



Spotting Injury and Violence Prevention on Your Radar Screen

Creating a Legacy in Public Health – A Guide for State and Territorial Health Officials

“History has shown us that injury is very amenable to change. The data tells us that it must be done and that it can be done, and yet injury usually is not the number one public health issue in most state offices.”

– Paul Halverson,
2009-2010 ASTHO President
Director and State Health Officer,
Arkansas Department of Health



To Our Members

In a given day, 475 Americans die from injuries – more than twice as many as from diabetes, and more than four times as many as from breast cancer. However, as a state health official you can influence the number of injuries and create a legacy of better health for generations to come. How? By pursuing and promoting proven strategies and policies.

Prevention is a centerpiece of our public health system, and research indicates that preventing injuries can have tremendous benefits. The societal burden of injuries is a heavy one, but injury prevention policies reinforced through evidence-based research can successfully reduce that burden and create significant, measurable outcomes. As a positive public health investment, these policies not only save lives, but create numerous benefits that outweigh implementation costs. Simply put, this *living* return on investment (ROI) is worth the effort.

There has never been a more optimal time for injury prevention policies. The recently enacted Patient Protection and Affordable Care Act of 2010 established a Prevention and Public Health Fund specifically to provide for an expanded and sustained

national investment in prevention and public health programs. The Fund supports programs authorized by the Public Health Service Act for prevention, wellness, and public health activities. Policymakers and public health officials in every state will be looking to implement proven prevention programs to take advantage of the new funding. As such, injury prevention presents little risk and a huge opportunity for success.


The need is apparent and the benefits are measurable. On the following pages, we'll discuss how to better understand what you can do to vigorously pursue injury prevention policies in your state that will help people of all ages live to their full potential. The following concepts are explored in this policy primer:

- The burden of injury in the United States
- Why focusing on injury prevention policy change is a smart idea
- Examples of state-level policy changes that could be models for replication in your state



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“Prevention is a national priority. Working to prevent injury and death through evidence-based interventions is a valuable investment of time and resources for a worthy cause.”

– Paul E. Jarris, MD, MBA,
Executive Director, ASTHO



Preventing Injuries Through Policy Change

Injuries – including injuries resulting from car crashes, falls, domestic violence and poisonings – are the leading cause of death among Americans aged 1 to 44 years, and the fifth leading cause of death for everyone overall. Injuries and deaths resulting from “accidents” have become so commonplace that we, as a nation, seem to have forgotten that they are preventable. We can identify successful strategies for supporting policy changes to minimize the number of injuries and injury-related deaths.

We All Pay: Lessening the Burden

A 2006 study in *Injury Prevention* estimated the lifetime costs associated with medical expenses and lost productivity resulting from injuries to exceed \$400 billion, with 40% of those costs attributed solely to motor vehicle crashes and falls. With so many Americans negatively affected by injuries every year, it's easy to make a case for injury prevention.

Now's the Time: An Opportunity to Improve Health

Injury prevention is a priority for the Centers for Disease Control and Prevention (CDC), which provides significant resources for researching, translating and disseminating, and evaluating interventions that work. Additional stakeholders and potential funders include federal agencies, such as the Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the U.S. Department of Transportation (DOT), as well as non-profit foundations and other private institutions.

Getting Set: A Framework for Policy Change

From consumer protection and child safety laws to traffic safety laws and more, we're all familiar with injury prevention policies. But how do you determine the best policy approach for your jurisdiction?

Perhaps the most important first step is to conduct an assessment that identifies the impact of injuries on your state. Some common review questions include:

- What is the specific burden of injury?
- Are certain injuries of particular concern because they represent the largest burden overall or because they disproportionately impact a vulnerable segment of the population?
- Are there *outlier* injuries (i.e., those that affect a small proportion of the population, but result in high costs to the state)?

To ascertain a complete and accurate understanding of the burden of injury in your state, you can utilize the Web-Based Injury Statistics Query and Reporting System (WISQARS), provided on the CDC's website. Once the burden is defined, you can then identify evidence-based interventions by using the CDC's Guide to Community Preventive Services. The Guide provides recommendations to the public health community, highlighting systematic reviews of relevant studies and summarizing evidence in support of the policy options described.

To assist public health leaders in identifying policy levers and crafting effective strategies for action, Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention, has provided a paradigm for public health action. This framework for change is called the Health Impact Pyramid and it includes five tiers:

- Socioeconomic factors
- Changing context for healthy decision-making
- Protective interventions
- Clinical interventions
- Counseling and education

Implementing policies at all levels of the pyramid can achieve the maximum possible sustained public health benefit. A similar framework called *The Spectrum of Prevention* can help to identify strategies for focusing injury prevention efforts. Health officials are uniquely positioned to work across all dimensions of both models and recognize gaps that might be filled, as well as existing efforts that might be strengthened. Equipped with a comprehensive understanding of both the burden of injuries in the state and where the opportunities for positive change lie, efforts can be focused on pursuing the most-needed, evidence-based injury prevention policies.



The Spectrum of Prevention

Levels of the Spectrum	Description
Influencing policy and legislation	Changing laws and policies to influence outcomes in health, education, and justice
Changing organizational practices	Adopting regulations and norms to improve health and safety; creating new models
Fostering coalitions and networks	Bringing together groups and individuals for broader goals and greater impact
Educating providers	Informing providers who will transmit skills and knowledge to others
Promoting community education	Reaching groups of people with information and resources to promote health and safety
Strengthening individual knowledge and skills	Enhancing an individual's ability to prevent injury or illness

(Source: Cohen L, Swift S. *The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention*, Injury Prevention, 1999.)

Making the Case: Anticipating Challenges and Messaging for Success

Injury prevention efforts will encounter challenges, ranging from apathy or resource constraints to active opposition to policy changes. Motorcycle helmet laws, for example, are extremely unpopular with some motorcyclists who have actively worked to repeal helmet laws viewed as encroachments on their personal liberties. But the fact remains that every public policy – even those centered on seemingly popular, relatively well-funded issues – encounter challenges and must be championed. However, the likelihood of facing challenges doesn't make a public health problem any less worthy of becoming a top priority.

When surveying the context of injury prevention in your state, include assessments of potential champions and potential barriers. What injury prevention efforts might the state's governing bodies support? Which groups and affiliations may be in opposition? What have been the experiences in other states? Ask and answer as many tough questions as you can ahead of time, before determining your course and taking action. Your personal investment in injury prevention and your leadership in promoting it will determine its success.

That being said, there's a particular investment you can make to ensure the success of your injury prevention efforts: developing and using clear, concise, consistent messages that convey the most important points you want your stakeholder audiences to absorb and that counter any opposing messages.

The following pages provide examples of successful injury prevention policy efforts across the nation, and include stories about how some of your colleagues are taking the lead in improving the health and safety of their communities by preventing injuries.

Working with the branch in your state health department that oversees and administers injury and violence prevention programs is an excellent place to start planning a policy strategy. Injury prevention coalitions or networks can also be key collaborators, as many states already have planning groups that engage communities in injury and violence prevention efforts. ASTHO partners with its affiliate, Safe States Alliance, the only national non-profit organization representing state-level injury and violence prevention professionals.

Messaging: "We're In This Together."

One opposing message you may encounter – and that injury prevention professionals have been negotiating for decades – is the same one that resonates from motorcyclists who are opposed to helmet laws: "Your legislation infringes on my personal liberty." We hear this from smokers, we hear it from drivers who don't want to wear seat belts, and we hear it from mothers who fear the risks associated with childhood vaccines.

It is an argument that needs to be anticipated and deflated. In a 2005 commentary in the American Journal of Public Health, Lawrence Wallack argued that the dominant American language values the freedom of individuals over the rights of communities and described the need for a "second language" focused instead on shared responsibility and egalitarianism. Such a concept is behind several successful public health movements

of the past, including the very successful "Friends Don't Let Friends Drive Drunk" campaign. Similar messaging strategies were used by anti-tobacco proponents to boost non-smokers' rights.

The development of positive, consistent messages that reiterate "we're in this together" must be a focal point of injury prevention policy efforts. The CDC's National Center for Injury Prevention and Control (NCIPC) published a useful messaging guide: "*Adding Power to Our Voices: A Framing Guide for Communicating About Injury*." The Guide can help you and your staff develop coordinated, meaningful messages around injury prevention that, when used consistently and across multiple outreach activities, will serve to counteract opposing messages.

ASTHO'S PRESIDENTIAL CHALLENGE 2009-2010

Spotting the Entry Point for Policy Change in Your State



Prescription Drug Overdose



Unintentional Poisoning and Suicide



Home and Recreational Safety



Falls Prevention Among Older Adults



Teen Dating Violence

INJURY PREVENTION AND CONTROL



Elder Maltreatment



Child Safety



Traumatic Brain Injury



Child Maltreatment



Motor Vehicle Safety

Discover additional strategies for advancing policy change at [astho.org](https://www.astho.org)

Success Stories in Injury Prevention Policy

We all share in the burden and experience of injury and violence, whether it's attributed to emotional stressors, to lives damaged or lost, or to staggering health care costs. The CDC's Injury Center has identified three types of injuries as top priorities on its national agenda to intensify and direct efforts:

- Motor vehicle crashes
- Falls among older adults
- Child maltreatment

Injuries within these three areas take a significant toll on both individuals and society, yet are responsive to policy changes informed by evidence-based interventions. Unintentional drug poisoning represents another issue emerging as a significant public health problem that requires a coordinated response. Both the NCIPC and ASTHO believe that these areas present immediate opportunities for state health officials to begin reducing the burden of injuries in their states.

Within each content area, we'll examine what works and identify steps you can take to enhance the safety and well-being of your constituents.

A "Winnable Battle:" Preventing Injuries from Motor Vehicle Crashes

Motor vehicle crashes take an enormous toll in the United States. According to the National Highway Traffic Safety Administration (NHTSA), a statistical projection of traffic fatalities in 2010 reveals that nearly 33,000 people died in motor vehicle crashes.

In 2009, more than 90 people died in motor vehicle crashes every day. An additional 2.3 million American adults are injured in motor vehicle crashes every year. The vast consequences of these tragedies include billions of dollars in health care expenditures, lost wages, property damages, travel delays, and legal and administrative fees.

Clearly, the societal burden of motor vehicle crashes is tremendous – but it doesn't have to be. The last 20 years have shown that injuries and deaths due to motor vehicle crashes can be dramatically reduced through proven policy changes.

What Works

There are numerous opportunities to prevent injuries before, during, and after an "event" – such as a motor vehicle crash – that has the potential to result in injury or death. Many

of these opportunities come in the form of policy changes that focus on specific driving-related issues:

- Use of seat belts
- Teen drivers and graduated driver licensing
- Impaired driving
- Use of mobile devices while driving

Other policy issues (such as child safety seats, use of helmets on motorcycles, access to trauma care centers, enhanced emergency medical services, joint road and highway safety planning projects and vehicle safety improvements), while not discussed in this document, remain very important. Every policy option available to decision makers requires a collaborative approach that includes local, state and federal entities.

Primary enforcement seat belt laws, graduated driver licensing (GDL) programs, and laws to reduce impaired driving have been identified as priority areas because they have considerable potential for dramatic reductions in injuries and fatalities.



Motor Vehicle Injury Prevention:

- 4,000 lives could be saved each year if everyone used seat belts
- 8,000 lives could be saved each year through attainable reductions in impaired driving
- 175 lives could be saved and 350,000 non-fatal injuries prevented every year with enhanced graduated drivers license policies

According to CDC Director, Dr. Thomas Frieden, preventing injuries related to motor vehicle crashes is one of six “winnable battles” for public health officials, measured by the following criteria:

- Evidence-based interventions and public health strategies exist and can be applied to the problem
- Strategies are scalable (i.e., reach a large number of those “at-risk”) and address leading causes of death and disability
- Broad implementation produces a significant impact over a short time period

Making it Click: Restraint Laws

When used, seat belts are one of the most effective interventions for preventing injuries and deaths resulting from motor vehicle crashes. Mandatory seat belt laws are an effective way to ensure that seat belts serve their purpose and keep passengers safe in the event of a crash. Seat belt laws are divided into two categories: *primary* and *secondary*. Primary seat belt laws allow law enforcement officers to ticket a driver for not wearing a seat belt, without any other traffic offense taking place. Secondary seat belt laws permit law enforcement officers to issue a ticket for not wearing a seat belt only when another citable traffic infraction has occurred.

As of July 2011:

- 32 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have primary seat belt laws
- 17 states have secondary laws
- New Hampshire has neither primary nor secondary seat belt laws for adults; however, the state has a primary child passenger safety law for children under 18

Source: Governors Highway Safety Association®, 2011

Importance of Taking the Right Steps: Graduated Driver Licensing (GDL)

Roughly 11 percent of drivers involved in fatal crashes are between the ages of 15 and 20 years. The elevated crash risk for beginning drivers is universal, and graduated driver licensing laws have consistently

demonstrated effectiveness in reducing such risk. Peer-reviewed evaluations of the effectiveness of GDL programs show that crashes involving new drivers can be substantially reduced by margins anywhere between 9% and 43%.

While all states have implemented some form of a GDL law, they vary greatly, with some not meeting the standard for *good* GDL laws, as set forth by the Insurance Institute for Highway Safety (IIHS). Three jurisdictions with effective GDL laws are California, the District of Columbia, and Washington, each of which enforces a *learner* stage with a mandatory holding period before the *intermediate* stage, and established minimum hours for supervised driving, as well as nighttime driving and passenger restrictions.

The most comprehensive state GDL programs are correlated with lower crash fatality rates for 16-year-old drivers, which are approximately 20 percent lower as compared to GDL programs without multiple components and restrictions for new drivers.

Maintaining Focus: Reducing Impaired Driving

In 2009, 10,839 people in the U.S. died in alcohol-impaired motor vehicle crashes, representing 32 percent of all traffic-related deaths. In the same year, research from IIHS estimates that 7,440 deaths would have been prevented if all drivers on the road had a blood alcohol concentration (BAC) below 0.08.

Alcohol-related crashes cost the American public an estimated \$114 billion in 2000, including over \$51 billion in monetary costs and an estimated \$63 billion in quality of life losses. **People other than the**

drinking drivers paid nearly \$72 billion of the alcohol-related crash bill – that is, 63 percent of the total cost of these crashes. Every state should consider enacting enhanced versions of these laws shown in the table below.

An Overview of Enacted Impaired Driving Laws

Name of Law	# of States
.08 alcohol per se law	50
Administrative License Revocation (+ DC, Northern Mariana Islands, and Virgin Islands)	42
Child Endangerment	39
Criminal Offense for BAC Test Refusal	15
Dram Shop	42 (+ DC)
Felony Laws (based on convictions)	46
Hospital Blood Alcohol Reporting	6
Ignition Interlocks	
Basic	50
Mandatory or Highly Incentivized	14
Increased Penalties for Drunk Drivers (+ DC, Guam)	47
Mandatory Alcohol Assessment/Treatment	37
Mandatory BAC Test	
Drivers who are killed	31
Drivers who survive	17
Sobriety Checkpoints (+ DC)	38
Social Host Liability	24

Source: Mothers Against Drunk Driving (MADD), 2011; NHTSA – Countermeasures That Work, 5th ed., 2010

With regard to underage drinking and impaired driving, there are some countermeasures geared exclusively to those under 21.

“Zero-tolerance” laws set a maximum BAC of .02 or less for drivers under 21. Violators have their licenses suspended or revoked. There is strong evidence that zero-tolerance laws reduce alcohol-related crashes and injuries.

Deterring underage consumption of alcohol requires collaboration between traditional highway safety organizations, such as law enforcement and motor vehicle departments, and also with community, health, and educational organizations with an expanded social agenda that goes beyond traffic safety and encourages the overall health and safety of young adults.

Making it Happen: Additional Steps

While policy changes are fundamental to reducing fatalities and injuries due to motor vehicle crashes, they are only part of the solution. According to the American Association of State Highway and Transportation Officials (AASHTO) and the Federal Highway Administration, policy changes are most effective when they take place within a culture of motor vehicle safety – which states can help create locally, as well as across the nation. This means looking to best practices and advocating for a collaborative approach that convenes local, state and federal stakeholders.

The first step is developing a broad-based coalition focused on improving traffic safety, including the creation of traffic safety commissions. In addition to the state health department, common partners

often include: state highway planning offices, state motor vehicle administrations, state departments of transportation, state departments of education, state police, emergency medical services, as well as grassroots groups, such as Mothers Against Drunk Driving. They also may include representatives from federal transportation-related agencies.

In addition to advocating for enhanced policies, such as those discussed in this section, and improved data collection and analysis, these state transportation safety coalitions are actively engaged in federal strategic highway planning processes, which are focused on improving safety on the nation’s roads. According to AASHTO, 80% of states participate in the process, but 100% should be participating if we are to create a national culture of traffic safety.

In general, fatalities in motor vehicle traffic crashes have been on a downward trend. Using preliminary data from the first quarter of 2011, NHTSA reports that motor vehicle fatalities are projected to be the lowest since 1975, a figure representing a 31 percent decrease from the near-term high reported during the first quarter of 2006.

The reason for this marked decline has been attributed to a reduction in crashes involving young drivers. Many experts believe this favorable trend is due to the variety of approaches that have been taken to reduce teen driver crashes, such as laws and sanctions, licensing policies, and educational programs.

Additional information on creating a culture of traffic safety in your state can be found in the *Resources* section at the conclusion of this document.

Standing Smart: Preventing Injuries Related to Falls Among Older Adults

Falling is the leading cause of injury deaths among older adults, and fall-related injuries place an enormous burden on society – to the tune of \$19 billion in total direct costs in 2000 for adults 65 years and older, according to the CDC. **One in three adults aged 65 and older falls every year, with 20-30% suffering moderate to severe injuries**, such as hip fractures and head trauma. And, two-thirds of older adults who have fallen once will fall again within six months.

Among adults over age 64, falls account for approximately 10% of emergency department visits and 6% of hospital admissions. Further, according to the CDC, that \$19 billion figure mentioned above is estimated to increase to \$55 billion by 2020.

Preventing falls among older adults would save lives, reduce healthcare costs and result in significant improvements in quality-of-life. What’s more: research has taught us that it is possible to prevent falls and dramatically improve outcomes. For example, a Connecticut-based pilot program focused on educating providers about relatively simple clinical interventions to help prevent falls resulted in an 11% reduction in the use of fall-related medical services – approximately 1,800 fewer emergency department visits and hospital admissions.

Falls among older adults are a consequence of aging. Falls prevention is another opportunity to help tip an issue toward success in your state and across the nation. Policy efforts that encourage



proven prevention activities can help achieve measurable reductions in falls and fall-related injuries and deaths among older adults in your state.

**Programs and Policies:
Working Hand-in-Hand**

Older adults can take several steps to protect their independence and reduce their risk of falling, including:

- Exercising regularly, focusing on increasing strength and improving balance
- Reviewing medications regularly to reduce side effects and drug interactions
- Scheduling an eye exam at least once a year and updating prescription eyewear to optimize visual acuity
- Performing home modifications, such as improved lighting and removal of trip hazards

States can help prevent falls by developing policies that encourage or require providers who regularly interact with elderly adults – such as primary care physicians, nurses, and adult daycare workers – to educate themselves and their patients about these steps and integrate them into their daily practice.

The CDC has identified, evaluated, and replicated a variety of successful falls prevention activities in communities across the country, including programs that help older adults increase strength and coordination through exercise and programs that promote the use of home safety visits to identify and recommend corrections for fall risks.

Where it Works: Massachusetts

In Massachusetts, an active Falls Prevention Coalition has been operating and a new Falls Prevention Commission was just legislated within the Department of Public Health. The recent legislation delegates responsibility to the Department for forging a public-private partnership with providers, legislators, governmental agencies and others. The Commission will identify epidemiological trends, potential interventions and programs for implementation. These assessments will take place in a variety of settings, such as hospitals, nursing homes, home health clinics and hospices.

Massachusetts has well over 100 organizations represented on a falls coalition and has measured a significant reduction in injurious nursing home falls over the past five years. A combination of regulations for hospitals and nursing homes around falls prevention policies and serious event reporting appears to be a winning combination of patient safety and injury prevention in Massachusetts.

Many evidence-based falls prevention programs – as well as the local, state and federal polices to support them – are the focus of the national Falls Free™ Coalition, created by the National Council on Aging (NCOA) in 2004. Since that time, Congress passed the “Safety of Seniors Act” in 2008 and 31 states have joined the national coalition and created – often through legislation – their own statewide falls prevention coalitions. Coalition members include public health and social service agencies, health care and community service providers, local and state leaders, and older adults and their families. The state coalitions are focused on creating and implementing state-specific action plans to raise awareness and promote falls prevention at the state level.

In Connecticut, where the state coalition celebrates a Falls Prevention Awareness Day, the Department of Public Health’s Injury Prevention Program works with local health departments to decrease home hazards, improve strength and balance training, reduce adverse medication reactions and increase awareness of fall risks and prevention among older adults and their families.

Connecticut’s outcomes over the past four years include:

- Over 550 home safety visits conducted and at least 77% of identified fall hazards corrected
- A reduction in falls among home safety visit recipients from 50% prior to the visits to only 3% at the four-month follow-up visit

- A 92% continuation of exercise among 370 older adults who completed an exercise class
- Improved identification of falls risks among 87% of 900 older adults who participated in fall prevention seminars and medication review programs

There are many states that work to build local coalitions or teams that promote evidence-based programs and services, and community solutions for older adult populations. Each state should determine the characteristics of its communities, the availability of resources and partners, and the level of awareness around the issue.

In terms of advocating for legislative funding to advance efforts around falls prevention, Washington is a prime NCOA-recognized example: A state legislator serving on the committee for long-term care services became aware of the high costs associated with falls, particularly hip fractures. In response, legislation was introduced that directed Washington’s use of a state Long Term Care fund to support capacity building efforts. The state health department’s statewide falls prevention program now expands on networking and community services, identification of service gaps, availability of affordable exercise programs for seniors, and education on falls risk identification and reduction.

“In Minnesota, a wide variety of partners – including state agencies, hospitals, health plans and other organizations – have come together to find innovative ways to prevent falls in our state. We are proud of the collaborative nature of our work, especially with our state hospital association. With our most recent adverse events report, we saw a 20 percent decrease in hospital falls that led to serious injury or death. But there is still much more work to be done.”

– Dr. Sanna Magnan, ASTHO Alumna and former Commissioner of Health, Minnesota

Additional Steps

Another focus of the Falls Free™ National Action Plan is to encourage changes in the falls-related reimbursement policies of Medicare and other relevant providers, such as Medicaid and private insurers. Despite the annual medical costs that result from falls, Medicare does not yet reimburse for falls prevention activities, maintenance of function, or medically necessary equipment and home modifications related to falls. The Affordable Care Act creates a new Medicare preventive benefit that authorizes not only a preventive visit, but also requires a personal prevention plan and increases access to health risk screenings and other prevention services.

For the Future: Preventing Child Maltreatment

Child maltreatment – including all types of abuse or neglect of children by a care-giving adult – is a difficult issue just to think about or talk about,

let alone take action to prevent. Historically, child maltreatment has been investigated and addressed after it has already begun, through state child welfare and foster care systems. However, research shows that **child maltreatment can be successfully prevented before it begins through positive and supportive interventions that promote safe, stable, nurturing relationships.**

And there is no doubt or argument that child maltreatment must be prevented:

- In 2008, child protection agencies identified more than 770,000 children (up to age 17) who had been abused or neglected – most often by their parents
- That same year, 1,740 children died – 80% of them under age 4 – as a result of maltreatment
- An estimated that 1 in 5 American children experience some form of maltreatment (*Pediatrics*, 2009)

These figures are generally considered to be conservative estimates of what is really happening to children. And the total direct cost of child maltreatment – including costs of hospitalization, mental health care, and law enforcement – has been estimated at \$33 billion.

Preventing child maltreatment is about more than preventing immediate harm to children. It's also about preventing a lifetime of adverse effects that result from such traumatic childhood experiences. Research shows that persistent stress can impair child development. Maltreated or abused children are more likely to suffer a broad range of problems throughout their lives, including chronic health problems like diabetes, heart disease and obesity as well as emotional health problems, like depression, substance abuse and suicide. They also are more likely to enter the child welfare system, as well as engage in high-risk and criminal activities.

What Works

Research shows that **rates of child maltreatment can be reduced through educational interventions**, such as home visiting programs, that seek to strengthen families by sending specially-trained providers into homes to help parents improve their parenting knowledge and skills, and provide them with resources and support to help them cope during times of stress.

The gold standard for this type of program is the **Nurse-Family Partnership**, which was launched in 1977 and currently serves 23,000 families in 32 states. The program, which dispatches registered nurses to the homes of young, low-income, first-

“Sometimes the critical role that prevention and public health agencies play in protecting children is not fully recognized in communities or at the state and national levels. The Public Health Leadership Initiative will advance child maltreatment prevention as a higher priority for public health and our partners through increased collaboration on behalf of all families.”

– Leah Devlin, DDS, MPH, ASTHO Past President

time mothers and their babies, has been shown to decrease abuse and neglect among children of low-income mothers by 79%. It also found that, **by age two, children were 35% less likely to visit the emergency room and 40% less likely to require treatment for injuries and accidents.**

The documented success of some home visiting programs in addressing a range of early childhood issues and strengthening families led to the creation of a new federal grant program under the Affordable Care Act: the Maternal, Infant, and Early Childhood Home Visiting Program will provide grants to states to deliver evidence-based home visitation services to at-risk families.

Another noteworthy and internationally-acclaimed educational intervention is Triple P America (Positive Parenting Program) funded by the CDC. This program is supported by a strong evidence base and is flexible in its application. Training is available to governmental agencies, communities, counties and states to serve families by boosting the confidence of and providing support for parents.

Additional Steps

Supported by the Doris Duke Charitable Foundation, in partnership with the CDC Foundation and the CDC's Division of Violence Prevention, the Public Health Leadership Initiative is a three-year project to identify best practice models of state public health leadership in the prevention of child maltreatment. Public health agencies commonly come in contact with children through various prevention programs and services which provide opportunities for preventing child maltreatment before it occurs.



Where it Works: New York and South Carolina

Today, other successful models for home visiting programs are underway in several states. Healthy Families New York, for example, has been recognized as a “proven program” by RAND Corporation’s Promising Practices Network. Research on this intensive home visitation program for families at risk found that, compared to a control group, participating mothers reported engaging in fewer neglectful, aggressive, and abusive behaviors toward their children.

In South Carolina, the Positive Parenting Program (referred to as Triple P) has been extensively evaluated and consistently shown to have positive effects on preventing child maltreatment. The program consists of five levels that range in intensity from broad, media-based public education campaigns to much more targeted individual interventions and supports, including home visits. In 2009, a CDC-funded evaluation of Triple P in 18 South Carolina counties found that, after more than two years, the intervention counties had fewer new cases of child maltreatment, lower incidence of abuse, and fewer injuries requiring hospital visits.

The purpose of the PHL Initiative is to assist and support state agencies as they work to better the lives of children and adults.

In 2009, the PHL Initiative conducted an environmental scan of state public health agencies' efforts to prevent child maltreatment. The scan revealed that the majority (82%) of state public health agencies indicated that child maltreatment is considered to be a very important or important issue to their agency and more than two thirds (69%) considered child maltreatment as a public health issue. However, the level of commitment and the extent of the state agencies' role in relation to child maltreatment prevention varied significantly: only 39% of state public health agencies indicated that they had a designated child maltreatment staff person or program. This discrepancy between the recognition of the problem and the state agency efforts to address the problem represents an important opportunity for you, as a state public health director, to provide leadership on this important issue. Regardless of how a state structures its response to child maltreatment, the commitment of the state public health director is critical to widespread adoption of the public health approach to the prevention of child maltreatment and to the long-term success of state agency efforts.

There is substantial documentation in the scientific literature demonstrating that children who are maltreated are at increased risks for illness, injury, and death. With its emphasis on primary prevention, public health is uniquely suited to make important contributions to reducing child

maltreatment and its consequences. With proven efforts in states like New York and South Carolina, as a state public health director, you can play a critical role in helping children start on the right path to reaching their fullest potential.

A Public Health Crisis: Preventing Prescription Drug Overdoses

The rate of poisonings in the United States – primarily in the form of prescription drug overdoses – has increased dramatically since 1990, according to the CDC. **In 2007, drug overdoses were second only to motor vehicles crashes as a leading cause of injury death, and represented the leading cause of death among Americans, ages 35 to 44.**

Unintentional drug overdose deaths involving powerful, addictive opioid analgesics – usually prescribed to treat pain – now exceed the number of overdose deaths resulting from illicit drug use.

Between 2004 and 2008, the U.S. experienced an increase by more than 110% in emergency department visits involving non-medical use of opioid painkillers.

According to a 2008 report by ASTHO and the CDC, rates of use and misuse of opioid analgesics are highest among adults in the lowest income brackets – those who have no health insurance or are enrolled in Medicaid – making the social costs of the problem significant. One national study estimated that opioid abusers had mean annual direct health care costs eight times higher than non-abusers.

As with the other injury prevention topics included in this guide, state health officers have an opportunity today to provide leadership on this critical public health problem.

What the States Are Trying

Prescription drug monitoring programs (PDMPs) are statewide electronic databases that enable states to monitor prescriptions, track physician prescribing patterns, and identify patients who might be “doctor shopping” or otherwise attempting to obtain large amounts of prescription drugs. In recent years, the number of states with these programs has grown rapidly. According to the Alliance of States with Prescription Monitoring Programs, 48 states currently have a prescription monitoring program in place or have passed legislation to implement one.

To the extent permitted by applicable state laws, these programs routinely send reports to providers identifying patients who are under age 65, who are being treated by more than one provider and who have been taking opioids for longer than six weeks.

Prescription drug monitoring programs are designed to:

- Reinforce the legitimate medical use of controlled substances
- Deter or prevent drug abuse and diversion
- Identify drug misuse among patients and facilitate access to treatment
- Provide valuable information about patterns and trends in drug use

States also are finding other types of drug laws useful in addressing the epidemic of prescription drug overdoses. Maine's Unused Pharmaceuticals Return Program, for example, places pre-addressed, stamped mailers in convenient locations to facilitate the return of controlled substances to a central processing location for tracking and safe disposal. Several resources are available to help states plan, implement, or enhance existing drug laws, including prescription drug monitoring programs. These include the Alliance of States with Prescription Monitoring Programs, the PMP Center of Excellence at Brandeis University, and the National Alliance for Model State Drug Laws.

Additional Steps

Beyond proactive reporting of selected patients to their providers, **the CDC also recommends that governmental benefit programs consider monitoring prescription claims information for signs of inappropriate drug use by enrolled patients.** State Medicaid programs, workers' compensation programs, Veterans Affairs programs and others provide low-cost opioid prescriptions to their clients who, national data suggests, may be more likely than privately insured populations to misuse controlled prescription drugs.

In addition, some Medicaid programs report success in reducing inappropriate use by using "lock-in" programs, which restrict payment to only one doctor who can prescribe opioids and one pharmacy that can dispense them. **Washington, for example, has reported**



Where it Works: Kentucky and Maine

The Kentucky All Schedules Prescription Electronic Reporting (KASPER) system, for example, helps physicians and pharmacists quickly identify, via phone or the internet, patients who may be exhibiting drug-seeking behavior. It also ensures that patients who truly need prescription drugs are able to obtain them and collects the data necessary to guide drug overdose prevention efforts. Following this example, the federal NASPER (National All Schedules Prescription Electronic Reporting) Act of 2005 authorized a grant program within the Department of Health and Human Services to help states create prescription drug monitoring programs. A similar federal grant program is operated by the Bureau of Justice Assistance within the Department of Justice.

savings of \$1.5 million per month in Medicaid costs with its Patient Review and Coordination (PRC) program. Most states, however, could benefit from strengthening their “lock-in” programs. With potential savings in the millions of dollars, private insurers might also be induced to adopt similar programs.

Conclusion

Research shows that preventing injuries, in particular, can result in significant savings in both lives and dollars. The human toll and financial burden of injuries affects hundreds of Americans every day and harms more than 50 million every year, at costs of more than \$400 billion in medical expenses and lost productivity.

Cost-outcome analyses of injury prevention programs conducted by the Children’s Safety Network and the Pacific Institute for Research and Evaluation demonstrate the following *living* return on investments (ROIs), as referenced in the introduction to this primer, which can be tailored to demonstrate the cost-effectiveness of many of the strategies previously described:

- **Zero Alcohol Tolerance for Drivers Under 21** yields an estimated cost savings of \$960 for a cost of only \$39 per driver
- **Nighttime Driving Restrictions Combined with Provisional Licensing Policies** for teenage drivers yields an estimated cost savings of \$680 for a cost of only \$84 per driver

- **Sobriety Checkpoints** yield an estimated cost savings of \$82,000 for a cost of only \$12,000 per checkpoint
- **Battery-Operated Smoke Alarms** yield an estimated cost savings of \$770 for a cost of only \$44 per smoke alarm
- **Poison Control Centers** yield an estimated cost savings of \$320 for a cost of only \$43 per call
- **A Child’s Bicycle Helmet** (for ages 3-14 years) yields an estimated cost savings of \$580 for a cost of only \$12 per helmet
- **Child Safety Seat Distribution** (for ages 0-4 years) yields an estimated cost savings of \$2,200 for a cost of only \$52 per seat provided

Source: *Children’s Safety Network, 2011*

As a state health official, you are in the right place at the right time to identify and “win” an injury prevention battle in your state. This publication identifies four areas that are ripe for immediate attention: motor vehicle crashes, falls among older adults, child maltreatment, and prescription drug overdose. The *Resources* section that follows provides helpful information to get started on any one or all of these topics.

This primer is intended to be a guide to assist health officials in making injury and violence prevention and control a priority for their state. Combined with creativity and passion, you can positively impact the health and safety of all persons residing within your state.

“Drug overdoses are now the second leading cause of injury death in the United States, exceeded only by motor vehicle fatalities. The magnitude of this public health problem deserves immediate attention.”

– Leonard Paulozzi, MD, MPH, Medical Epidemiologist
Division of Unintentional Injury Prevention, NCIPC

Resources

Children's Safety Network
www.childrensafetynetwork.org

Council of State and Territorial
Epidemiologists
www.cste.org

Guide to Community
Preventive Services
www.thecommunityguide.org

National Association of County and City
Health Officials
www.naccho.org

National Center for Injury Prevention
and Control (CDC)
www.cdc.gov/injury

NCIPC/WISQARS Database
[www.cdc.gov/injury/wisqars/
dataandstats.html](http://www.cdc.gov/injury/wisqars/dataandstats.html)

National Conference of State
Legislatures
www.ncsl.org

Pacific Institute for Research
and Evaluation
www.pire.org

Prevention Institute
www.preventioninstitute.org

Safe States Alliance
www.safestates.org

Motor Vehicle Crashes

AAA www.aaapublicaffairs.com

AAA Foundation for Traffic Safety
www.aaafoundation.org/home/

American Association of State Highway
and Transportation Officials
www.transportation.org/

Governors Highway Safety Association
www.ghsa.org/

Make Roads Safe
www.makeroadssafe.org

National Association of State
EMS Officials
www.nasemsd.org/

National Highway Traffic Safety
Administration
www.nhtsa.gov

National Transportation Safety Board
www.nts.gov/

Child Maltreatment

Administration for Children and
Families (U.S. Department of Health
and Human Services)
www.acf.hhs.gov

Association of Maternal and Child
Health Programs
www.amchp.org

Future of Children Princeton
Brookings, The
www.futureofchildren.org

Pew Center on the States, The
www.pewcenteronthestates.org

Promising Practices Network
www.promisingpractices.net

Public Health Leadership Initiative
www.cdc.gov/violenceprevention/phl

Zero to Three
www.zerotothree.org

Falls Prevention Among Older Adults

Administration on Aging
www.aoa.gov

Agency for Healthcare Research
and Quality
www.ahrq.gov

Center for Healthy Aging
www.healthyagingprograms.org

Connecticut Department of Public Health
www.ct.gov/dph

Massachusetts Department of
Public Health
www.mass.gov

Minnesota Department of Health
www.health.state.mn.us

National Council on Aging
www.ncoa.org

VA National Center for Patient Safety
www.patientsafety.gov

Prescription Drug Overdose

Alliance of States with Prescription
Monitoring Programs
www.pmpalliance.org

National Alliance for Model State
Drug Laws
www.namsdl.org

National Association of State Alcohol/
Drug Abuse Directors
www.nasadad.org

Office of National Drug Control Policy
www.ondcp.gov

Substance Abuse and Mental Health
Services Administration
www.samhsa.gov



(202) 371-9090 tel
(202) 371-9797 fax
2231 Crystal Drive, Suite 450
Arlington, VA 22202
www.astho.org

Spotting Injury and Violence
Prevention on Your Radar Screen
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