.4 (12.3–19.1) 1,123	9.3 (7.8–11.0) 1,114
Ever tried to kill themselves	7.5 (6.1–9.3) 2,236	10.5 (7.9–13.7) 1,122	4.7 (3.6–6.0) 1,110

Georgia, High School Youth Risk Behavior Survey, 2013

Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	28.0 (25.9–30.2) 1,957	33.6 (30.5–36.8) 959	22.4 (19.0–26.1) 987
Seriously considered attempting suicide (during the 12 months before the survey)	14.3 (12.2–16.8) 1,941	16.0 (13.7–18.7) 960	12.5 (9.8–15.8) 971
Made a plan about how they would attempt suicide (during the 12 months before the survey)	12.2 (10.6–14.0) 1,594	13.0 (10.4–16.1) 776	11.3 (9.7–13.3) 810
Attempted suicide (one or more times during the 12 months before the survey)	8.8 (6.8–11.4) 1,701	8.4 (6.0–11.8) 860	8.7 (6.5–11.4) 827
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	3.4 (2.5–4.5) 1,674	3.0 (2.0–4.5) 853	3.7 (2.4–5.7) 811

Healthy People 2020 goal:

Decrease the suicide rate (age adjusted, per 100,000 population) from a baseline of 11.3 in 2007 to 10.2 in 2020. Georgia status, as of 2012, is 11.8 compared to the national 2012 rate of 12.9.

Year	National Suicide Deaths	National Youth Deaths	National Rate	GA State Ranking	State Rate	GA Losses	GA Youth Losses
2008	36035	4298	11.8	44	10.1	981	124
2009	36909	4371	12	37	11.5	1134	126
2010	38364	4600	12.4	40	11.7	1133	145
2011	39518	4822	12.7	39	11.8	1157	132
2012	40600	4872	12.9	41	11.8	1168	129

FOR MORE INFORMATION

OASIS Online Analytical Statistical Information System - *includes suicide loss data and emergency room visits and overnight stay data. http://oasis.state.ga.us/oasis/*

High School and Middle School Youth Behavior Risk Survey – Data Sheets and Youth Online System.
http://nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS

Georgia Student Health Survey II

http://www.gadoe.org/curriculum-instruction-and-assessment/curriculum-and-instruction/gshs-ii/Pages/Georgia-Student-Health-Survey-II.aspx

We know that the only way to impact the crisis of suicide is to use multiple strategies implemented simultaneously and sustained.   Programming needs to support prevention, intervention and aftercare. The programs that Georgia is using and has found most impactful:

- Multileveled School Intervention: including Protocol Development, broad gatekeeper training, resources development, Sources of Strength – school based peer program www.sourcesofstrength.org
- Lifelines: *A Comprehensive Suicide Awareness and Responsiveness Program for Teens* http://www.hazelden.org/web/public/lifelines.page. This program includes components for prevention, intervention and postvention.
- Broadly training for counselors and support staff in CSSRS - Columbia Suicide Severity Rating Scale and Safety Planning. http://www.cssrs.columbia.edu/ and http://www.suicidesafetyplan.com/
- Training on how to help adolescents in crisis: http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/

Highlights of what have we have accomplished in Georgia:

- **Building Suicide Prevention Coalitions** on a local level bringing awareness, education, resources, support and trainings out into communities across Georgia. Starting at 0, we now have 14 active community coalitions with 4 more communities in the startup planning progress. Some of these coalitions cover multiple counties.

- Broadly training hundreds of community members, professionals, teachers, parents, pastors and any interested citizens in gatekeeper programs, **QPR (Question, Persuade, Refer) and Mental Health First Aid.**

- Implementing **Suicide Prevention, Help Seeking and Resiliency Building programs** for the middle and high schools throughout the state. Source of Strength www.sourcesofstrength.org

- Bringing **Intervention and Postvention programs to schools** to give them a model for building teams within the school and community to help them respond appropriately at the moment of a crisis.

- **Responding to requests for support** from local communities when suicide crises and clusters have emerged.

- Hosting, organizing and executing **three Statewide Stakeholders Conferences** with the last one having more than 400 attendees from all over the state with representation from a broad variety of participants including professionals, survivors, military, aging, faith, LBGT, Hispanic, Asian, veterans, and more. This was a three-day conference

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Want More Information?

GSPIN - Georgia Suicide Prevention Information Network – Website created and maintained by SPAN-GA through a grant with DBHDD, Suicide Prevention Program to create a single location for all prevention, intervention and aftercare network and information statewide.
www.gspin.org

WHO – World Health Organization
http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

AAS American Association of Suicidology
www.suicidology.org

SPRC – Suicide Prevention Resource Center,
http://www.sprc.org/

Georgia's State Plan:
http://gspin.org/system/files/filedepot/15/2001GAStatePlan.pdf

Sources of Strength (*Free* curriculum for Suicide Prevention)
www.sourcesofstrength.com

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with multiple tracks designed to meet the needs of all participants.

- Hosting, organizing and executing **five Statewide College Conferences** to introduce programs and resources, and guide colleges in building teams or task forces to do prevention, intervention and aftercare work on campus to meet the needs of this high risk population. *The fifth College Conference will be held in Macon May 16, 2014.*

- Training, assisting and providing ongoing support for peers and professionals in leading **Survivors of Suicide Support Groups**. We have grown from 9 groups to 32 groups in Georgia with 4 more in progress. And as an extension of this work we have been able to offer families that have lost a loved one to suicide – **an annual family grief support camp - Camp SOS**. *May 2014 was the third year for Camp SOS*

- Developed, printed and ongoing distribution of over 10,000 **"Purple Packets"** which deliver comfort and resource information to survivors of a suicide loss statewide, using the coalitions and support groups around the state as a part of the mass distribution system to funeral directors, hospitals, patients advocates, victims' advocates, first responders, and faith community among others, we have distributed thousands of packets to support survivors who themselves have an up to 5 times higher risk of suicide.

- While successfully executing the development of SOS Groups for adults, we were constantly asked, *"but what about our kids".* So we have held consultative meetings to develop a Georgia Model for **SOS Groups for Children & Teens**, The Starfish Program, and held our first "train the trainer" training in May 2013, with the first pilot program hosted in September 2013. A refresher course and a new train the trainer+ class held in October 2014.

- Providing **training for professionals** and those who work closely with families that have lost loved ones to suicide – improving and increasing community resources.

- Built, maintain and grow a statewide suicide prevention information network**, www.GSPIN.org with a Broadcast Network** to connect all stakeholders: survivors, coalitions, colleges, the prevention community and others to all of the efforts, activities and trainings opportunities around the state.

- **Training for Hospitals** in suicide/suicide attempt discharge protocols.

- Partnering with NAMI GA to train First Responders in **Crisis Intervention Team Training** arming officers and EMS with skills to work with suicide attempters and survivors of suicide loss.

- Training for **psychological autopsies** for coroners and others close to suicide losses.

- **Rolling out CSSRS** (Columbia Suicide Severity Rating Scale) and **Safety Planning** to the provider network statewide.

- Hosted and/or supported **conferences for the Aging Population, Military, Veterans**, and others.

Action Plan and Recommendations

What to when children shows signs that they may be considering suicide:

- Remain calm.
- Ask the youth directly if he or she is thinking about suicide.
- Focus on your concern for their wellbeing and avoid being accusatory.
- Listen.
- Reassure them that there is help and they will not feel like this forever.
- Do not judge.
- Provide constant supervision. Do not leave the youth alone.
- Remove means for self-harm.
- *Get help*:
  - Peers: do not agree to keep the suicidal thoughts a secret and instead tell an adult, such as a teacher, parent,, or school psychologist.
  - Parents: seek help from school or community mental health resources as soon as possible.
  - School staff: take the student to the designated school mental health professional or administrator

Recommendations for Schools

- Always notify parents, even if a child appears to be at low risk for suicidal behavior. Parent notification is a critical part of suicide prevention.
- Provide supportive mental health services for students
- Promote a positive school climate through positive student/adult relationships and establishing student behavioral expectations
- Establish protocols for helping students at risk of suicide and responding to suicide deaths
- Provide educator trainings in suicide awareness and prevention

Protective Factors	
School and community connectedness	Cultural or religious beliefs discouraging suicide and promoting healthy living
Peer support and close social networks	Easy access to effective medical and mental health resources
Psychological or emotional well-being and strong problem-solving skills	Family support and connectedness to family and parental involvement
Safe school environment	Restricted access to alcohol and over-the-counter and prescription medications

Action Plan and Recommendations

- Each and every county/community in Georgia should organize a Suicide Prevention Coalition. This is the hub for developing, implementing and sustaining suicide prevention, intervention and aftercare work throughout their community (whatever area they choose to include be it an area within a county, a countywide effort, or a combination of counties working together for the entire population of all counties combined). The Suicide Prevention Program supported by SPAN-GA and other vendor agencies is available to help establish, share framework, organize, train and support on an ongoing basis the development and ongoing work of these coalitions.
- Information on an on-going basis about forming coalitions, organizing this work can be found at www.gspin.org/coalitions
- The foundation for this work is with the use of a program, Georgia's Suicide Safer Communities and the menu of options for evidence based suicide prevention, intervention, and postvention strategies.
- Each community should create a strategy to become a Georgia Suicide Safer Community and go to www.gspin.org/coalitions to see how to create a plan to achieve the ranking. This roadmap to community prevention includes pre-planning, awareness, identifying resources, funding, expansion of efforts and sustainability.

Recommended policy goals and partners

Mandated training for all school staff with a requirement for the training to be a evidenced based - best practice program from a select list.

Same mandate included in the mandated reporter requirements.

Increased funding and staff for the suicide prevention program with specific goals to be met simultaneously and a sustainability plan.

Regular reporting of updated data! Epidemiologist assigned to publish a comprehensive data sheet annually for broad distribution. (meeting a list of required information and statistical data)

Establishment of an advisory council to monitor national and statewide efforts, advise and support the continual movement required to keep Georgia aligned with our national and state plan. This council should have broad representation from Education, Public Health, Mental Health, DOJ, DJJ, and others key partners in suicide prevention with a clear mission and outline for keeping suicide prevention, intervention and aftercare activities on target each year.

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