



Promoting communication and collaboration to improve the health of urban women, children and families

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Improving Mental Health in Urban MCH

Lately, it seems as if the nation’s attention has been more focused on the complex interplay of mental health factors impacting the social well-being of people and communities. Events such as the shooting recently played out on the campus of Virginia Polytechnic Institute and State University make for headline news, but maternal and child health populations in our nation’s cities face a myriad of mental health concerns each and every day.

What is the role of MCH in addressing mental health? Is there “space” between the silos of chronically over-tasked and underfunded local urban health departments to adequately respond to the needs of ever-changing and increasingly mobile populations? CityMatCH recently queried selected urban MCH leaders for their observations, approaches and lessons learned with respect to the integration and delivery of needed mental health services in urban public health; their responses offer up a tapestry of hope, frustration, creativity and inspiration. In this edition of CityLights, we have synthesized their responses, and taken a closer look at selected issues raised, i.e., teen suicide prevention, adolescent and young adult mental health, and the role of CityMatCH in assisting our membership to focus attention on mental health.

CityMatCH is uniquely positioned to help focus national attention on the multifaceted and complex issues faced by women, children and families in cities – from non-English speaking populations representing countless different languages, cultures and unique patterns of health care access and usage, to women experiencing postpartum depression and falling through cracks in the safety net, to inner city adolescent males who have no hope or ability to see a path toward the future – and much more. This CityLights offers just a small glimpse, beginning below with responses to an electronic leadership roundtable recently conducted.

CityMatCH encourages readers to think beyond the standard boundaries of mental health service provision, and to consider the jigsaw puzzle of factors that may impact mental health: poverty, stress, education, access to care, place and environment, culture, freedom, hopes, and dreams. We recommend you look outside your toolbox of established strategies and thoughtfully consider strategic partnerships within your health departments and beyond – to nontraditional partners and to the women, children and families you have pledged to serve. So much is at stake.

Inside This Issue...	
CityView.....	2
CityIssues.....	3
Policy&Practice...4	
CityMatCHNews...7	

MCH Leaders Assess Local Urban Mental Health Services

Recently, CityMatCH hosted an E-mail Roundtable of selected urban MCH leaders; selected highlights from their responses follow:

CityMatCH: Describe your health department’s priorities around addressing mental health among the MCH populations in your jurisdiction.

Synkewecz: Our health department has made a commitment to mental health through direct services and as partners in community-wide planning to assess the local mental health (MH) system and identify needs and priorities. MH professionals and resources are needed to expand and improve services. Our department was the first in Florida

to become a MH Medicaid provider and is currently negotiating Medicaid managed care contracts.

Belanger: The most desirable way to address mental health (MH) issues in the MCH population or within any selected group is to embrace it as a regular part of health and health care. Once normalized, the stigma that often comes when individuals seek help for MH concerns becomes a non-issue. Within our health department, we are incorporating and integrating MH awareness and interventions into existing programs and services.

Harris: When MH issues are identified in the clinic setting, referrals are

made to a social worker or other community MH provider. Referrals are made by a home visiting service for mothers who have delivered preemie babies; have a history of MH problems; tested positive for drugs upon delivery; demonstrate poor social support systems; or who have displayed poor parenting /coping skills.

CityMatCH: Is your health department focusing mental health efforts on a particular population or issue? What are the unique needs of your community?

Belanger: In Maine, teen suicide rates remain significantly higher than

(Continued on page four)

To be continued...



Magda G. Peck, ScD,
Founder, CEO & Senior
Advisor to CityMatCH

“The good thing is that it takes a lot less time to tell the story than to live the experience,” quipped a storytelling friend who visited soon after I became the miraculous beneficiary of a second life. Here is the first part my story; I’ll keep it short.

Traveling alone on an icy interstate mid-morning late last January, cell phone off, seatbelt on, I left the road. Twice flipped, once hit by an oncoming car, we landed together in a snowy ditch. I crawled out of the wreck, conscious but confused, and searched for others in need of help, unaware that it was I who was hurt.

Sideline with a broken neck, I lost control of more than my car. They patched up my cervical spine 21st century style, with sea coral and titanium; my head finally is screwed on tight. Surrounded by family and friends, and showered with best wishes from near and far, I was cared for so well for so long, by so many loving people. I have mended remarkably well.

I learned first hand that every life-threatening event heralds a new gestation. Serious injury requires trimesters of healing. The first three months are for repairing the damage and reclaiming activities of daily living: fixing tea, taking walks, relearning to bathe alone and put on a bra. Folks who have been down this path once before warned me: the mind becomes clearer with restoration of body and soul. And they were right. Torn rudely from a self-imposed, over-extended schedule, I stopped.

Stopping brought extended moments of unexpected quiet. I was able to distinguish between artificial airs and genuine noise. The sun’s warm caress on late winter afternoons felt magically primordial. Time once scarce, seemed abundant, yet distorted. Pain braided with anxiety and fear abated first with drugs, then slowly with recovery. Tears of inexplicable gratitude and faith welled up and spilled over. Reacquainted with

daytime sounds and smells, residency was reestablished right at home. All that was not essential fell aside, and what is most important was revealed anew.

The second trimester after trauma calls for deeper healing from the inside out to restore mental well-being. Physical therapy is starting to expand my left arm’s range of motion, but how to deal with pent-up old stress, plus an unfamiliar range of emotions? Colleagues, staff, and partners have been remarkably resilient, respectful and ever resourceful. We mostly laugh at my stiff neck and new hair, and occasional holes in my short term memory about the details of the daily operation. Working nearly full time now is unexpectedly harder. Unable and willing to return to breakneck speed, yet loathe to disappoint, I get stuck. I am a public health leader back with backlogged commitments and apologetic colleagues cued up at my door. In that snowy ditch I was transformed from human *doing* to human *being*. How do I reconcile a legacy of hard driving performance and expected productivity with reclaimed basic humanity?

I pay attention. With social filters down, I am more sensitive to people behaving poorly, blinded by power or insecurity or ignorance. Having lost control, I can tell better now when folks are holding on to it. I have zero tolerance for racist and sexist behaviors, however unintended. Taking fresh note of how things look and feel, I am sorting through current obligations and emerging opportunities to see what truly must be done, and what I uniquely can do.

I am trying to take better care of all of me. I am asking for help, and getting it too, for mind and body and spirit. I am learning actively and retooling around leadership following injury (see March’s *Harvard Business Review*) and redefini

Peck Receives 2007 Sparks Award

In May 2007, Magda Peck, ScD, received the prestigious Robert D. Sparks, MD Award in Public Health and Preventive Medicine from the University of Nebraska Medical Center (UNMC), recognizing her for outstanding innovation and impact on preventing disease and promoting health through public health education, research and practice, with particular attention to the needs of Nebraska and its citizens. Recipients demonstrate excellence, creativity, and distinguished collaboration in advancing effective approaches to improving public health.

Dr. Peck has been a national and local advocate for social equity and public health, providing leadership in prevention research, education and policy for maternal and child health. In addition to her ground-breaking work with CityMatCH, Peck is professor of pediatrics at UNMC and clinical professor of pediatrics at Creighton University. Peck is the founding director of the UNMC/University of Nebraska – Omaha Graduate Program in Public Health and the Great Plains Public Health Leadership Institute. Over the years, Peck has received numerous accolades, including the American Public Health Association’s MCH Young Professional Award (1990), the Whitney Young Award from the Urban League of Nebraska (1999) and the National Maternal and Child Health Epidemiology Award for National Leadership from the Coalition for Excellence in MCH Epidemiology (2004).

ing my relationship to time and work (check out this month’s *Systems Thinker* newsletter article).

The late summer final trimester post-trauma should see an overdue shift away from *me*, back to all of *us*. By virtue of class and race and geography, I have always had extraordinary privilege. With more than enough knowledge, full access and quality of care, and abundant caring, I received first tier care from ditch to discharge - not likely for most others on this earth.

Once home, it was hard to figure out how to navigate and negotiate health care systems’ poor handoffs and poorer communication. It has to be better. Recharged and recovered, count on my renewed commitment to equity and quality, regardless of who’s hurting, how or where.

Being so hurt yet destined to recover fully has been the oddest blessing: the best of the worst. Thanks for every wish and prayer. They must be working, for the sweetest part of this story is that it will be continued.

The MCH Influence on the Mental Health of College Students



Edward P. Ehlinger, MD, MSPH, Director & Chief Health Officer, Boynton Health Service, University of Minnesota (Ed. Note: Dr. Ehlinger also served as the first Chair of the CityMatCH Board of Directors)

I was on vacation in Florida, 1,200 miles from my home, rocking my eight day-old grandson, when my daughter called from another room, “Dad, something bad is happening at Virginia Tech.”

When I saw the headlines on her computer screen, my mind immediately traveled to Blacksburg, Virginia where I clearly pictured my college health and counseling colleagues in the midst of a nightmare that had become a frightening and deadly reality. They would be among those responding to the carnage but given the stressed and distressed students seeking assistance daily at college health and counseling services, my first thought was for their personal safety. I silently hoped they had been spared physical injuries so that they would be available to help others.

My mind jumped to my own campus, a large urban university with a complex, diverse student body 850 miles from Virginia Tech. While the University of Minnesota has many unique characteristics and is located in a markedly different part of the country, it has more similarities to Virginia Tech and other post-secondary institutions than differences. All colleges and universities are educating, both inside and outside the classroom, twenty-first century students who embody the dreams of their parents and our hopes for the future. With those hopes and dreams come expectations, competition, pressure, and stress at a level never before seen in society. With assaults on students’ mental health occurring at every institution, what was happening in Blacksburg could have been occurring on any college campus.

A quick call to my staff reassured me that everything on our campus was stable; surveillance and communication plans established to handle these kinds of situations were being activated. Only then did my mind settle back on

the infant in my arms who had slept through my cross-country mind trips, Internet news searches, and cell phone calls confident, that in an adult’s arms everything would be all right.

As my grandson peacefully slept, I realized that most of today’s college students probably had similar experiences as infants over eighteen years ago. Yet on this day, the news from Virginia about the rampage of a mentally ill student was telling them and every future college student that everything was *not okay*. The institutions, systems, and services put in place by the hands of adults were no guarantee of safety or protection. Their present and future had just become ominous and threatening.

While pacing the floor and humming lullabies, the question that kept returning to my mind was “*what, if anything, had really changed?*” Mental health issues have been a major concern on college campuses for centuries and a debate exists about whether or not the true prevalence of mental illness among college students has changed significantly over the last few decades. Certainly, more students are coming to college carrying mental health diagnoses and prescriptions for psychotropic medications. More are receiving new mental health diagnoses after enrolling. Is this a true increase or merely the result of more intense screening, expanded diagnostic criteria, or greater acceptance of mental illness and treatment? Regardless, the visibility and priority of mental health issues on campus has increased tremendously.

One potential factor influencing this rise in mental health diagnoses and visibility is the unique characteristics of this generation of traditional-age college students. Offspring of the baby-boom generation, they have been tightly programmed, monitored, and protected throughout their lives. Even on campus, many maintain close, often daily, contact with parents. Parents are more involved with on-campus activities than any previous generation.

Today’s college students have been given numerous opportunities never before available. With those opportunities come burdensome expect-

tations of achievement and success. Failure is often not an option and even average achievement is often looked upon as failure.

Potentially complicating and exacerbating this stress is the fact that this generation of college students is “wired” like never before. “Screen time” in multiple forms has increased dramatically. E-mail, cell phones, text messaging, web pages and the like allow students to electronically communicate instantaneously at all hours of the day. Stress-reducing sleep is often postponed so as not to miss “important” messages. Ironically, this never-ending communication seems to be occurring at the expense of personal connections and the attendant interpersonal learning and problem-solving.

One consequence from this lack of human interactions is a decline in civility and empathy with an accompanying increase in personal and cyber bullying, cultural insensitivity, and harassment in various forms. Another purported consequence is a rise in individual high risk behaviors. Credit card debt and gambling are at historically high levels, abuse of prescription drugs is a rapidly evolving phenomenon, and high risk drinking has taken on an extreme form. None of these maladaptive behaviors nurtures one’s self-esteem or foster positive self-images. The ubiquitous presence of violence in the media, daily threat of terrorism, a dichotomous black/white political environment, and the fallout of September 11, 2001 helps create a social environment less supportive of tolerance, appreciation of differences, or creation of a positive sense of community.

With those thoughts in mind it was becoming clearer why mental health concerns on college campuses have become such a pressing concern and why every college administrator and college health professional was paying close attention to Virginia Tech. This could easily have been happening on their campus.

Just then, my grandson awoke and began to cry. My attempts to calm him were only marginally success-

(Continued on page six)

Urban MCH Leaders Assess Local Urban Mental Health Services

Continued from page one

the national average (6.0/100,000 vs 4.3/100,000). Therefore, we are working to provide psychiatric and counseling services to youth through school-based health centers. Primary care staff have been trained to better identify and respond to students at risk. We target postpartum women because Maine PRAMS data suggests that about half of all women who give birth in Maine will experience some depression postpartum and of these, close to eight percent will experience severe depression. Through our MCH home-visiting program, we focus on education and early identification to assure prompt connection to treatment. Another growing concern is the direct effects of trauma experienced by our military and the secondary effects experienced by their families due to war.

Pies: We place emphasis on the mental health needs of two populations: adolescents and foster care children/youth. Demand is growing for school-based programs to address issues of youth mental health. A slight, but important increase in county teen suicide rates (see related story on page six) has brought attention to issues of alcohol, drugs, depression, and youth violence. We are also involved in a county-wide project to address the needs of children who have been witnesses of domestic violence.



Roques: Since Hurricanes Katrina and Rita hit the Gulf Coast and New Orleans in 2005, the Baton Rouge area has increased its population by approximately 30,000 people, with many new residents living in transitional housing communities near Baton Rouge. Some have lost most or all possessions and must negotiate the Baton Rouge metropolitan area for social and health services. Many experience de-

What is an E-Roundtable?

It is a virtual conversation tool comprised of a series of questions delivered via E-mail and synthesized for publication. CityMatCH uses this tool to stimulate discussion among select participants.

E-Roundtable Participants

Lisa Belanger, MSN, NP

Program Manager, Family Health Services
Portland (ME) Public Health Division,
Health & Human Services Department

Zenobia Harris, MPH, BSN

Patient Care Leader-Central Region
Arkansas Department of Health

Cheri Pies, MSW, DrPH

Director, Family, MCH Programs
Contra Costa County (CA)
Health Services Department

Jamie M. Roques, RNC, MPA, MPH

Regional Administrator
Baton Rouge Parish (LA) Health Unit 2

Carol Synkewecz, MPH

MCH Director, Duval County (Jacksonville,
FL) Public Health Department

pression, anxiety, Post-Traumatic Stress Disorder and other mental illness due to hurricane displacement and trauma. The Baton Rouge MH Clinic has seen a 30 percent increase in post-Katrina office visits. Transitional housing areas are reporting problems with child abuse, sexual abuse, domestic violence and substance abuse as people struggle to cope with the loss of their community/support system while living in close proximity to each other in tiny FEMA trailers.

Nurses in the Infant Mental Health program screen, identify and refer children ages 0-6 who may have behavioral, emotional or bonding difficulties. Clinical social workers in the health unit see children ages 6-18 years experiencing emotional or behavioral problems and affected by the hurricanes. Women of childbearing age, pregnant women and new mothers are screened for domestic violence, substance abuse, alcohol abuse and depression, including postpartum; those with positive screens are referred to a brief interventionist. Social workers provide supportive counseling and referrals for families of children with special

health care needs.

CityMatCH: Describe your health department's capacity to address mental health priorities. What barriers affect your ability to enhance the mental health of your community?

Pies: We have limited mental health capacity within MCH but have an outstanding Mental Health division in our health department; collaboratively, we can begin to address the needs of our youth. Funding for appropriately trained staff is the most significant barrier. Cross-collaboration between schools, community centers, law enforcement, community based organizations, and others is needed to produce a better environment in which to live, grow up, and contribute to the community.

Roques: The health department in the Baton Rouge area provides services to seven parishes; each has a health unit facility – Baton Rouge region has four social workers – too few to provide direct MH services. However, the addition of MH social workers to Region two facilities has helped to assist children age 6-18. We address MH issues via early identification of symptoms/behaviors with prompt referral to appropriate programs. Supportive counseling is provided by the public health social work staff when needed, often upon referral by public health nurses.

Barriers are numerous: few prevention programs exist; MH symptoms must be severe to qualify for state MH clinic services; lack of knowledge about mental illness in the community, and stigma for those who need treatment. Mental illness is seen as a weakness while alcohol abuse is practiced openly and more socially accepted (Mardi Gras, festivals, etc.). Public education is needed to encourage MH treatment.

Harris: The capacity to address mental health priorities is minimal. For many reasons (i.e., resignation, reassignment, attrition, and other factors) the department has few social workers or other mental health professionals.

Synkewecz: The shortage of mental health professionals! We are working to increase the competency of primary care providers (i.e. pediatricians) in behavioral health diagnosis and interventions and to address concerns

during pediatric visits -- before children develop serious disorders. Many children and families present with very serious disorders...and have experienced serious problems for long periods of time. Case Management and strategies to follow children and families closely are essential; if we could better intervene, monitor, and advocate for families, more progress could be made.

CityMatCH: What cross-cultural lessons can be learned as diverse populations grow in your community?

Belanger: We are fortunate to have been chosen by The Robert Wood Johnson Foundation to launch a *Caring Across Communities* project that tailors services to meet the needs of cross-cultural populations. We will serve eight of the largest linguistic groups of immigrants and refugees in Portland Public Schools, creating an MH service delivery response for children and youth reflect-

ing their cultural norms and values. This promises to further enhance our capacity to address MH priorities within these populations.

Pies: We must be flexible and prepared for a range of issues related to migration, immigration, acculturation, and racism. As diverse populations grow, we will see migrations of people. Struggles related to finding new places to live, schools to attend, and making new friends will raise mental health issues for all populations. As individuals adapt to new environments and cultures, family pressures and tensions rise, leading to MH issues. Racism seems an intrinsic part of the cross-cultural experience. We must stay alert to the issues, address them in various contexts, and acknowledge the ways public health professionals can both contribute to and address racism locally.

Roques: After the hurricanes,

people/families of different cultures (Vietnamese, Hispanic, African American, white) were displaced and are now living together in "new" communities near Baton Rouge. We learned to be flexible, often providing services via mobile units deployed to transitional housing sites. We worked with other agencies and programs to develop health services, school assistance and social services for those who remain displaced. Thousands who lost their homes have not returned to New Orleans; we strive to link them with medical homes to provide access to primary care physicians, dental care, and other services. The Hispanic population is growing, thus increasing the need for bilingual staff, cultural competence and sensitivity training.



CityMatCH Responds: *Thinking beyond the Leadership E-Roundtable*

The final roundtable question asked **"What can CityMatCH do to help your health department enhance mental health in your jurisdiction?"** Respondents' answers are a snapshot of expectations reflecting CityMatCH's history of capacity-building, training, and advocacy, elevating important local issues onto the national stage. CityMatCH works to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities; clearly, addressing mental health capacity is a key concern. CityMatCH believes all children and families deserve to be healthy and achieve their optimal growth and development in all aspects – physical, intellectual, social, emotional, and spiritual – of their lives.

Knowing that, how can CityMatCH best address mental health? Belanger suggested member capacity-building: "I expect CityMatCH to act as a clearinghouse for solid MCH-related information and best practice models; to stay ahead of the curve, keeping members alert to new developments, trends and resources related to MCH and Mental Health issues." CityMatCH NewsBriefs bi-weekly compendium of resources informs readers on these and other key issues. "E-Alerts" provide

members with timely MCH information sent electronically. Topically-based editions of *ResourceInfo* parallel each edition of *CityLights* and are available on-line at citymatch.org,

Pies and Synkewecz stressed national awareness-raising and creating a broad vision for addressing mental health. Said Pies, "If we are to make a difference in the way young people respond to difficult situations and begin to address community violence in our neighborhoods, we must consider education, racism and poverty. CityMatCH has the ability to help focus attention on these broad and challenging issues. CityMatCH can be a leader, spotlighting the complex issues faced by foster care children and children exposed to domestic and other types of violence." Synkewecz asked CityMatCH to "keep these topics on the priority agenda locally and nationally, to offer models to learn from each other, to seek suggestions for resource planning and provide research opportunities." CityMatCH uses its position pragmatically, to advocate for the needs of local, urban public health, and ensures that the unique concerns of members are brought forth nationally.

The shortage of trained mental health professionals on staff was another common thread in the E-Roundtable.

Zenobia Harris said, "CityMatCH must advocate for the recruitment, hiring, and utilization of additional social workers and other licensed mental health professionals to assist in providing the best overall quality mental as well as physical health."

Finally, the critical importance of data to make the case for advancing member health department's capacity to address mental health issues was noted. Strong skills in data use and in translating data to action to make a measurable difference in the mental health of MCH populations is crucial. CityMatCH's **DaTA** Institute (see related story on page eight) offers proven tools for communities seeking to make positive changes through effective use of data and will soon be taking applications for this coming year's Institute.

Urban women, children and families have unique mental health needs and deserve special attention. This E-Roundtable has offered just a glimpse into current health department ability to address these needs. Responses will inform CityMatCH efforts in the month's and years ahead. We truly welcome your ideas and comments. For more information, contact Maureen Fitzgerald, MPA at 402-561-7500 or via E-mail at mfitzger@unmc.edu

Take AIM: Teen Suicide Prevention Strategies and Resources

In the United States, teen suicide is a serious public health issue, ranking third among leading causes of death among teenagers.¹ Female teens are much more likely to attempt suicide than males, but male teens are four times more likely to succeed.² A review of suicide statistics for teens and young adults reveals shocking numbers: according to the *National Adolescent Health Information Center* at the University of California, San Francisco, in 2003, 4,232 adolescents and young adults ages 10-24 took their own lives.³

What puts teenagers at risk?

Identified risk factors include previous suicide attempts; depression and/or alcohol or substance abuse; family history of mental disorders, substance abuse, or suicide; stressful situation or loss; easy access to guns; exposure to other teenagers who have committed suicide; history of physical and/or sexual abuse; poor communication with parents; incarceration, and lack of access or an unwillingness to seek mental health treatment.⁴

What is being done to address this crisis? The 1999 Surgeon General's *Call to Action to Prevent Suicide* has promoted a three-pronged suicide prevention strategy of – awareness, intervention, and methodology (AIM) and provided a set of 15 essential recommendations.⁵ Because those with mental and substance abuse disorders may be at the

greater risk for suicidal behavior, these recommendations focus on addressing the problems of undetected and under-treated mental and substance abuse disorders in conjunction with other public health prevention approaches.

In an effort to incorporate best practices and research toward reducing the incidence of suicide nationwide, the Substance Abuse and Mental Health Services Administration (SAMHSA) samhsa.gov/matrix2/matrix_suicide.aspx launched a *National Suicide Prevention Initiative* (NSPI), a collaborative, multi-project initiative. Three prevention programs are currently underway: a *National Suicide Prevention Lifeline* (Lifeline), a *Suicide Prevention Resource Center* (SPRC), and the *National Strategy for Suicide Prevention* (NSSP). Links to each may be found at mentalhealth.samhsa.gov/cmhs/nspi/

For example, **the Lifeline** offers 24-hour a day, seven days a week, toll-free suicide prevention services, giving immediate assistance to any caller seeking mental health assistance. Callers are immediately routed to the closest Crisis Center in their area. Because teens frequently link to Internet sites to get information, **Lifeline worked with the popular MySpace site to create a** customized profile that provides teens with critical information, Lifeline phone numbers, resources, and tools. The Lifeline's pro-

file can be found at: myspace.com/suicidepreventionlifeline

A number of national resources exist to support professionals working to address suicide prevention in their communities. Among them, the Centers for Disease Control and Prevention and other Federal agencies have sponsored the *National Youth Violence Prevention Resource Center*, which provides current research, information, publications and resources on the Internet at safeyouth.org/scripts/teens/who.asp The Center for Mental Health Services within SAMHSA's National Mental Health Information Center promotes teen suicide prevention via positive youth development, resilience, recovery, and the transformation of mental health services delivery for children and youth with serious mental health needs and their families.

Also, 120 Crisis Centers nationwide have produced a web "blog" to encourage discussion among crisis centers and members of the suicide prevention community across the country: crisiscenters.wordpress.com/

¹ Centers for Disease Control and Prevention. **WISQARS (Web-based Injury Statistics Query and Reporting System)**

² Centers for Disease Control and Prevention. (2000). **Youth risk behavior surveillance - United States, 1999**. In: CDC Surveillance Summaries, June 9, 2000. *MMWR* 2000;49(No. SS-5), p. 10.

³ 2006 Fact Sheet on Suicide: Adolescents & Young Adults; <http://nahic.ucsf.edu/downloads/Suicide.pdf>. ⁴ <http://www.safeyouth.org/scripts/faq/suiciderisks.asp>

⁵ <http://www.mentalhealth.samhsa.gov/suicideprevention/calltoaction.asp>



College Students and Mental Health

(From page three)
ful and the anxiety of both of us began to escalate. Only when my daughter caringly and confidently took him,

changed him, swaddled him, rocked him, and nursed him, did he calm down. I was impressed with how attuned she was to him and with the skills she had developed during the last week. I realized one doesn't learn those parenting skills in a week. Knowing how to sensitively, effectively, and compassionately interact with someone, no matter the age, is a skill developed over many

years. She had been preparing for moments like this all of her life.

I was struck with the connection between caring for a newborn and what was transpiring on the Virginia Tech campus. Current events don't happen on a random and haphazard basis; they occur in a complex evolutionary manner from a myriad of events, ideas, and experiences influencing and shaping their final presentation. Individual, family, environmental, and societal influences are all part of the expression of today's events. Today's events help shape the form of events far into the future. As I watched my daughter care for her infant son, I realized that all the work that people

do to reduce poverty, improve child development, foster social justice, increase educational achievement, enhance communication, and strengthen parent-child bonds, helps prevent a myriad of future physical and mental health problems.

Because we are all in this work together, my work in college health is made easier or harder by the influences on children long before they get to college. I smiled as I realized that my grandson was getting a good start for eventually being a healthy college student. My smile then turned into a wish that he and all of his future college colleagues will receive the help of many others in our communities in order to achieve their potential as part of our hope for our collective future.

MCH Leadership Competencies v2 Document Released

"An MCH leader inspires and brings people together to achieve sustainable results to improve the lives of the MCH Population."

The MCH Leadership Competencies, version 2.0 was recently released and offers a warehouse of information -- MCH leadership is defined; core MCH Leadership Competencies identified; essential knowledge and skills outlined; a conceptual framework for the development of an MCH Leader provided, and potential uses for the Competencies discussed.

CityMatCH members and leaders will find these competencies helpful in guiding personal assessments of their MCH leadership skills and for constructing plans for personal improvement. They also have been designed to facilitate clear and consistent job descriptions, performance reviews, coaching and mentoring of new MCH professionals; and to create a template that can be used in MCH training programs educating future leaders.

The latest release belies years of effort, beginning in 1987 when HRSA's Maternal and Child Health Bureau (MCHB) convened a leadership training conference of MCHB-funded grants. In 1993, the Association of Teachers of MCH developed a list of MCH Competencies. As MCHB began looking at how their MCH Training Programs defined leadership and how one determined success in producing leaders, an analysis was commissioned from the Center for Educational Outcomes, which resulted in the publication, "Assessment of MCH Training Programs: Working Towards Data-driven Standards of Excellence in Leadership Education."

An MCH Leadership Competencies Workgroup was convened and an initial draft of MCH Leadership competencies synthesized. CityMatCH has consistently represented the concerns

of the local urban public health community to the Workgroup; CityMatCH Board Chair, Mary Balluff, MS, joined the Workgroup prior to the development of version 1.0. Mark Law, MS, CityMatCH staff, was subsequently invited to join the workgroup.

The MCH Leadership Competencies can be downloaded in pdf format from the collaborative website of the MCH Training Grantee Network located at: <http://www.leadership.mchtraining.net/>

Visit the website to join in an interactive feedback and discussion forum regarding both version 2.0 and the previous version, and help inform the final document. For more information, contact: Mark Law at 402-561-7500 or via E-mail at mlaw@unmc.edu

1 Adapted from: George, B. (2006, October 30). Truly authentic leadership. *U.S. News & World Report*, 52.

Farewell to Dr. Greg R. Alexander

On February 20, 2007, Dr. Greg R. Alexander, 56, of Tampa, FL died of heart failure. At the time, Alexander was a professor of public health and pediatrics at the University of South Florida. "Dr. Greg Alexander's scholarly work helped shape the conversation around infant mortality in this country – his intellect and wit will be sorely missed," said Patrick Simpson, CityMatCH Acting Executive Director.



A lifelong advocate for children and an MCH/perinatal epidemiologist, Dr. Alexander held public health faculty positions in MCH departments at the Johns Hopkins University and the universities of Hawaii, Minnesota and Alabama at Birmingham. He was familiar also to CityMatCH as the editor of the Maternal and Child Health Journal.

Fund for Young Scholars: In his name, donations may be made to the Greg R. Alexander Fund for Young Scholars in Maternal and Child Health at the University of South Florida, MDC-70, 12091 Bruce Blvd., Tampa, FL, 33612. For more information regarding the Fund, please call: 813-974-3676.

2007 Board Elections Underway

Balloting in the 2007 CityMatCH Board of Directors Election is underway and will conclude on June 15, 2007.

Ballots have been mailed to all CityMatCH member representatives in mid-May. Representatives will be elected to fill selected regional positions, "at-large" positions, and positions on the Nominating Committee. This year's nominees include the following CityMatCH member representatives:

At-Large (Two Open Seats) Curtis Fenton, Geraldine Perry-Williams, Bill Ridella.

South East Regional: Carol Synkewecz

South Central Regional: Zenobia Harris

North Central Regional: Deborah Hendricks, Norma Tubman

West Regional: Cynthia Harding, Audrey Stevenson

CityMatCH Nomination Committee

(Two Open Seats): Sherry Williams, Cheri Pies, Belle Marks

CityMatCH would like to thank the current Nomination Committee (Belle Marks, Pamela Stuver, Sherry Williams, and Patrick Simpson) for their guidance in shaping a ballot of outstanding candidates.

For more information, contact Mark Law, M.S., Membership Services Coordinator, at 402-561-7500 or via E-mail at mlaw@unmc.edu



Coming Soon: 2007-2008 DaTA Institute Applications

Applications for the 2007-2008 **DaTA** Institute will be available online on July 1, 2007 with completed forms due September 3, 2007. An informational conference call has been scheduled for July 17th at 2:00 p.m. Eastern Time to provide additional information on both the application process and the Institute. To learn more, visit the **CityMatCH** website at citymatch.org or contact Sarena Murray at 402-561-7500 or via E-mail at smurrayp@unmc.edu.

Since 1997, **CityMatCH** has invited urban MCH practitioners to come together within local teams for training in leadership and data use skills, scientific thinking, data methods, planning, evaluation, political strategy development and more. Skills participants learn are directly applied to a project of importance in their local communities throughout the nine-month **DaTA** Institute. This year's **DaTA** Institute activities begin in October 2007 and conclude in late summer 2008 at the annual **CityMatCH** Urban MCH Leadership Conference.

At the heart of the nine-month curriculum is the **DaTA** Institute "Hands On" Workshop in which the team core members are given opportunities to implement skills which they have learned and to work with **CityMatCH** faculty through a combination of didactic lectures and case study materials.

During this year's workshop, **CityMatCH** teams were joined by participants from the U.S.-Mexico Border Cities Project. Recently, **CityMatCH** began a partnership with U.S.-Mexico border assignees from CDC's Division of Reproductive Health to adopt portions of the **DaTA** Institute to their region and to assist these cities in enhancing their ability to translate data to action. Look for more to come on this unfolding initiative in upcoming editions of *CityLights*.

SAVE THE DATE!

Join us for the 2007 **CityMatCH** Urban MCH Leadership Conference:

"Building the Best Environments for Families and Children"

August 26 - 28, 2007 -- Denver, Colorado -- The Marriott Denver Tech Center.
For more information, or to register online, visit the web at www.citymatch.org



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