



Weaving a Safety Net:

*Integrating Injury and
Violence Prevention
into Maternal and Child
Health Programs*

A publication of the Children's Safety Network

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Prevention into Maternal and
Child Health Programs

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The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center

The Children's Safety Network is a national resource center for child and adolescent injury and violence prevention. State maternal and child health (MCH) and injury and violence prevention (IVP) programs play a lead role in keeping children healthy and safe. CSN works with state MCH and IVP programs to address injury and violence prevention among children and adolescents. We provide customized and state-specific technical assistance in a number of ways:

- Address the unique issues of specific states
- Develop various training materials and events
- Monitor and synthesize the latest research
- Provide data and cost analysis information
- Provide technical assistance in both topical areas and core programmatic areas
- Monitor national and state trends that impact injury and violence prevention

CSN is a project at Education Development Center, Inc. (EDC), an international nonprofit organization that conducts and applies research to advance learning and promote health. EDC currently manages 325 projects in 35 countries and is located in Newton, Massachusetts.

The Association of Maternal and Child Health Programs (AMCHP)

The Association of Maternal and Child Health Programs is an important resource and advocate for quality health care for women, children and families. For over 70 years, we've worked to protect the health and well-being of all families, especially those who are low-income and underserved. AMCHP represents state public health leaders who promote the health of America's families. Our members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, adolescent health coordinators and other public health leaders. Members of this national nonprofit organization also include academic, advocacy and community-based family health professionals, as well as families themselves.

The State and Territorial Injury Prevention Directors Association (STIPDA)

The State and Territorial Injury Prevention Directors Association (STIPDA) is a national non-profit 501(c)(3) organization of professionals committed to strengthening the ability of state, territorial and local health departments to reduce death and disability associated with injury and violence. To advance this mission, STIPDA engages in activities to increase awareness of injury, including violence, as a public health problem; provide injury and violence prevention and control education, training, and professional development for those within the injury and violence prevention field; enhance the capacity of public health agencies to conduct injury and violence prevention programs; and support public health policies designed to advance injury and violence prevention.

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CSN also wishes to thank all the state and local health agencies that provided examples of how they integrate injury and violence prevention into maternal and child health services. In particular, CSN appreciates the time and valuable information provided by staff from the Massachusetts Department of Public Health to develop the case study at the end of this document.

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INTRODUCTION

The prevention of injury and violence fits squarely within the mission of maternal and child health (MCH) programs. MCH services that already serve high-risk populations are uniquely placed to be effective conduits for injury and violence education and prevention. This publication will explore how injury and violence prevention (IVP) activities can be integrated into MCH programs and services at both the state and local levels.

WHY SHOULD MATERNAL AND CHILD HEALTH (MCH) PROGRAMS BE INTERESTED IN INJURY AND VIOLENCE PREVENTION INITIATIVES?

Injury and violence prevention is an important part of overall MCH goals.

The Maternal and Child Health Bureau 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 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."¹

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. In addition to these national measures, states select their own performance measures after reviewing needs assessment data. Thirty-two states have currently developed one or more state performance measures related to injury and violence. Examples of these include motor vehicle-related mortality rates among adolescents and injury rates related to child abuse or maltreatment, domestic violence, or unintentional injury.

Injuries are a leading cause of death and hospitalization among MCH populations.

The prevention of injury and violence leads to better health outcomes for women, children, and adolescents. Injuries and violence are a major threat to women and children in the United States today. In the U.S., in 2005, 353,125 children and adolescents, ages 0–19, were hospitalized for injuries.² Approximately 20,456 children between the ages of 0 and 19 die of injuries annually in the U.S. Injury, including both unintentional and intentional injuries, accounts for more deaths than all other causes combined (approximately 60% of all deaths in this age group). The following chart highlights the leading causes of death among children and young people age 0 to 19.

**Injury accounts
for more deaths
among children
0–19 than all other
causes combined**

* Maternal and Child Health Bureau, Title V Social Security Act



Five Leading Causes of Death, United States 2005, All Races, Both Sexes³

Age Groups				
Rank	1–4	5–9	10–14	15–19
1	Unintentional Injury 1,664	Unintentional Injury 1,072	Unintentional Injury 1,343	Unintentional Injury 6,616
2	Congenital Anomalies 522	Malignant Neoplasms 485	Malignant Neoplasms 515	Homicide 2,076
3	Malignant Neoplasms 377	Congenital Anomalies 196	Suicide 270	Suicide 1,613
4	Homicide 375	Homicide 121	Homicide 220	Malignant Neoplasms 731
5	Heart Disease 151	Heart Disease 106	Congenital Anomalies 200	Heart Disease 389

Injuries, and specifically violence, also have 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.^{4,5}

Addressing and preventing violence against women of reproductive age improves women's overall health as well as that of their children. Women who are abused are at higher risk for substance abuse (including tobacco and alcohol abuse), depression, and suicide.⁶ Violence against pregnant women increases the risk of low weight gain during pregnancy, anemia, infection, low birth weight, and first- and second-trimester bleeding.

Children with special health care needs are also at significant risk for injuries.^{7,8} These children are 3.4 times more likely to suffer child abuse and neglect.⁹ Falls are the number one concern for children who have problems with mobility. Sensory-neural deficits such as blindness or deafness create significant challenges in negotiating the environment and increase the risk of injury.

MCH service providers reach populations most at risk of injury.

The populations MCH programs target for a variety of health problems—low-income families, minorities, rural populations, and children with special health care needs—are the same ones at greatest risk for injuries. 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 providers are well positioned to add IVP services to programs already in place. Integrating IVP activities into the repertoire of local MCH service providers can be an efficient and cost-effective method of preventing injuries and violence as well as furthering the health-related goals of the programs to which these activities are added.¹⁰

Injuries result in major costs to individuals, families, and the health care system.

MCH agencies focus their attention on people who are at greatest risk of incurring these costs. The death of a child results in the greatest number of lost years of potential life.¹¹ In 2000, the total lifetime costs of injuries for people ages 0–24 is \$294,288 million dollars.¹¹ There are many prevention programs that can



reduce the economic burden. For example, smoke alarm purchases yield an estimated cost savings of \$940 for a cost of only \$33 per smoke alarm and Poison Control Centers yield an estimated cost savings of \$290 for a cost of only \$43 per call. Other cost effective programs include: child safety seat (CSS) distribution; CSS misuse reduction; and parent training programs to reduce violence.¹²

IDENTIFYING OPPORTUNITIES FOR INTEGRATION

MCH program administrators and staff interested in integrating IVP activities into existing MCH services should first answer several questions.

It is best to choose injury risks that both MCH providers and their clients will see as directly related to a program's primary mission.

Which MCH services could include injury and violence prevention?

It is extremely important that IVP activities both fit well with existing services and preserve the integrity of the program's central mission. Delivering too many health messages at once can dilute the impact of individual messages as well as the overall effectiveness of the program. It is best to choose injury risks that both MCH providers and their clients will see as directly related to a program's primary mission. For example, prenatal

counseling encourages behaviors such as good nutrition to promote the health of the fetus and the infant. Reminders to always buckle up during pregnancy (and after) and to obtain a child safety seat would be a natural addition to this counseling. It makes sense to include domestic violence assessments in a program for pregnant teens; other injury messages—about bike and pedestrian safety, for instance—would seem less relevant. Emphasizing the direct relationship between preventing injuries and the primary health goal of the service provider—such as positive birth outcomes—will enable providers to see the integration of IVP activities as an important health-promoting measure, not a misguided bureaucratic mandate.

Adolescent health programs present opportunities to connect with teens and impact their health and safety in a positive way. Sexually transmitted infections (STIs) are associated with dating violence, violence against women, and sexual abuse.¹³ Women and teens who seek services for STIs should be screened for violence and referred for services. The connection between the two and what to do if you are in an abusive relationship should be explicitly addressed. Substance abuse is a risk factor for physical abuse and neglect.¹⁴ Additionally, infants born with conditions related to substance abuse (for example, fetal alcohol spectrum disorders) may have behavioral challenges that make parenting more difficult.¹⁵ Preventing child maltreatment should be addressed in parenting classes.

What types of injury prevention interventions can be used?

Efficiency is key to integration. Successful integration of IVP activities into existing MCH programs ideally entails cost-effective services using trained professionals who understand their clients and whom their clients are apt to trust. Although it often does not provide the focus and programmatic flexibility of a dedicated IVP program, integration can be a valuable method of message delivery when programs have limited resources and are interested in reaching the same high-risk populations. IVP activities should be not only effective but also appropriate for the available resources, including program staff or health care providers' time. Activities may be minimal, such as providing educational materials or adding IVP messages to lists of healthy behaviors. Or they may be more

Integration can be a valuable method of message delivery when programs have limited resources and are interested in reaching the same high-risk populations.



intensive, involving direct provider training and client counseling on issues such as home safety or installing a child safety seat and, include formative, process, impact and/or outcome evaluation.

What resources and training do MCH providers need?

The support of stakeholders, service providers, and their staff is essential. In part, this cooperation can be achieved by making the case for mutual benefits. But this support can also be garnered—and maintained—by providing the support and resources necessary to add and sustain the new IVP activities.

Understanding and providing the resources program staff need to effectively carry out IVP activities is essential to successful integration efforts. First and foremost, both program managers and staff need an understanding of why an injury or violence prevention activity should be integrated into service delivery, and how it complements rather than competes with their primary mission. They might also require training, educational materials for clients, equipment such as child passenger safety seats or smoke alarms, a change in workload or schedule, or referral relationships with other agencies if (for example) they are adding assessments for domestic violence or suicide.

A good place to start locating the knowledge and technical expertise for integration efforts is your state's IVP program. For a list of directors of state IVP programs, contact Children's Safety Network (CSN) at www.ChildrensSafetyNetwork.org or contact the State and Territorial Injury Prevention Directors Association (STIPDA) at <http://www.stipda.org/displaycommom.cfm?an=1&subarticlenbr=4>.

CSN can provide information on a wide variety of resources as well as contacts with IVP and MCH professionals. To contact a lead for Maternal and Child Health Programs in your state, contact CSN or the Association of Maternal and Child Health Programs at www.amchp.org.



INTEGRATION OPPORTUNITIES

» INFANT AND CHILD HEALTH PROGRAMS

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC serves low-income women, infants, and children up to age five who are at nutritional risk. Direct client contact with at-risk women and children provides an opportunity for anticipatory guidance on issues of injury and violence prevention. The use of developmentally and culturally appropriate anticipatory guidance and the provision of training for WIC educators can enhance IVP messages.

- The Maine Injury Prevention Program (MIPP), located within the Division of Family Health, routinely distributes informational resources, including a poster and brochure on **shaken baby syndrome** (SBS), booklets on child discipline and development, and other safety materials from agencies such as the U.S. Consumer Product Safety Commission. The Maine WIC program provided funding for the production of many of these materials. Additionally, child passenger safety seat distribution sites in the towns of Augusta and Waterville are located within WIC clinics.
- In some areas of Texas, such as Dallas and the Rio Grande Valley, WIC clinics promote the Safe Riders' **child passenger safety** seat distribution program. Low-income families are able to obtain a child safety seat and related safety education through the program.
- The Massachusetts Case Study at the end of this document describes how the Massachusetts Department of Public Health integrated domestic violence prevention in WIC clinics.

Child Death Review teams (CDR)/Child Fatality Review teams (CFR)

Most states have established comprehensive and multidisciplinary teams that review child fatalities to determine ways of preventing all unnatural child deaths, including those from injury and violence. By participating in local and state CDR teams and using child mortality data to improve the health and safety of children, MCH and IVP professionals may gain greater understanding of the causes of injury and methods of injury prevention.

- Virginia uses its CDR report recommendations to guide IVP activities. For example, a recent CDR report recommended addressing deaths due to shaken baby syndrome, and State MCH and IVP programs coordinated an educational campaign on the issue with local health departments. Within the past two years, the CDR team recommended action to address **hyperthermia in motor vehicles**, and the State MCH and IVP programs conducted a campaign in the spring and summer of 2006 involving law enforcement and other community partners. Campaign organizers persuaded convenience stores and child care centers to post window stickers showing the dangers of leaving children alone in motor vehicles during hot weather.

Child care and day care

Child care settings are ideal venues for providing information and training for both child care providers and parents on a variety of IVP topics, including child passenger safety, home and residential safety, drowning prevention, poisoning prevention, child maltreatment prevention, and burn prevention.



- 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.
- With a Healthy Child Care America grant from the Maternal and Child Health Bureau, New Mexico has developed a **home safety** curriculum and manual for home child care providers in the State. In 2004 approximately 50 trainers received certification to provide the course "Improving the Safety of Home Day Care Environments" at the State's Regional Early Care Education Conferences, where home child care providers receive mandatory annual education. About 5,000 providers have received the training in the past two years. The course covers the full range of unintentional injury prevention categories for children, including water, fire, firearm, and animal safety; burns and airway obstruction; fall and poison prevention; and indoor air quality maintenance. Instruction on indoor air quality includes guidance on how to keep the home clean and pest free without the use of dangerous chemicals that can trigger asthma attacks as well as invite ingested poisoning episodes.
- The Maine Injury Prevention Program (MIPP) routinely provides child care professionals with printed resources on shaken baby syndrome, child development and discipline, and other safety topics from agencies such as the U.S. Consumer Product Safety Commission (CPSC). MIPP staff members conduct child safety in-services to child care staff that cover such topics as fire, water, and **playground safety**; burns; and safe sleeping. The State's child passenger safety coordinator provides consultation and training to child care centers on transportation safety, both in school buses and in other vehicles. MIPP staff members have consulted with State early childhood programs on training for transporting children in child care.
- The Missouri Department of Health has developed a basic **child passenger safety** training module for child care nurse consultants to use in teaching child care providers about child passenger safety.
- In the Healthy Child Care Iowa campaign child care nurse consultants conduct injury **hazard identification assessments** on site in child care settings. Iowa worked with the CPSC to develop a hazard identification tool, and the resulting injury prevention assessment was added as a required component of the Iowa Quality Rating System for child care businesses. These documents can be found at www.dhs.state.ia.us/igrs.¹⁶ During fiscal year 2007, more than 800 child care businesses took part in the injury prevention assessment.
- The Child Care Nurse Consultants in Chicago, Illinois, make presentations to child care providers on a host of injury and violence prevention topics from playground safety, to **bullying prevention** to mental health and sexual abuse. And, in Vermilion County, the nurse consultant started a Child Passenger Safety Team called the Vermilion County Red, White and Blue Child Passenger Safety Team and provides training to parents, foster care programs and agencies that transport children. Wayne County distributed 150 packets of information on bullying prevention to a large child care facility.

Oral health providers

Dental providers can incorporate screenings for child maltreatment into regular dental check-ups.

- The **Prevent Neglect and Abuse** through Dental Awareness (PANDA) coalition included partners such as the Missouri Division of Family Services and the Missouri Dental Association. The coalition's educational programs offer information on the history of family violence in the U.S., clinical examples of confirmed abuse and neglect, and discussions of legal and liability issues involved in family violence interventions. While originally intended for dental audiences, the PANDA programs are also presented for physicians, nurses, teachers, child care workers, and anyone with an interest in preventing violence.¹⁷



Home visiting programs

Guidance on IVP issues can be integrated into home visiting services, which tend to focus on abuse and neglect prevention. Screening for violence among adults (such as intimate partner violence) can also be integrated into home visiting services if providers are appropriately trained. New parent visits are an opportunity to communicate a variety of safety messages.

- The mission of Kentucky's Health Access Nurturing Development Services (HANDS) program is to support families as they build healthy, safe environments for the optimal growth and development of children. The program provides home visitation to first-time families to assist them in meeting the challenges of parenting, beginning with a mother's 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 MCH program. After the family is screened, a trained home visitor works 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. 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 zero incidents of substantiated physical, sexual, or emotional abuse.
- In Minnesota, public health nurses and other trained staff on home visits to families with young children can use the **Home Safety Checklist** developed by the Minnesota Department of Health to guide non-threatening discussions with parents on hazards in the child's living environment that may be a source of injury. The home visitor can offer guidance and suggest simple changes that parents can make to create a safe home for their children. The Family Home Visiting program is administered through the State's MCH program, which provides Federal TANF (Temporary Assistance for Needy Families) funding directly to local public health departments for their home visiting programs. Additionally, the MCH program supports the local programs with five staff members who provide education, training coordination, and program evaluation.
- A group of Maine child safety advocates worked together with the Maine Injury Prevention Program to create a safety assessment form for home visiting staff to use in assessing the safety needs of their clients. Staff members also receive educational materials and equipment (poison prevention stickers, carbon monoxide detectors, smoke alarms, etc.) for distribution to clients. Home visitors provide information on the installation and use of various **safety equipment**. In addition, the State's child passenger safety (CPS) coordinator recently trained Families First staff and some home visitation nurses to be CPS technicians.
- In Utah, visiting nurses provide new parents with injury prevention packets covering issues such as child passenger safety, shaken baby syndrome, and **toy safety**.

Well-child visits

In some states, children are required to receive well-child examinations prior to entering school. These visits represent an important opportunity to disseminate IVP messages and other information.

- In California, **bicycle helmets** and information on their use were distributed to low-income kindergarten-bound children and their parents through a combined effort involving rural health clinics as well as the Epidemiology and Prevention for Injury Control (EPIC) Branch, the Maternal, Child and Adolescent Health (MCAH) Branch, and the Child Health and Disability Prevention Program (CHDP) of the California Department of Health Services. The CHDP sponsors well-child visits, which are required for children entering kindergarten, at health clinics for low-income families. In this joint project, the rural health clinics provided each child with a helmet as the reward for getting his or her



check-up; CHDP provided the technical assistance on fitting helmets correctly; EPIC and MCAH shared the costs for purchasing the helmets, videotapes, and brochures. Many of the rural health clinics successfully sought local funding and continue to conduct this program each fall.

School health programs, school nurses, and school-based health centers

IVP messages can be integrated into anticipatory guidance provided during acute care visits at school-based health centers. School nurses and school health education programs sponsored by MCH programs can also be forums for IVP topics as well as school-wide violence and bullying prevention initiatives.

The Centers for Disease Control and Prevention's Division of Adolescent and School Health (DASH) sponsors grants for coordinated school health programs to state departments of education <http://www.cdc.gov/HealthyYouth/partners/funded/cshp.htm>. DASH emphasizes the development of partnerships with state health departments, and some states have used these partnerships to foster IVP initiatives. The grants have been used to train school nurses in partnership with state IVP professionals; develop a comprehensive reporting system for school-based injuries; produce teen driving safety programs; and train those who work with youth to identify suicide risk signs.

- The Virginia Division of Injury and Violence Prevention Program (DIVP), funded in part with Title V grant dollars, partners with the Division of Child and Adolescent Health and the State's Department of Education (DOE) to support school nurses. DIVP staff participate in an annual summer institute that provides training and resources to school nurses. In addition, DIVP partners with school nurse consultants and the DOE on the development, dissemination, and promotion of **school safety guidelines** for all Virginia schools.
- Some of the 66 school-based health centers (SBHC) in Connecticut receive Title V funding. The majority of SBHC sites have formal plans to address intentional injury, including injuries from bullying. Several SBHC staff members are involved in **bullying prevention** activities in their schools and communities. Activities conducted to prevent bullying include, but are not limited to, anger management, social skill building, conflict resolution, and life stress management. Support groups for gay, lesbian, bisexual, and transgender (GLBT) students or a Gay/Straight Alliance are offered at some schools. Presentations related to bullying prevention are also provided at some schools.
- With funding support from Utah's MCH program, **school-based injury surveillance** data are collected from all State school districts, with an emphasis on elementary school-age youth (classroom and playground injuries) and secondary school-age youth (sports injuries). The program produces five-year data summary reports on student injury and answers data requests to assist in determining local priorities.
- In Rhode Island, the Department of Education and the Department of Health partnered to develop a regulation that all schools in the State must develop a **transportation safety plan** and that all school playgrounds must comply with the U.S. Consumer Product Safety Commission's playground safety guidelines.



» ADOLESCENT HEALTH PROGRAMS

Abstinence education, comprehensive sexuality education, and other teen pregnancy prevention programs

IVP issues that can be integrated into these activities include child maltreatment prevention, sexual violence prevention, and suicide prevention. A correlation between suicidality and sexual behaviors has been reported in studies of the Youth Risk Behavior Survey.¹⁸ Sex education and teen pregnancy prevention programs may be delivered in school or community settings through clinical, educational, or counseling services. Local providers can be encouraged to inquire about past or current abuse or thoughts of suicide and refer to local services as needed.

- Staff members from the Oklahoma Bullying Prevention Initiative have provided technical assistance in bullying prevention to Oklahoma's State-funded adolescent pregnancy prevention projects. These projects also address issues of **sexual coercion** and healthy relationship skills with middle school students.

Teen parenting programs

Teen parenting is associated with a variety of health and social issues, including violence and poverty. Besides offering interventions to prevent violence before, during, and after pregnancy, teen parenting programs may help prevent child abuse and neglect through parent education and support.¹⁹ These programs can also provide information, safety devices, and other resources on home safety and child passenger safety.

- The Maine Injury Prevention Program (MIPP) routinely provides teen parenting programs with printed resources on shaken baby syndrome (SBS), child development and discipline, and other safety topics. Information about child passenger safety is made available upon request to teen parents. Since teens are still attending school, MIPP provides **training for bus drivers** on transporting infants in school vehicles.
- In Idaho, staff members from the Department of Health and Welfare participate in parenting groups and child care classes at local high schools. The facilitator chooses a subject and lets the teens discuss personal experiences and problem-solving approaches on such topics as child care, **partner relationships**, and self-esteem. One session of the prenatal class series focuses on child safety issues and includes a discussion of the symptoms of postpartum depression and the interventions available to treat it. The director of the Children's Advocacy Center speaks about abuse prevention and is a board reviewer of infant deaths in one county.

Young father programs

The goals of young father programs may include the improvement of parenting skills, educational levels, and employment capabilities. Providers of these programs can offer unintentional injury and child abuse prevention as part of parenting education. **Violence prevention** can also be an indirect result of the services—such as assistance in finding employment—offered through these programs. Paternal unemployment has been found to be a significant risk factor for child abuse.²⁰



School health programs, school nurses, and school-based health centers

- The Oklahoma School Health Program provides information about **bullying prevention** and developing healthy relationships through its monthly School Health Resource Packets as well as a newsletter and calendar. In cooperation with the state Department of Education's safe and drug-free schools coordinator, the program also offers multiple workshop and training opportunities.
- The Virginia Health Department supports **bullying prevention** in schools and uses bullying prevention resources from the Stop Bullying Now Campaign www.stopbullyingnow.hrsa.gov.
- The Missouri Department of Health works with some school nurses to use the injury prevention module of the CDC School Health Index to **assess school facilities**.
- The Maine Injury Prevention Program (MIPP) provides school-based health centers with bullying prevention training and technical assistance; **youth suicide prevention** awareness education; gatekeeper and Lifelines training; and technical assistance in prevention programming. *Kids and Guns: Making the Right Choice*, a 30-minute video (that included parents) about the importance of restricting children's access to firearms, was provided to law enforcement professionals, including school resource officers, for use with middle school students. The MIPP health educator conducts trainings on SBS, brain injury, poison prevention, and inhalant prevention.

» PROGRAMS SERVING CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Prenatal care programs

It is important to include coverage of the following issues in the prenatal care services offered to women who are likely to give birth to a child with special health care needs: child abuse and neglect prevention, including shaken baby syndrome prevention; residential safety; safe sleep; **crib safety**; and child passenger safety.

Home visiting programs

There are a number of safety suggestions that can be made during home visits including

- develop evacuation plans based on the special needs of families
- install smoke alarms that have flashing lights for those with hearing impairment
- assure **safe storage of firearms**, especially if a child or adolescent is depressed or suicidal.

Transportation safety programs

Providers can work with child passenger safety programs to ensure that appropriate restraints are used, or provided to, families.

- The child passenger safety (CPS) coordinator in the Maine Injury and Violence Prevention Program assists families who have children with special health care needs in selecting and obtaining the appropriate **child safety restraints** for use in motor vehicles. The CPS coordinator also trains bus drivers and transportation directors to transport these children safely in school vehicles.



» WOMEN'S HEALTH PROGRAMS

Postnatal care programs

Some hospitals require that all new parents be informed about shaken baby syndrome prevention before discharge and that infants be properly seated in a child passenger safety seat upon release. Other messages to integrate into the guidance include crib safety and the risks associated with bed-sharing.

- A variety of safety materials—such as the Shaken Baby Syndrome poster and brochure as well as materials on child passenger safety and **home safety**—are routinely included in the new parent packages of many of Maine's birthing hospitals.

Family planning clinics (Title X)

These clinics often provide screening services for domestic violence and are an excellent place to discuss programs involved in **rape and domestic violence prevention**. Such clinics could also discuss the benefits of developing a safety escape plan with women and their families.

Family case management

- The Stephenson, Macon, and Wayne County Health Departments in Illinois use a health education protocol that includes IVP issues. Among these are safe sleep, **poisoning prevention**, safe travel (seat belts and safety seats), shaken baby syndrome, home safety check, home drowning prevention, and housing rights for victims of domestic or sexual violence, gun safety, positive parenting and connecting fathers with their children.



MASSACHUSETTS CASE STUDY: INTEGRATING INJURY AND VIOLENCE PREVENTION ACTIVITIES INTO MCH PROGRAMS IN MASSACHUSETTS

Information for this case study was generously provided by the following staff members of the Bureau of Family and Community Health of the Massachusetts Department of Public Health:

- Alicia High, Assistant Health and Human Service Coordinator, Women, Infants, and Children (WIC) Program, Nutrition Division
- Carlene Pavlos, Director, Division of Violence and Injury Prevention (DVIP)
- Cindy Rodgers, Director, Injury Prevention and Control Program (IPCP), Division of Violence and Injury Prevention (DVIP)
- Anne Sheetz, Director, School Health Services (SHS), Division of Child and Adolescent Health

Introduction

This case study describes how the Massachusetts Division of Violence and Injury Prevention (DVIP) worked with other units of the Bureau of Family and Community Health (the Massachusetts maternal and child health agency) to integrate injury and violence prevention activities into their programs. These activities include domestic violence screening, fire safety education, self-injury and suicide prevention, emergency preparedness, sexual assault prevention, product safety, violence prevention, and safe walking and bicycling.

The maternal and child health (MCH) units with which DVIP collaborated include Family Planning; Women, Infants, and Children (WIC); Early Intervention/Prevention; Tobacco Control; School Health Services; the Division of Health Promotion and Disease Prevention; and the Division of Perinatal, Early Childhood, and Special Health Needs. The participants in these efforts found that incorporating injury and violence prevention activities into MCH programs is an efficient and cost-effective means of protecting the women and children served by those programs from injury and violence.

Preventing Domestic Violence

Carlene Pavlos, director of DVIP, reports that 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. The bureau engaged in an iterative process to confirm this need and shape a response. Carlene said that “We developed surveys to find out what Family Planning and WIC needed. Was domestic violence an issue? Did it ever come up? If it did, did staff know what to do? What did they need to respond?” This process served as a catalyst for the creation of State Performance Measure 10: “The degree to which the State has developed and implemented comprehensive education, screening, and referral protocols for violence against women and children” as well as a program to meet that performance measure: the Domestic Violence Screening, Care, Referral, and Information Project (DV SCRIP), which teaches MCH staff to identify and help clients who are victims of intimate partner violence.

Although DV SCRIP was developed by DVIP, 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 DV SCRIP. 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. Alicia explained:

WIC is more than nutrition. WIC staff connects women and children to many services that they need. WIC is unique because we provide services to families representing many cultures, and we have WIC staff members that represent the population being served. We want to make sure that women who come to WIC feel comfortable and safe. We want women to know that WIC is a resource for when they need a referral for domestic violence. Pregnancy is a time when a woman experiencing domestic violence may want to make a change. Women who are victims of domestic violence are often isolated. Some abusers make it hard for victims to leave the house or connect with other people. When pregnant, postpartum, and breastfeeding women come to WIC for their appointments, we have a good opportunity to intervene.

Initially, 35 WIC programs in Massachusetts received DV SCRIP 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 DV SCRIP training, staff from local domestic violence programs and State agencies—such as the Domestic Violence Unit of the Department of 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. DV SCRIP 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 DV SCRIP 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.

Working with victims of domestic violence can be intimidating. Alicia High remembers that her own reaction when she first heard about DV SCRIP was “We’re going *there?*!” She felt a similar resistance from WIC program staff, who repeatedly told her at first that domestic violence was “just not our business.” But Alicia and WIC staff in general have come to understand how DV SCRIP can contribute to their program—and how they can contribute to stopping domestic violence. Alicia underwent extensive training in domestic violence issues so that she could offer WIC staff the expertise, technical assistance, and support they need when working on such a traumatic issue.

Despite their initial hesitation, DV SCRIP has proven wildly popular with WIC staff. Carlene Pavlos reports that DVIP “doesn’t have to sell the importance of DV SCRIP to WIC anymore. WIC sees training about domestic violence as a priority and views DVIP as the partner that helps make it happen. Local WIC providers are banging on our door for training.” In fact, the expansion of DV SCRIP to all WIC programs in Massachusetts was made possible through WIC financial support of a DV SCRIP training consultant. DVIP would like to move to a train-the-trainer format that would allow WIC’s own trainers to implement DV SCRIP as part of the standard WIC training for all staff.

DV SCRIP has also proved popular with other MCH programs in Massachusetts. The demand from the Family Planning Program, for example, outstripped DVIP’s training capacity. Fortunately, the Family Violence Prevention Fund, a nonprofit organization, offered a member of its staff as a DV SCRIP trainer for the Family Planning Program.



Working with WIC

DV SCRIP is only one example of how DVIP works with other MCH programs such as WIC to prevent injuries and violence. Cindy Rodgers, director of DVIP's Injury Prevention and Control Program, reports:

DVIP is occasionally called upon to respond to an issue that has become a high priority even though we have no funding for that activity. Working with other MCH programs can help us respond to these needs. For example, WIC is funded to produce WIC Minutes—public service announcements that run on local radio stations. When an injury or violence topic comes to public attention, we work with WIC to produce WIC Minutes on these issues. WIC also has a graphic designer, which we do not. We used DVIP expertise and WIC design resources to develop fliers for parents on window safety, kids in cars, and shaken baby syndrome, all of which are then distributed at WIC programs.

The Bureau of Family and Community Health also found that inviting staff from MCH units and other Department of Public Health divisions to sit on program advisory boards can pave the way for integration. For example, the bureau invited representatives of WIC and the Massachusetts Tobacco Control Program to sit on the advisory board of Fire Safe Massachusetts. Alicia High reports that information shared at this meeting, such as the capabilities of the enhanced 911 system, was disseminated to WIC programs. In addition, fire safety materials developed by DVIP are distributed to local WIC programs to help teach WIC clients about fire prevention as well as what to do if a fire occurs. WIC also encourages their clients to participate in the bureau's Early Intervention Partnerships home visiting program, during which they are provided with fire prevention education and smoke detectors.

Integrating Injury and Violence Prevention Activities into School Health Services

The School Health Services (SHS) unit of the Bureau of Family and Community Health has also taken an active role in integrating IVP efforts into its programs. Some of these efforts have been conducted in collaboration with DVIP.

SHS's *Comprehensive School Health Manual* includes a chapter on the prevention of both intentional and unintentional injuries, as well as a chapter on mental health, which includes material on the prevention of self-injury and suicide. This manual is distributed to all school nurses, superintendents, school committee chairpersons, board of health directors, and school-based health centers.

SHS contracts with Northeastern University to operate the School Health Institute, which offers continuing education programs for school health personnel. The institute has featured injury prevention topics, including suicide and sexual assault. In 2008 DVIP will be participating in a Violence Prevention Issues program presented by the School Health Institute. Other institute programs have covered topics including depression prevention, mental health issues, and emergency preparedness training.

The director of SHS sends a weekly e-mail to approximately 1,800 school nurses. This e-mail regularly includes information provided by DVIP staff as well as product recall information provided by Cindy Rodgers, director of the Injury Prevention and Control Program. SHS also works closely with Alan Holmlund, director of the Injury Prevention and Control Program's Suicide Prevention Program, on preventing and responding to youth suicides.

SHS ensures that school nurses and other school health personnel have complete and current information on important points of entry into the health care delivery system for victims of intentional injuries, including services such as the Suicide Prevention Program, the Sexual Assault Nurse Examiner Program, and rape crisis centers.



Promoting Smart Growth

The rising interest in smart growth—a movement that seeks to promote community environments that encourage walking and bicycling—has also provided an important opportunity for DVIP to work with MCH programs interested in promoting physical activity and reducing obesity among Massachusetts residents. Research demonstrates that one of the challenges to getting people to incorporate walking and bicycling into their daily lives is to provide safe places for them to participate in these activities without fear of violence or a collision with a motor vehicle.

DVIP's Cindy Rodgers and Lea Susan Ojamma from the Division of Health Promotion and Disease Prevention presented on injury prevention and obesity prevention at a Smart Growth Alliance meeting. Although the Injury Prevention and Control Program does not have the time to speak at other smart growth events, Lea does, and she continues to integrate the injury prevention perspective into her concern with promoting fitness and reducing obesity.

The rising interest in smart growth provided an important opportunity for DVIP to work with MCH programs interested in promoting physical activity and reducing obesity among Massachusetts residents.

Preventing Suicide

The Bureau of Family and Community Health's Suicide Prevention Program has also worked with other MCH units. For example, the Suicide Prevention Program

- educated staff of the Division of Perinatal, Early Childhood, and Special Health Needs unit about new mothers and depression
- trained school health nurses about youth suicide at the annual School Health Institute, which is sponsored by the bureau's School Health Services unit
- provided information to the DVIP staff to help write a chapter on suicide, violence, and unintentional injuries for the School Health Unit's *Comprehensive School Health Manual*.

Conclusion

The Massachusetts case study shows that there are many ways to engage potential partners in initiatives to bring injury prevention into MCH services and to implement these initiatives in a sustainable way, even when it may seem initially that injury prevention has little in common with other programs. Membership on a program advisory board can give department representatives new opportunities to learn about overlapping goals and to share injury prevention information with their staff. Regular e-mails on injury prevention topics and in-person presentations at meetings and conferences provide other avenues for spreading the word about how to combine injury prevention with existing programs. Training is an essential first step in the implementation of integration, and it lays the groundwork for real and enthusiastic participation by frontline staff and management. Training helps staff understand the need for injury prevention, learn about risk factors in the populations they serve, practice screening protocols, meet the individuals to whom they will be making referrals, and ask questions about how their own roles will change. The further step of incorporating injury prevention into policies and procedures manuals makes integration a core part of program operations. As the Massachusetts experience clearly demonstrates, integrating IVP activities and information into MCH services can extend the reach and strengthen the capacity of programs dedicated to both IVP and MCH goals and can advance the health and well-being of women, children, and families.



TECHNICAL ASSISTANCE FROM CHILDREN'S SAFETY NETWORK

However you decide to integrate IVP activities into your program, Children's Safety Network is available to take you from start to finish. CSN's Economics and Data Analysis Resource Center (EDARC) can assist you in examining your state's data on deaths and hospitalizations to determine the injury causes your MCH agency may want to address—especially those related to the national and state-selected Title V performance measures. We can help you identify MCH services into which you can incorporate injury and violence prevention activities. CSN will provide examples of evidence-based strategies and effective resources you can use when implementing an IVP intervention. We can also assist you in the planning and implementation of integration activities and describing how these activities will help you achieve injury and violence prevention goals and objectives. One of our most important services is connecting you with injury and violence prevention partners who are essential in your efforts to incorporate IVP into MCH services.

Many of the programs described in this document do not include a formal evaluation component. CSN encourages programs to implement evaluation that will not only provide the programs themselves with important feedback, but will also offer additional guidance to others who want to replicate their success. Please contact CSN for assistance with your evaluation needs as well.

To connect with the people from the examples provided in this document or other partners listed, please contact CSN at www.ChildrensSafetyNetwork.org. CSN is also interested in new examples to share, so please contact us with your examples and ideas.



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