

# Pulse

A monthly newsletter from the Association of Maternal and Child Health Programs



Special thanks to the Children's Safety Network (CSN) for partnering with AMCHP to produce this issue of Pulse, which covers topics related to violence and injury prevention.



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## From the CEO

### Making the Connection between MCH and Injury Prevention

How many members of the MCH community attended the recent conference of the State and Territorial Injury Prevention Directors Association in Oklahoma City? I wish I could say I was one of many, but in fact there were only a few of us present. During the meeting I was struck by how many sessions were MCH-related and how much of injury prevention involves interventions for mothers, children, and families. Most of the conference participants were state injury program directors that were not situated within the maternal and child health sections of their agencies. The participants I talked with noted that while they understood the link between state injury prevention programs and state maternal and child health programs, it was hard to make the connection because their programs were in separate divisions with separate funding. At the meeting it became clear to me that we have some work to do to enhance collaboration between MCH and injury prevention programs!

MCH and injury prevention program collaboration is more than just a good thing to do. It is absolutely vital to addressing one of the leading causes of death for children. Over 20,000 children between the ages of 0 and 19 die of injuries annually in the U.S. Unintentional and intentional injuries account for more deaths than all other causes combined. The Maternal and Child Health Bureau's Strategic Plan: FY 2003–FY 2007 recognizes that safety from injury and violence is an essential part of health when it describes the Bureau's mission to "improve the physical and mental

**Violence and Injury Prevention**  
June 2008

From the CEO *continued*

## Making the Connection between MCH and Injury Prevention

health, safety, and well-being of the maternal and child health (MCH) population, which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs." As many of you know, two of the Title V National Performance Measures specifically concern injuries: the rate of deaths to children age 14 and younger caused by motor vehicle crashes and the rate of suicide deaths among youths age 15 through 19.

Perhaps no other issue represents the disconnection between science and policy than our national approach to injury prevention. The U.S. spends billions of dollars every year to provide health insurance to children – in part to treat injuries – while last year the entire budget of the CDC's National Center for Injury Prevention and Control was only \$134 million. At this level the CDC is only able to fund 30 states for basic injury prevention programs. Anecdotally, AMCHP is hearing about cuts to MCH-specific injury prevention programs in states due to reductions in federal funding for MCH. There are few better illustrations of where our public policy favors treatment over prevention. We know that public health efforts to prevent injuries have been highly successful and deserve to be celebrated. Injuries to children are down 45 percent over the past 20 years, and the CDC estimates that 240,000 lives were saved between 1966 and 1990 because of improved motor vehicle and highway design, increased use of safety belts and motorcycle helmets, and enforcement of laws regarding drinking and driving and speeding. Similar results are possible with other types of injuries. The current funding environment puts maintaining these successes and doing even better in the future at risk.

Injury, specifically violence, has a profound effect on the health of pregnant and postpartum women. Homicide is a leading cause of death in pregnant and postpartum women in the United States. Addressing and preventing violence against women of reproductive

age improves women's overall health as well as that of their children, and their families.

Injury prevention is an issue for MCH programs. Families who need lead screening, immunization services, and oral health and nutrition education also need free or low-cost child safety seats, bicycle helmets, and domestic violence prevention services. MCH programs are well positioned to add injury and violence prevention components to existing programs. Some examples include:

- Providing mothers with car seats through WIC clinics
- Teaching home safety and offering safety devices as part of home visits
- Implementing bullying prevention programs as part of school health programs
- Providing teens with guidance on safe driving practices at school-based health centers
- Addressing intimate partner violence prevention at teen parenting programs

AMCHP is committed to working with partners such as the Children's Safety Network, who partnered with us to produce this issue of Pulse, and the State and Territorial Injury Prevention Directors Association to reduce injury among MCH populations. Making the connection between state injury prevention programs and state MCH programs is a vital piece of moving our national agenda forward. With your help, we can reduce the number of injuries to our nation's mothers, children, and families.





## Success Stories

### MCH and Injury Prevention

#### Child Passenger Safety Training

Connecticut has used MCH block grant funding to develop child passenger safety (CPS) training for child care providers, child care health consultants, and the Department of Public Health's child care licensing staff. The workshops cover CPS basics, State laws, and local resources so that child care professionals can provide accurate information to the families with which they work. The MCH program also offers booster seat distribution and education at child care programs serving low-income families (such as Head Start) and has run several classes titled "Safe Travel for All Children: Transporting Children with Special Health Care Needs." These activities are conducted in cooperation with State and local Safe Kids coalitions.

#### Bullying Prevention

Starting in 2006, the Virginia Department of Health (VDH) implemented the Olweus Bullying Prevention Program in 45 schools across the state, reaching almost 40,000 students in two years. The issue of bullying had been coming up repeatedly for staff in Virginia's Division of Injury and Violence Prevention, a unit of the MCH agency. It surfaced in their Title V needs assessment; in discussions with staff from other agencies, school personnel, and parents; and in the findings of investigations into incidents of school shootings. It became apparent that bullying had a widespread health impact and was related to depression, suicide, sexual violence, and other issues on which they were already working.

VDH immediately saw the benefits of addressing bullying. They had a lot of experience working on school-based programs and a staff who could easily integrate bullying prevention training into their MCH work. They also had some discretionary financial resources to use for materials and trainings.

Moreover, they realized that effective bullying prevention programs were available, and they chose

Olweus, an evidence-based model program by Blueprints for Violence Prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Juvenile Justice and Delinquency Prevention, and the United States Department of Education. Olweus is also highlighted on the Stop Bullying Now! website (<http://stopbullyingnow.hrsa.gov/>).

VDH began by using funds from the MCH Block Grant to support existing Olweus programs with training and start-up resources, including videos, manuals, and books. VDH also gave small grants to 18 community-based organizations, enabling them to start bullying prevention projects and activities. Building on this successful work and with CDC planning and implementation grants, VDH expanded its bullying prevention efforts to schools throughout the state.

VDH is evaluating its bullying prevention project and is collecting data on changes in bullying-related knowledge, attitudes, behaviors, and school and classroom practices. It is extending the understanding of bullying beyond disciplinary or behavior management issues to encompass the broader impact of bullying on individual and societal health. VDH informs bullying and violence prevention activities with health and mental health data, information, and research on the relationship of bullying to suicide risk, depression, and chronic disease. This information resonates with providers, who, as individuals, parents, and community members, see themselves as having more of a stake in addressing this problem.

#### Domestic Violence Screening

Preliminary work on the 2000 Massachusetts Title V Needs Assessment revealed that MCH service providers wanted more information on identifying and responding to domestic violence. As a result, Massachusetts' Bureau of Family and Community Health engaged in an iterative process to confirm this need and shape a response. This process served as a catalyst for the

## Success Stories *continued*

### MCH and Injury Prevention

creation of the Domestic Violence Screening, Care, Referral, and Information Project (DVSCRIP), which teaches MCH staff to identify and help clients who are victims of intimate partner violence.

Although DVSCRIP was developed by the Division of Violence and Injury Prevention, the need for this training extended across many MCH programs. The division worked with other MCH programs—including WIC, the Early Intervention Prevention Program, and the Family Planning Program—to train their staff in DVSCRIP. The collaboration with WIC proved especially successful. Alicia High, Assistant Health and Human Service Coordinator for the State WIC program, reports that although WIC is primarily a nutrition assistance program for low-income children as well as women who are pregnant, breastfeeding, or postpartum, it is also a strategic opportunity to intervene in domestic violence. Initially, staff at all 35 WIC programs in Massachusetts received DVSCRIP training. Four of these WIC programs served as pilot sites for the routine domestic violence screening of pregnant, postpartum, and breastfeeding women. As part of the DVSCRIP training, staff from local domestic violence programs and State agencies—such as each of the Domestic Violence Units in the Departments of Social Service and Transitional Assistance—were invited to speak at these trainings. This approach helped WIC staff learn about the programs to which they can refer victims of domestic violence, and it provided an opportunity for staff to meet the individuals who would be accepting these referrals. DVSCRIP also teaches staff to care for their own emotional health, a critical skill for service providers addressing domestic violence issues.

The pilot program was later expanded into a statewide effort to train all staff in every WIC program in Massachusetts to routinely screen pregnant, postpartum, and breastfeeding women for domestic violence. The success of DVSCRIP also prompted WIC to add a domestic violence section to the State's WIC

Operations Manual. This section includes policies and procedures on screening, staff roles, referrals, and self-care.

### Prevention of Child Abuse and Neglect

Becoming a parent for the first time definitely is a learning experience, but the Kentucky Department for Public Health (DPH) has an innovative program proven to be an invaluable resource for new moms and dads.

Known as Kentucky's Health Access Nurturing Development Services, HANDS provides home visitation for first-time families to help meet the challenges of parenting, beginning with pregnancy and continuing through the child's first two years of life. During the prenatal period, the health department, a doctor's office, a place of worship, or friends and relatives may refer a new family to the state Maternal and Child Health program. After the family is screened, a DPH staff person visits the home to work with new parents on parenting skill development, provides guidance on what to expect as a baby grows, offers suggestions on making the home safe, and more.

HANDS is modeled after Healthy Families and Healthy Start programs, which are used nationwide. Kentucky combined these approaches to integrate pieces of the social and medical concepts from each, creating a program that addresses such issues as low birth weight, pre-term infants, child abuse and neglect, domestic violence, underdeveloped parenting skills, teen pregnancy, financial difficulties, and substance abuse. Piloted in 1999, HANDS expanded to 15 counties in 2000 and was established in all of Kentucky's 120 counties by the end of 2003. The program has worked with more than 40,000 families from inception to current date.

HANDS begins with a screening program that looks at 16 risk factors, including substance abuse, a history of

## Success Stories *continued*

### MCH and Injury Prevention

psychiatric care, depression, marital status, smoking, poor prenatal care and a history of abortion. If any one of these risk factors is present, the family is eligible for HANDS home visitation services. The family will be offered a meeting with a professional who will complete a more in-depth assessment that considers such factors as mental health, parenting experience, coping skills, support system, anger management skills, expectations of the infant's milestones and behavior, plans for discipline, perceptions of the new infant, bonding, and parental strengths. This assessment takes about an hour. If the results indicate that a family may be overburdened, home visiting services are provided to

the family. Parents who are not appropriate for HANDS but could benefit from some services are provided with information and referrals to community agencies.

Birth indicators based on 2000–2003 data showed that HANDS participants have fewer premature births, fewer low- and very low-birth weight infants and fewer birth defects when compared to other first-time parents who did not participate in the program. A 2004 study of child abuse and neglect found that participating teens had no incidents of substantiated physical, sexual, or emotional abuse.

#### An interview with Lloyd Potter, MPH, PhD Director of the Children's Safety Network

### Movers & Shakers

#### Q: How did you get involved in violence and injury prevention?

As I was finishing up my MPH from Emory University, the Centers for Disease Control and Prevention was preparing to launch the National Center for Injury Prevention and Control. I was interested in understanding more about the causes and prevention of violence, so I applied for a position, and I was hired. This resulted in a rapid and deep involvement in youth violence and suicide prevention over the next eight years. In 2000, I joined the Children's Safety Network and have found the efforts of CSN to assist States with development and evaluation of their childhood injury prevention efforts to be deeply rewarding.

#### Q: What is one of the most rewarding accomplishments of your career?

My efforts to provide leadership and support in the work that led to publication of the Surgeon General's Call to Action to Prevent Suicide was one, if not the, most rewarding accomplishment. Publication and



dissemination of this document symbolized a substantial launch in a number of federal, state, and local efforts to advance a public health approach to preventing suicide.

#### Q: Who are our key partners in MCH injury prevention efforts?

Injury prevention, in fact all prevention, occurs where we live, work, and play. Yet all too often, individuals in our society have little or no awareness of their risk for injury or things that they can do to reduce that risk.

#### Q: What emerging issues do you see within the MCH field?

Injury is the leading cause of death and hospitalized morbidity for children and adolescents. For children, unintentional injuries from motor vehicle crashes, drowning, and fires and burns are of most concern. For adolescents, injuries from motor vehicle crashes, suicide, and homicide are major concerns. Over the past decade, we have seen significant advances in our understanding of effective ways to prevent injuries to children and adolescents. We are beginning to see reviews of evidence based strategies for injury prevention

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## Movers & Shakers *continued*

**Q: In this issue of Pulse, several pieces highlight trends in fatalities among children due to motor vehicle crashes, and among teens due to suicides. Please elaborate on those trends (motor vehicle fatalities, improving; teen suicide, worsening) and what impact this information may have on the maternal and child health care field.**

The reduction we've seen in motor vehicle death rates among youth aged 0-14 is likely the result of more children being appropriately restrained while riding in a motor vehicle. Public awareness campaigns, car and booster seats that are easier to install correctly are likely behind this trend. State health department efforts in partnership with organizations such as SafeKids have certainly played a key role leading to this trend. While progress has been made, there are still many children who ride in motor vehicles inappropriately restrained. To maintain the progress made and to facilitate additional progress, MCH involvement to incorporate child passenger safety into child well-being communications and education in various MCH settings is crucial.

The suicide rate among youth aged 15-19 had been declining until 2004 when we saw an increase followed by a slight decline in 2005. Firearm suicide rates in this age group have been gradually declining over this time period at the same time suicide by suffocation (largely hanging) has been increasing and was largely responsible for the increase we saw in 2004. At this point, it is unclear why suicide by suffocation has been increasing, but it is clear that our focus on preventing suicide among youth must expand and we must work to find ways to reach vulnerable youth. MCH can play a key role in efforts to educate clinicians and parents about things they can do to promote mental health and prevent suicide among youth.

### **Q: What do you do for fun?**

I manage my son's little league baseball team, help with my daughter's soccer team, and travel and camp with my family.

## Feature

### Missouri's Experience with the Safe Families Action Learning Lab

*"Participation in the Safe Families Action Learning Lab was a valuable experience for the Missouri team. Having access to national experts was a tremendous opportunity as we crafted our planning for the state. Prior to this experience, the state pulled together local and state partners to address the issues of domestic violence and child abuse and neglect but in isolation of one another. Through this Action Learning Lab, we pulled together all programs and partners addressing interpersonal violence and now have a State Team that is much richer in resources and expertise."*

— Melinda Sanders, MSN, RN, Missouri Title V Director and Section for Healthy Families and Youth Administrator

Missouri was one of four states involved in the AMCHP and Family Violence Prevention Fund's Safe Families Action Learning Lab and Mini-grant initiative. Since 2006, AMCHP and The Family Violence Prevention Fund (FVPV) have provided funding and technical assistance to Maine, Massachusetts, Missouri and New Mexico to form essential and non-traditional partnerships and to implement projects addressing intimate partner violence and perinatal health disparities. The states have utilized this assistance to leverage their current work in this area and further improve services and resources for women around intimate partner violence. These four states have made impressive strides in partner violence prevention and intend for their efforts to be replicable for others working on this issue.



While each of the four state teams have done tremendous work, this article highlights the accomplishments of the Missouri team. The goal of the Missouri Safe Families team was to increase provider knowledge and training for screening and referral services for domestic violence and perinatal health. Missouri's activities included improving and increasing the capacity of current programs, providing trainings, and increasing awareness by promoting initiatives such as Denim Day (<http://www.dhss.mo.gov/WomensHealth/DenimDay/>) and the Healthy Marriage Initiative (<http://www.acf.hhs.gov/healthymarriage/>).

The Missouri team worked with home visiting programs such as Building Blocks of Missouri (<http://www.southeastmissourihospital.org/womens/buildingblocks.htm>) and the Missouri Community Based Home Visiting program (<http://www.dhss.mo.gov/HomeVisiting/>) to address intimate partner violence and health disparities. The Building Blocks of Missouri program provides prenatal and early childhood home visits by nurses to low-income first-time mothers for up to two years after birth. The Building Blocks program assists mothers by promoting healthy and safe parenting to reduce the risk for child abuse and neglect. The Missouri Community Based Home Visiting program provides intensive sustained visits and case management by nurses and paraprofessionals to families at risk for infant mortality, morbidity, and child abuse or neglect. The Missouri team also worked with Alternatives to Abortion, a program that provides services or counseling to pregnant women carrying their unborn child to term. The program also assists women in caring for their dependent child(ren) for up to one year after birth. Services provided may include: prenatal care, medical and mental health care (including substance abuse treatment), parenting skills education, newborn/infant/child care, housing and utilities, educational assistance, food, clothing, supplies, job training and placement, establishment of responsible paternity, transportation, and DV protection.

In July 2007, the Missouri Safe Families state team trained staff from the Missouri Department of Health

and Senior Services' (DHSS) Home Visiting and Alternatives to Abortion on domestic violence, recovery, empowerment, understanding the abuser, screening, interviewing, and developing a personal safety plan. The team also provided training at the Sexual Assault Prevention Conference – The Spectrum of Prevention in August 2007. Assault and domestic violence advocates, nurses, social workers, and administrative staff from shelters and hospitals were trained on how to screen for domestic violence in a healthcare setting.

The team continues to have a strong commitment to reducing domestic violence and health disparities. During the Action Learning Lab, they formed sustainable partnerships and they will be meeting again to determine the next steps to effectively address domestic violence in Missouri. Stay tuned for a more in-depth discussion of Missouri's activities in AMCHP's Lessons Learned Report coming soon.

## Feature

### Finding Funding for Injury and Violence Prevention

*“How can we stretch out limited dollars to maximize our impact?”*

*“Our injury prevention funding is never secure. It varies every year, depending on the federal budget and state priorities.”*

Sound familiar? There is a critical lack of funding for core public health functions to support both statewide and community-based injury and violence prevention programs.

Here are some tips for finding funding

- Understand your needs
- Be timely
- Find a champion
- Have a good plan
- Use data to illustrate risks and benefits
- Integrate
- Partner
- Become a “cause”
- Have persistence
- Demonstrate that you are worthy of funding
- Stay connected

Following are some examples for places and ideas to find funding:

Federal agency funding can come from the Health Resources and Services Administration/Maternal and Child Health Bureau, Centers for Disease Control and Prevention’s National Center for Injury Prevention and Control, National Highway Traffic Safety Administration, Office of Juvenile Justice and Delinquency Prevention, CDC’s Preventive Health and Health Services Block Grant, and CDC’s Division of Adolescent and School Health. State public health resources can come from line items in state budgets, funded legislative mandates, and regulations that require others to use their resources.

Corporate sponsorships can come from companies or branches of the company that are located in your state, insurance companies, cause-related marketing and in-kind donations. Foundation funding can come from national foundations and/or state and local foundations that only fund programs in their own state or jurisdiction.

Unique resources can be found in partnering at the state level with agencies such as State Highway Traffic Safety Departments, State Departments of Education, and State Mental Health Services. Another avenue that has been successful for some includes establishing fees, fines and funds. For example, ticket proceeds for having a child unrestrained, or fines for leaving a child unattended in a car can be applied to safety programs. Some states have specialized vanity license plates that can provide thousands of dollars for programs. For state-specific examples, download the CSN fact sheet, “Finding Funding for Injury and Violence Prevention” at [http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/07f12e066bff841c85257091005d9058/\\$FILE/FUNDING.pdf](http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/07f12e066bff841c85257091005d9058/$FILE/FUNDING.pdf).

For information on foundations providing resources to local health agencies for injury and violence prevention, check out NACCHO’s website for the Foundation Funding Guide: <http://www.naccho.org/topics/hpdp/injuryprevention/funding.cfm>.



## Feature

# Title V: National Performance Measure #10 *Cost-Benefit of Child Safety Seat Programs*

Motor vehicle collisions are the leading cause of fatal injuries. There is a cost associated with fatal and non-fatal injuries. Motor vehicle collisions often result in medical costs, lost work time, and diminished quality of life. The total annual cost of motor vehicle related death and injury is over \$240 billion. Interventions to reduce motor vehicle injuries include efforts to improve driver and pedestrian safety, vehicle design, and road design. Child seats are an effective way of reducing child injuries in motor vehicle crashes.<sup>1</sup>

The Children's Safety Network has a fact sheet series, *Injury Prevention – What Works? A summary of cost-outcome analysis for injury prevention programs*, that can help you determine if your chosen injury intervention has documented cost-effectiveness. Three types of child seat programs with cost-benefit analyses are included in these facts sheets<sup>2</sup>: Child Safety Seat Laws, Child Safety Seat Distribution (Ages 0-4), and Child Seat Misuse Reduction through education campaigns and check points. Child Safety Seat Laws require that children ages 0-4 be appropriately restrained when traveling in passenger vehicles. Child Safety Seat Distribution (Ages 0-4) encompasses giving away approved child safety seats to parents and caregivers. Child Seat Misuse Reduction addresses car seat checkpoints to ensure that child safety seats are properly installed in vehicles, children are appropriately fastened in the child seat, and parents and caregivers have an understanding of procedures.

In the fact sheet series, over 100 injury interventions are examined, with child seat programs featured as interventions 1, 5, and 6. All three child seat programs are cost-effective and yield a good return on investment. For more details on the fact sheet series or to look at other cost-benefit ratios, visit the Children's Safety Network website at [www.childrenssafetynetwork.org](http://www.childrenssafetynetwork.org).

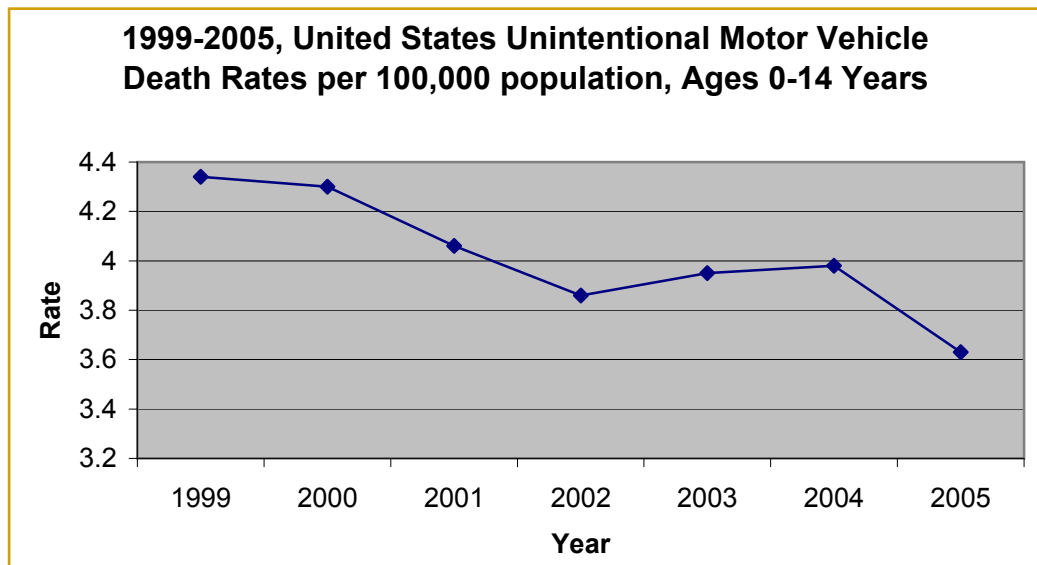
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2) Injury Prevention – What Works? A summary of cost-outcome analysis for injury prevention programs. Children's Safety Network Economics and Data Analysis Resource Center fact sheet series (September, 2005). <http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/a2126ad88e9d48408525722d007da14c?OpenDocument>

## Data and Trends

### Unintentional Motor Vehicle Death Rates for ages 0–14 years, 1999-2005, United States



There are two Maternal and Child Health Bureau national performance measures related to injury and violence.

The first is the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Overall, the rate has declined 16% since 1999, and has followed the pattern of the all-injury rates for this age group which are also decreasing over time.

In addition to the NPMs, some states have additional state-based performance measures for motor vehicle injuries, these states include: CA, CO, DE, KS, ME, NH, PA, WV, & WI.

If you are interested in tracking motor vehicle injuries for your state, CSN can help you set-up a state-based performance measure.

[www.childrensafetynetwork.org](http://www.childrensafetynetwork.org)



## Resource Bank

# Violence and Injury Prevention Resources

## Guide to Integrating Injury and Violence Prevention into MCH Programs

Injuries, both intentional and unintentional, are a leading cause of death and hospitalization among populations served by Maternal and Child Health agencies. In fact, two national performance measures require MCH programs to report on injury issues, suicide in adolescents and motor vehicle fatalities in children under 14. This document provides direction on incorporating injury and violence prevention into the full spectrum of established MCH programs such as WIC, child death review, home visiting, school health, and parenting interventions. The guide stresses achieving maximum impact by framing injury prevention messages within the primary mission of particular MCH programs and getting the most out of limited resources. Contact CSN for copies:

[csn@edc.org](mailto:csn@edc.org).

*Children's Safety Network National Injury and Violence Prevention Resource Center. (2008). Weaving a safety net: Integrating injury and violence prevention into maternal and child health programs. Newton, MA: Education Development Center.*

## Tool to Assist in the Development of Bike Safety Programs for Children and Youth

This tool was created for State Maternal and Child Health agencies and injury prevention programs to disseminate to local health departments and community organizations interested in developing effective bike safety programs for children and youth. The document summarizes strategies drawn from comprehensive reviews of high quality evaluations to ensure the best possible chances of success. It includes a discussion of bicycle injuries among children and provides annotated lists of the following resources: guides for planning programs; contacts for partners and funding; program evaluation guides; and sources of "off-the-shelf" education materials for dissemination to parents, kids and communities.

[http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/0d6bd74f906f7529852574350074e6b1/\\$FILE/CSNBikeSafety\\_brochure.pdf](http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/0d6bd74f906f7529852574350074e6b1/$FILE/CSNBikeSafety_brochure.pdf)

*Children's Safety Network National Injury and Violence Prevention Resource Center. (2008). Promoting bicycle safety for children: Strategies and tools for community programs. Newton, MA: Education Development Center.*

## Report on Preventing Youth Suicide in Rural America

The Suicide Prevention Resource Center (SPRC) and the State and Territorial Injury Prevention Directors Association (STIPDA) formed a workgroup to generate recommendations to prevent suicide among rural youth. This report details the recommendations for state-level agencies to address data and surveillance, services, screening and identification, gatekeeper training, bereavement, promoting help-seeking behaviors, and survivor issues.

<http://www.sprc.org/library/ruralyouth.pdf>

*STIPDA Rural Youth Suicide Prevention Workgroup (2008) Preventing youth suicide in rural America: Recommendations to states. Atlanta: State and Territorial Injury Prevention Directors Association (STIPDA) and Newton, MA: Suicide Prevention Resource Center (SPRC)*

## Summary of Cost-Benefit Analysis for Injury Prevention Programs

Prevention not only saves lives, but also saves dollars.

This set of fact sheets summarizes the incidence of injuries and cost savings of interventions to prevent injuries due to motor vehicles, impaired driving, open-flame/burns, and violence. It also includes cost savings realized by other health/miscellaneous services and substance abuse prevention programs that can act to prevent injury and violence. These data can provide compelling arguments for funding legislative and programmatic injury prevention efforts.

[http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/a2126ad88e9d48408525722d007da14c/\\$FILE/Injury%20Prevention%20-%20What%20Works.pdf](http://notes.edc.org/HHD/CSN/csnpubs.nsf/cb5858598bf707d58525686d005ec222/a2126ad88e9d48408525722d007da14c/$FILE/Injury%20Prevention%20-%20What%20Works.pdf)

*Children's Safety Network Economics and Data Analysis Resource Center (2005). Injury prevention: What works? A summary of cost-outcome analysis for injury prevention programs. Calverton, MD: Pacific Institute for Research & Evaluation*

## Resource Bank *continued*

### Violence and Injury Prevention Resources

#### HRSA's Stop Bullying Now! Campaign

This resource collection features information for kids, parents, educators, and communities to address the problem of bullying. Bullying is now recognized, not a normal part of growing up, but as a preventable source of trauma and distress to young people which can have life-long consequences. Campaign materials including guides, PSAs, camera-ready art, and "webisodes" with characters created for Stop Bullying Now!, raise awareness and teach children and adults how to respond to, prevent, and Stop Bullying Now! Two webinars geared toward public health professionals explain how the program has been used by states, schools and community groups.

Stop Bullying Now! Campaign:

<http://stopbullyingnow.hrsa.gov/index.asp>

Community Action: What YOU can do to Stop

Bullying Now webinar: <http://www.mchcom.com/archivedWebcastDetailNewInterface.asp?aeid=447>

Bullying Prevention: The role YOU play (webinar)

Powerpoint: [http://www.childrensafetynetwork.org/presentation/BullyingPrevention\\_Webinar\\_Jan31.ppt](http://www.childrensafetynetwork.org/presentation/BullyingPrevention_Webinar_Jan31.ppt)

Audio: [http://easylink.playstream.com/sprc2/csn\\_bullyingprev.wax](http://easylink.playstream.com/sprc2/csn_bullyingprev.wax)

#### The National MCH Center for Child Death Review

The Center provides technical assistance, training and support at the state, national and local level. Services include guidance on strategic planning and program development, descriptions of state child death review teams and information on how to use child death review recommendations to prevent injury in children.

<http://www.childdeathreview.org/home.htm>

#### Report on Cause-of-Injury Coding Strategies

This CDC report provides strategies state surveillance systems can use to ensure uniform, high quality external cause of injury coding for nonfatal injuries, which can identify trends and help set priorities for injury prevention programs. Currently, the quality

of E-coding varies substantially from state to state. Establishing and adhering to standards that require uniform and high quality cause of injury coding will make it useful for injury surveillance and prevention activities at the local, state, and federal levels.

<http://www.cdc.gov/mmwr/PDF/rr/rr5701.pdf>

*Annest JL, Fingerhut LA, Gallagher SS, Grossman DC, Hedegaard H, Johnson RL, Kohn M, Pickett D, Thomas KE, Trent RB; Centers for Disease Control and Prevention (CDC). Strategies to improve external cause-of-injury coding in state-based hospital discharge and emergency department data systems: recommendations of the CDC Workgroup for Improvement of External Cause-of-Injury Coding. Morbidity and Mortality Weekly Report; Recommendations and Reports. 2008 Mar 28;57(RR-1):1-15*

#### Review of School-Based Programs for the Prevention of Violent and Aggressive Behavior

The Task Force on Community Preventive Services, an independent arm of the CDC, is charged with providing comprehensive reviews of the evidence, and recommendations based on those reviews, for issues relating to public health. Universal school-based programs to reduce or prevent violent behavior are delivered to all children within a classroom, grade or school. During 2004-2006, the Task Force on Community Preventive Services conducted a systematic review of the effectiveness of these programs. The results of this review provide strong evidence that universal school-based programs decrease rates of violence and aggressive behavior among school-aged children. On that basis, the Task Force recommends the use of universal school-based violence prevention programs.

[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5607a1.htm?s\\_cid=rr5607a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5607a1.htm?s_cid=rr5607a1_e)

*Hahn R, Fuqua-Whitley D, Wethington H, Lowy J, Liberman A, Crosby A, Fullilove M, Johnson R, Moscicki E, Price L, Snyder SR, Tuma F, Cory S, Stone G, Mukhopadhaya K, Chattopadhyay S, Dahlberg L; Centers for Disease Control and Prevention (CDC); Task Force on Community Preventive Services. The effectiveness of universal school-based programs for the prevention of violent and aggressive*



*behavior: a report on recommendations of the Task Force on Community Preventive Services. Morbidity and Mortality Weekly Report; Recommendations and Reports. 2007 Aug 10;56(RR-7):1-12.*

### Best Practices Guide to Child Passenger Safety

This guide to evidence-based strategies in child passenger safety uses previously developed comprehensive guidelines and an assessment tool for state highway safety offices to examine their OPC programs and focus resources where they are most needed. Special attention is given to occupant protection for children between the ages of 8 and 16, who are older than recommended ages for booster seats and still too young for driver education.

<http://www.ghsa.org/html/publications/OPC/OPC.pdf>  
*Governor's Highway Safety Association and State Farm Insurance. (2008). Occupant Protection for Children (OPC): Best Practices Manual. DC: Governor's Highway Safety Association.*

### Summary of Data from National Violent Death Reporting System

In 2002, the Centers for Disease Control and Prevention (CDC) established the National Violent Death Reporting System (NVDRS). NVDRS connects data from sources which were fragmented before the NVDRS was established such as toxicology reports; crime reports; medical/coroners reports; death certificates; and other sources providing a comprehensive picture of violent death for researchers and public health practitioners. This report, for the first time since the creation of NVDRS, summarizes and examines data on nearly 16,000 violent deaths occurring in 16 states surveyed by the system in 2005.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm>

*Karch DL, Lubell KM, Friday J, Patel N, Williams DD; Centers for Disease Control and Prevention (CDC). Surveillance for violent deaths--National Violent Death Reporting System, 16 states, 2005. Morbidity and Mortality Weekly Report; Surveillance Summaries. 2008 Apr 11;57(3):1-45.*

### Suicide Prevention Resource Center (SPRC)

Established in 2002, the Suicide Prevention Resource Center (SPRC) is funded by SAMHSA to provide technical assistance, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. The Center's Training Institute includes workshops for mental health professionals and community groups, a discussion series to foster dialog among practitioners, researchers and others, and distance learning opportunities. SPRC's products include publications on the scope of the suicide problem, prevention information geared toward specific roles such as student, clergy etc.; and a registry of best practices which examines programs against expert and consensus statements and adherence to standards

<http://www.sprc.org>



By Brent Ewig, AMCHP Director of Policy and Government Affairs

## View from Washington

Last month, the Senate Health, Education, Labor and Pensions Committee held a hearing on childhood injury prevention. The hearing was timed to coincide with the 20th anniversary of the Safe Kids Worldwide organization, and celebrated new reports showing that childhood injury deaths are down 45 percent over the past 20 years. The hearing featured testimony from our partners at the State and Territorial Injury Prevention Director Association. As a sign of how AMCHP is increasingly being viewed as a resource on the Hill, we were invited by Chairman Ted Kennedy's office to distribute a press statement at the hearing, and provide questions for members to use to help shape a productive dialogue.

Our statement pointed out that despite substantial progress, injury remains the leading cause of death among children in the U.S. We let the Committee know that support for efforts to promote safe communities and prevent childhood injuries is a high priority on AMCHP's public policy agenda. We also highlighted the significant opportunities for prevention, and the need for increased attention and investment in this area.

In our statement and conversations with Hill staff, we pointed out that last year the entire budget of the CDC's National Center for Injury Prevention and Control was only \$134 million. At this level the CDC is able to fund only 30 states for basic injury prevention programs. When compared to the tens of billions spent on health insurance—that in part pays to treat injuries—we have a compelling example of where public policy favors treatment over prevention. Similarly, we noted that the Title V Maternal and Child Health (MCH) Services Block Grant—which is intended to improve the health of all children and families and includes two national performance measures related to injury prevention—has been reduced by over \$60 million over the past six years. Most state MCH programs have identified injury prevention as a pressing need, but have been hampered by limited and declining resources to implement proven programs and

policies that prevent injuries.

To continue and accelerate progress, we are highlighting how fully-funded state programs can:

- Educate families on the appropriate type and use of child safety seats via partnerships with local children's safety coalitions and state departments of transportation, and support programs to dispense car seats, cribs, smoke detectors and other home safety equipment;
- Support home visiting and other community-based case management programs that promote injury prevention;
- Work with providers to assess for intimate partner violence in health care visits, including prenatal care and postpartum visits; and,
- Promote "Back to Sleep" campaigns in settings that provide prenatal care, well child care and parenting education classes such as WIC clinics, social service agencies, community health centers and child care centers.

Our country has already made significant progress in establishing some of the infrastructure, policies and programs that combat childhood injury. By expanding these systems to meet current needs and utilizing the proven programs and strategies that address preventable injuries, we can save even more children's lives while providing a cost savings to the nation during economically troubling times.

We will continue to urge Congress to lead a national dialogue on how we can move desperately needed public resources upstream to focus on the prevention of childhood injuries and reduce the demand on health insurance programs to pay for treatment. Fully funding the Title V MCH Block Grant at \$850 million and expanding CDC Injury Center funding to support all states are two important steps we can take to enhance childhood injury prevention, and will continue to be part of AMCHP's advocacy message.