



Alabama 2014 State Fact Sheet

Unintentional injuries and violence are the leading causes of death, hospitalization, and disability for children ages 1-18. This fact sheet provides a snapshot of data on the injury-related Maternal and Child Health Block Grant National Performance Measures and Health Status Indicators, with a special focus on disparities based on race, gender, and rural/urban residence.

The fact sheet is intended to be a helpful and easy-to-use tool for needs assessments, planning, program development, and presentations.

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

This 2014 state fact sheet includes data that was available as of May 2014. The fact sheet will be updated as new data is made available at the federal level.

Major Causes of Injury Death

Table 1: Leading Causes and Total 5-Year Incidence of Deaths by Age Group, Alabama, 2006-2010

Rank	Age Groups					
	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Congenital Anomalies 503	Unintentional Injury 168	Unintentional Injury 138	Unintentional Injury 131	Unintentional Injury 739	Unintentional Injury 1,041
2	Short Gestation 472	Homicide 36	Malignant Neoplasms 37	Malignant Neoplasms 36	Homicide 182	Homicide 373
3	SIDS 245	Congenital Anomalies 34	Heart Disease 13	Homicide 24	Suicide 127	Suicide 259
4	Maternal Pregnancy Comp. 129	Malignant Neoplasms 24	Congenital Anomalies 10	Heart Disease 19	Malignant Neoplasms 44	Heart Disease 118
5	Respiratory Distress 110	Heart Disease 21	Benign Neoplasms ****	Suicide 18	Heart Disease 35	Malignant Neoplasms 87

Note. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes.

Table 2. Leading Causes and Total 5-Year Incidence of Injury Deaths by Age Group, Alabama, 2006-2010

Age Groups						
Rank	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Suffocation 74	MV Traffic 50	MV Traffic 60	MV Traffic 61	MV Traffic 530	MV Traffic 681
2	Homicide 27	Drowning 46	Drowning 24	Homicide 24	Homicide 182	Homicide 373
3	MV Traffic 13	Homicide 36	Fire/Burn 19	Suicide 18	Suicide 127	Suicide 259
4	Unspecified ****	Fire/Burn 27	Suffocation ****	Other land transport 16	Poisoning 67	Poisoning 185
5	Drowning ****	Suffocation ****	Other land transport ****	Suffocation 13	Drowning 44	Drowning 42

Note. All mechanisms of suicide and homicide were combined according to intent. Each listed mechanism is unintentional except those otherwise noted. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes.

Major Causes of Hospital-Admitted Injuries

These results are preliminary.

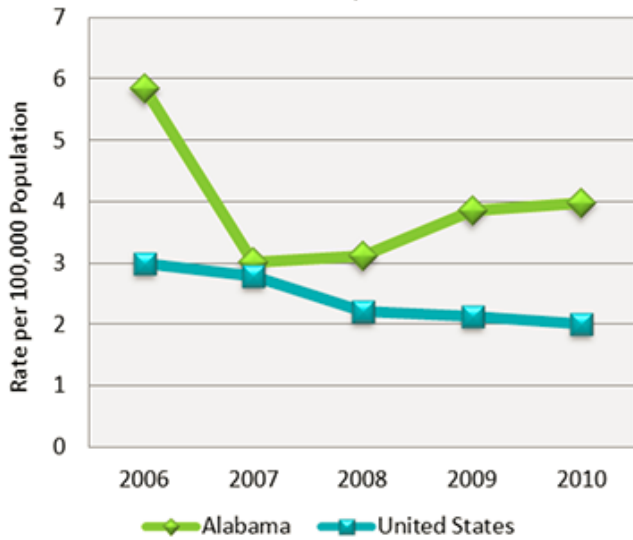
Table 3: Leading Causes and Annual Incidence of Hospital-Admitted Injuries by Age Group, Alabama Residents, 2011

Age Groups						
Rank	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Four Tied† *	Fall *	MVT *	MVT 13	MVT 42	MVT 63
2	Suffocation * Assault *	Poisoning *	Fall * Unspecified *	Transport, Other *	Self-Inflicted 19	Self-Inflicted 25
3	—	Drowning/ Submersion * Unspecified *	Other Specified, NEC *	Fall *	Fall 11 Struck By/ Against 11	Assault 14
4	—	MVT *	Struck By/ Against *	Self-Inflicted *	Transport, Other *	Fall 11
5	—	Six Tied†† *	Seven Tied††† *	Other Specified, NEC *	Poisoning *	Transport, Other *

Note: MVT = Motor Vehicle Traffic. NEC = Not Elsewhere Classifiable. Each listed mechanism is unintentional except those otherwise noted. * = indicates that the cell value ranges from 1 - 10 and is suppressed for data confidentiality purposes. †For ages < 1, four mechanisms were tied for the first ranking including *Unintentional Fall* and *Other Specified, NEC, Undetermined, and Unspecified*. ††For ages 1 - 4, six mechanisms were tied for the fifth ranking including *Unintentional Bites & Stings, Other Natural/Environmental, Other Specified, NEC, Pedal Cyclist, Other, Struck By/Against, and Transport, Other*. †††For ages 5 - 9, seven mechanisms were tied for the fifth ranking including *Unintentional Bites & Stings, Cut/Pierce, Other Natural/Environmental, Pedal Cyclist, Other, Pedestrian, Other, and Transport, Other, and Self-Inflicted*. Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2014. Incidence based on 2011 data from the state and obtained from the Alabama State Inpatient Databases (SID), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). These injuries exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility, different acute care hospital), medical misadventures, and/or who suffered non-acute injuries. All counts were based on the patients' state of residence.

Motor Vehicle-Related Deaths for Children 0-14 Years of Age

Figure 1: Rate of Deaths Caused by Motor Vehicle Crashes, Children Aged 0 through 14, Alabama and US, 2006-2010



Reducing unintentional motor vehicle deaths to children ages 0-14 is a Maternal and Child Health Block Grant National Performance Measure (Number 10). Motor vehicle-related deaths remain a major cause of death for this age group. Figure 1 shows the change in the rate of state motor vehicle-related deaths compared to the US rate from 2006-2010. Overall, the rate of death per 100,000 population declined steadily across the US during this period. Figure 2 provides a breakout of the fatalities by type distinguishing motor vehicle occupant deaths (of any vehicle type) from pedestrian and pedal cyclist fatalities. This information allows states to understand which types are responsible for most of the fatalities.

Figure 3 breaks out the fatalities by race and age group. There are considerable differences between races suggesting variations in social norms, safety practices, and the presence of risk factors, including child restraint system (CRS) or safety belt usage, alcohol involved crashes, and the use of helmets.

Many factors may affect this variation. Figure 4 provides a breakdown of fatalities by gender and, although there is little variability between males and females for the 10-14 age group, there is an increasing difference in the 15-24 age group. Figure 4 suggests that the female rate decreased for 20-24 year olds compared with the 15-19 year olds while male fatalities increased for 20-24 year olds.

Figure 2: Percentage Distribution of Motor Vehicle Traffic Fatalities by Type, Children Aged 0 through 14, Alabama, 2006-2010

27% of children ages 0 through 14 involved in a motor vehicle fatality were occupants of the vehicle.

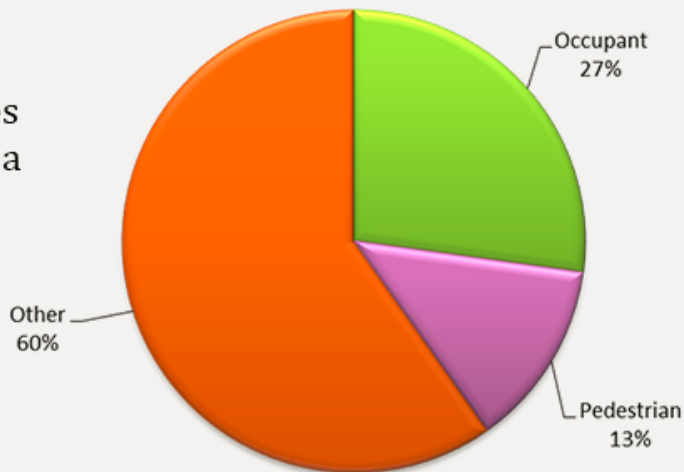


Figure 3: Motor Vehicle Traffic Fatality Rates by Race, Children and Youths Aged 0 through 24, Alabama, 2006-2010

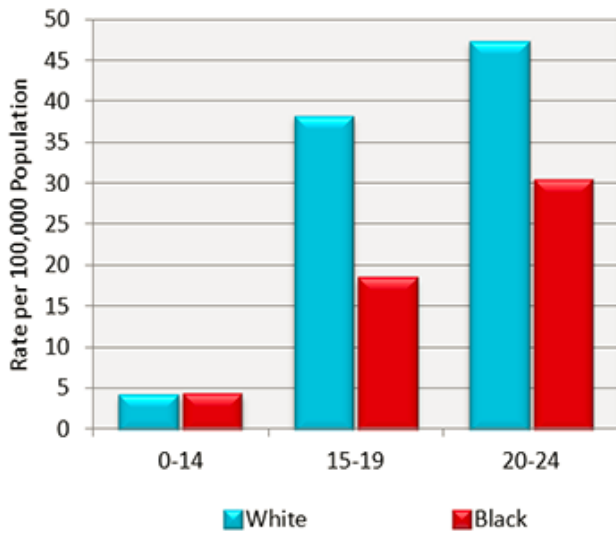
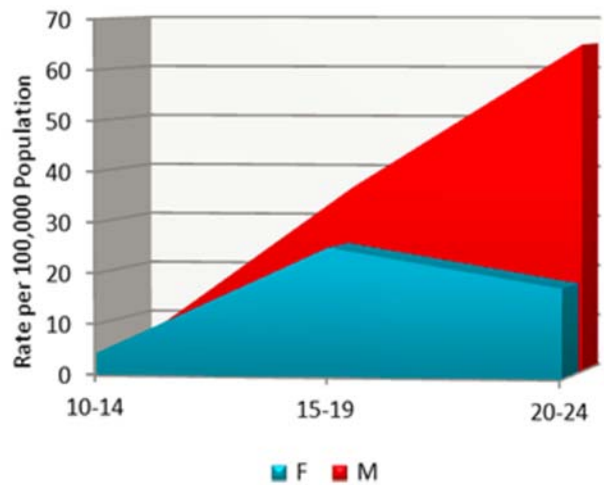
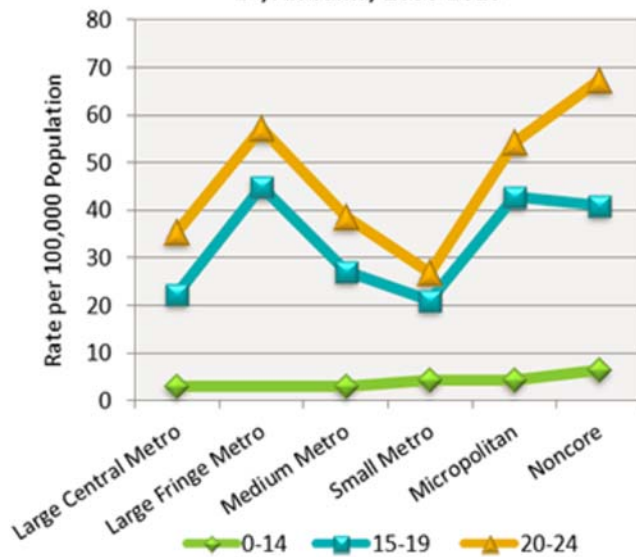


Figure 4: Motor Vehicle Traffic Fatality Rates by Gender, Children and Youths Aged 10 through 24, Alabama, 2006-2010



One way of understanding disparities is to look at the rate of injuries by place of occurrence. To show this, CSN has provided the rates for the 0– 14, 15-19 and 20-24 age groups using the urban-rural classification system developed by the National Center for Health Statistics (NCHS). To show how injury rates vary by level of urbanization, [a table based on the classification system can be found here](#) and defines six levels of urbanization: large central metro, large fringe metro, medium metro, small metro, micropolitan, and noncore. Figure 5 shows how the rate varies by age group by place of occurrence/urban-rural setting. This information allows the state to better understand any disparity that may occur between the different settings. Data are provided only for those areas in which 20 or more deaths occurred.

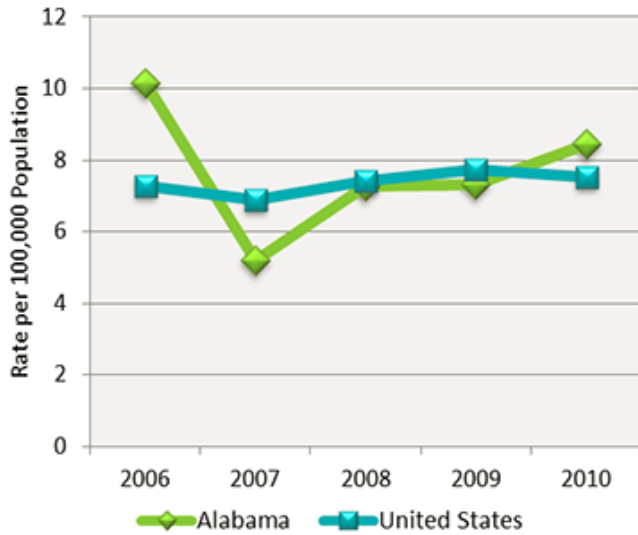
Figure 5: Motor Vehicle Traffic Fatality Rates by Urbanicity, Children and Youths Aged 0 through 24, Alabama, 2006-2010



Many of these motor vehicle related deaths can be prevented through the implementation of a broad range of evidence-informed interventions and programs. These data are intended to provide a broad overview of the magnitude of the problem and to highlight possible disparities which may exist by race, gender, and urbanicity.

Suicide Deaths for Youths 15-19 Years of Age

Figure 6: Rate of Suicide Deaths, Youths Aged 15 through 19, Alabama and US, 2006-2010



Reducing suicide deaths in youth 15 to 19 years of age is a Maternal and Child Health National Performance Measure (Number 16). Suicide is the 4th leading cause of death and the 3rd leading cause of injury-related death among US youth 10-24 years of age. According to the 2011 Youth Risk Behavior Surveillance Survey (YRBSS), 15.8% of students seriously considered attempting suicide and 7.8% of students attempted suicide one or more times in the 12 months prior to the survey. Although progress has been made over the past decade in reducing the rate of completed suicides nationally, this reduction has leveled off in the last few years. The following figures provide state-specific data related to suicide. Figure 6 shows the state rate from 2006-2010 for 15-19 year olds in comparison to the US rate for the same age group and time period. Figure 7 provides information on the means used by the 15-19 year olds for completed suicides. It is important to note that the actual number of suicides is often quite small thus resulting in considerable variation when looking at year to year rates.

Figure 7: Percentage Distribution of Completed Suicides by Means, Youths Aged 15 through 19, Alabama, 2006-2010

60% of children ages 15 to 19 completed suicide by using a firearm.

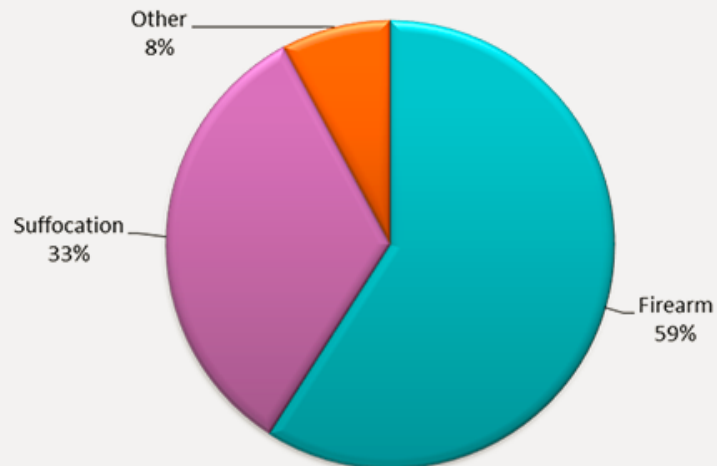


Figure 8: Percentage of High School-Aged Children with Suicide Ideation, Alabama and US, 2003-2011

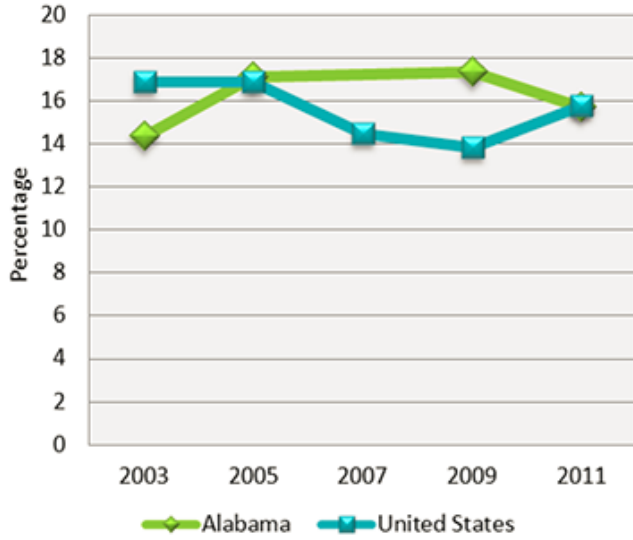


Figure 9: Percentage of High School-Aged Children Treated for Suicide Attempt, Alabama and US, 2003-2011

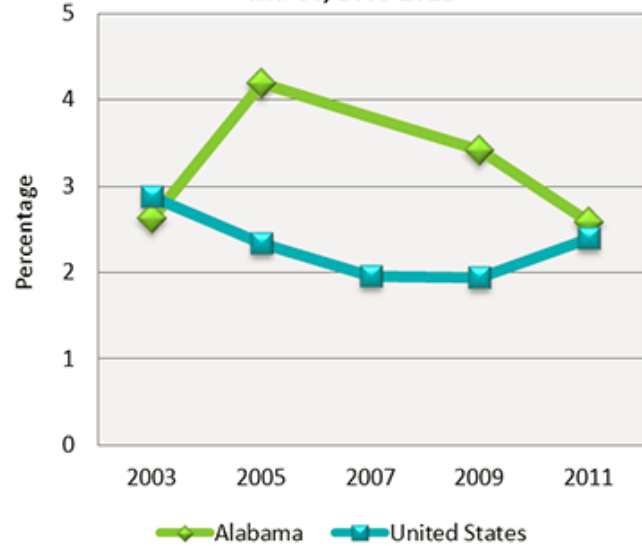


Figure 10: Rate of Completed Suicides by Race, Youths Aged 15 through 24, Alabama, 2006-2010

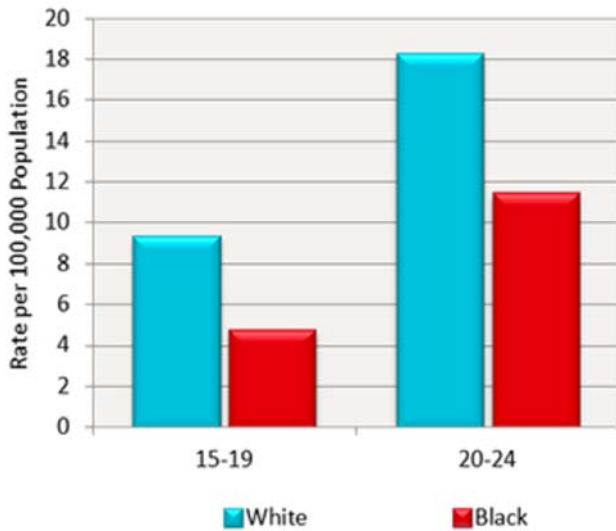
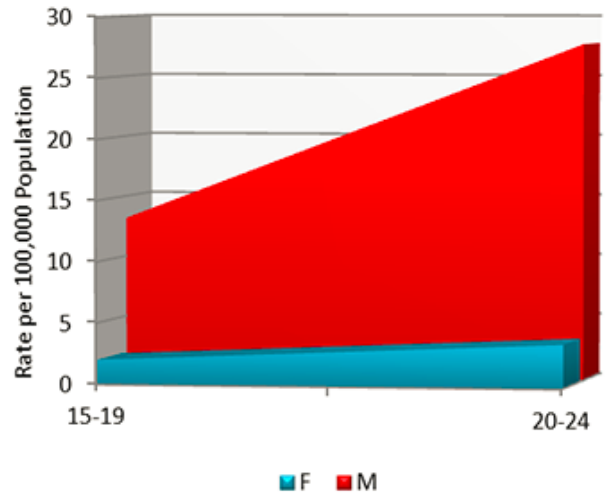


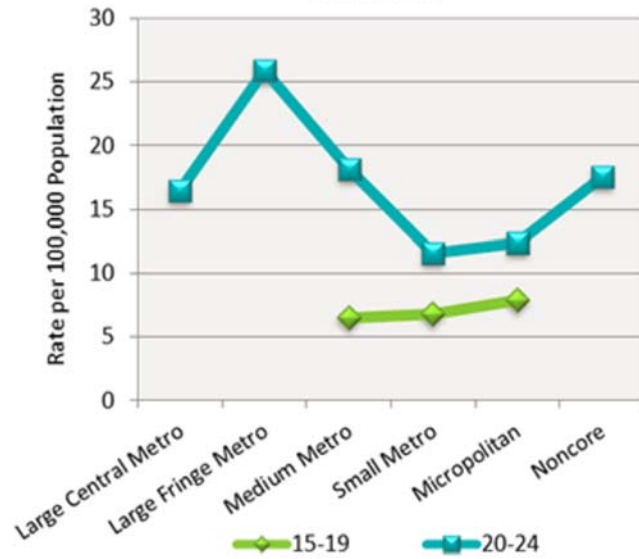
Figure 11: Rate of Completed Suicides by Gender among Youths Aged 15 through 24, Alabama, 2006-2010



The YRBSS provides information about behaviors that contribute to unintentional and intentional violence among youth. Figures 8 and 9 provide information on the percentage of high school students with suicide ideation and the percentage who reported being medically treated for a suicide attempt from 2003-2011, respectively. This information and other information available in the YRBSS can help states understand how behaviors are changing within this age group.

Figure 10 shows how the rate differs by race for 15-19 and 20-24 year olds from 2006-2010. Figure 11 shows the difference by gender for the same age group and time period with the male rate for both age groups exceeding the female rate. Figure 12 looks at the variation in rate by urbanicity for 15-24 year olds with the rate increasing as rurality increases (see definition of urbanicity in Motor Vehicle section). This information provides a better understanding of the magnitude of the problem in different parts of the state, helping the state to identify environmental risk factors and facilitate decision making on where to target its suicide prevention efforts.

Figure 12: Rate of Completed Suicides by Urbanicity, Youth Aged 15 through 24, Alabama, 2006-2010



Unintentional and Undetermined Drug Poisoning Deaths for Youths 15 -24 Years of Age

Poisoning is the 3rd leading cause of injury-related death among US youth ages 20-24 and the 5th leading cause of injury-related death among US youth ages 15-19. Drug overdose death rates among all ages in the US have more than tripled since 1990 and have never been higher. (1) Poisoning can be intentional or unintentional; poisoning cases reported here include prescription medications, illicit drugs and other, unspecified drugs. According to the national survey Monitoring the Future, in 2013 15 percent of high school seniors used a prescription drug non-medically in the past year. (2) Every day in the U S, an average of 2,000 teenagers use prescription drugs for the first time without a doctor's guidance. Youth who abuse prescription medications are also more likely to report use of other drugs. (3) Many teens falsely believe that because prescription medicines are prescribed by a physician, are inexpensive, and are widely available they are safer than illicit drugs.

Figure 15 provides state-specific fatality rates for motor vehicle traffic, suicide, and drug poisoning for youth aged 15 through 24 for the period 2006-2010. Overall in the US, the rate of motor vehicle-related fatalities for this age group has decreased significantly from 2006 to 2010. However, the rate of fatalities for both suicide and drug poisoning has remained stable with a slight increase from 2009 to 2010. Figure 16 provides data on the rate of unintentional and undetermined drug overdoses in the state compared to the national rate. Figure 17 shows the percentage distribution of fatal unintentional and undetermined drug poisoning by drug type for the period 2006-2010.

Figure 15: MVT, Suicide and Drug Poisoning Fatality Rates, Youths Aged 15 through 24, Alabama, 2006-2010

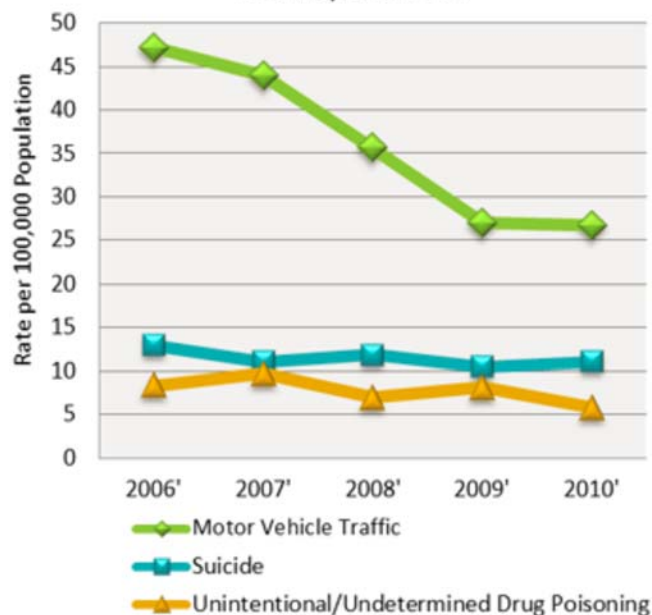


Figure 16: Rate of Fatal Unintentional and Undetermined Drug Poisonings, Youths Aged 15 through 24, Alabama and US, 2006-2010

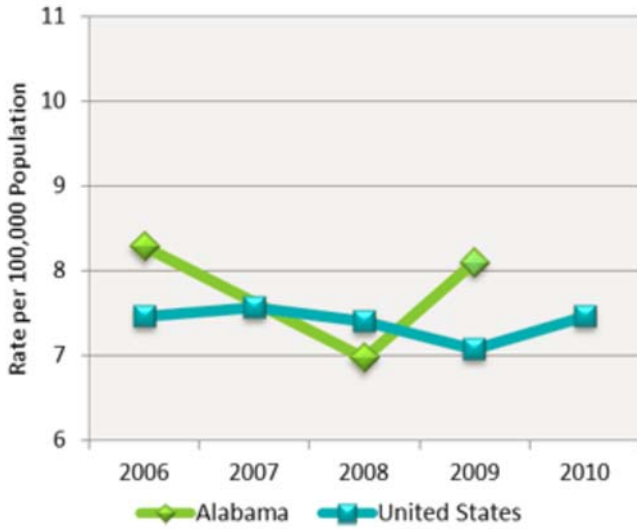
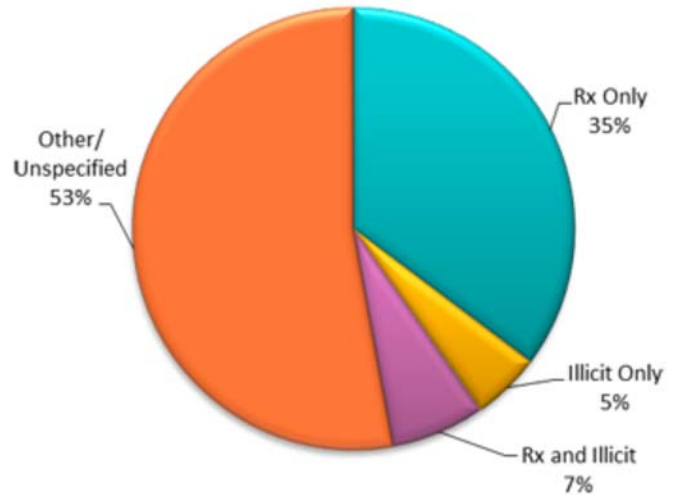


Figure 17: Percentage Distribution of Fatal Unintentional and Undetermined Drug Poisoning by Drug Type, Youths Aged 15 through 24, Alabama, 2006-2010



IVP Health Status Indicators

The Maternal and Child Health Bureau requires every state to report on 12 Health Status Indicators. Six of the indicators are related to IVP. The two figures below reflect the data reported for the IVP Health Status Indicators by the state in their Maternal and Child Health Block Grant Application Form 17, 2013.

Figure 13: Nonfatal Injury Health Status Indicators, Alabama, 2008-2011

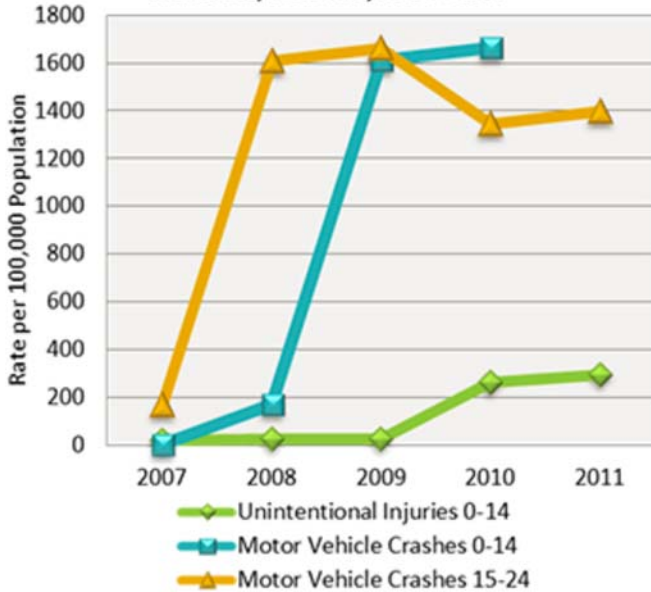
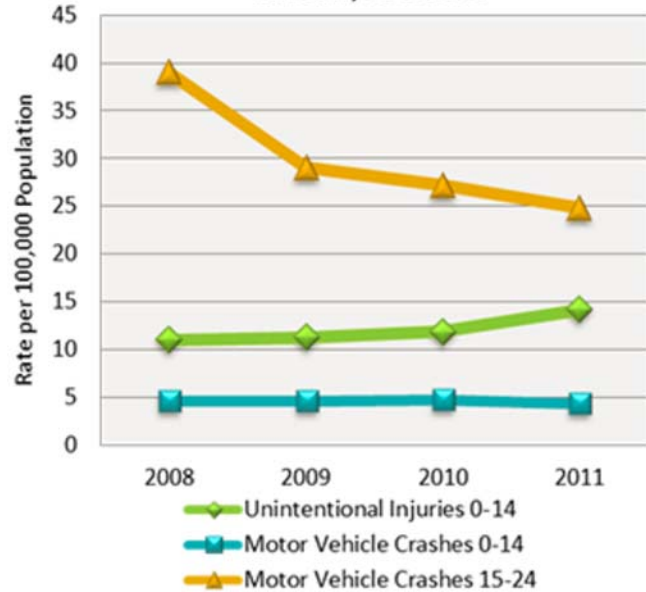


Figure 14: Fatal Injury Health Status Indicators, Alabama, 2008-2011



State Specific Performance Measures and Priority Needs

Each state develops up to 10 State Performance Measures and Priority Needs. The following provides information about the states' selected 2014 injury-related Performance Measures and Priority Needs.

Alabama has the following injury-related State Performance Measure:

- Increase the degree to which statewide fetal and infant mortality review (FIMR) is implemented.

Alabama has the following injury-related Priority Needs:

- Promote positive youth development to reduce high risk behaviors in adolescents.
- Reduce the prevalence of violent behavior, including homicide and suicide, committed by or against children, youth, and women.

Citations and Sources

Drug Poisoning Section, 1: Centers for Disease Control and Prevention. Vital Signs: Overdoses of Prescription Opioid Pain Relievers-United States, 199-2008. MMWR 2011; 60: 1-6.

Drug Poisoning Section, 2: Monitoring the Future (sponsored by National Institute on Drug Abuse at The National Institutes of Health) www.monitoringthefuture.org/pubs/monographs/mtf-overview2013.pdf

Drug Poisoning Section, 3: NIDA Drug Facts. www.Teens.drugabuse.gov/drug-facts/prescription-drugs

Table 1 Source: WISQARS Leading Causes of Death Reports, 2006-2010

Table 2 Source: National Center for Health Statistics, Multiple Cause of Death Data, 2006-2010

Table 3 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Table 4 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Figure 1 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 2 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 3 Source: WISQARS Injury Mortality Reports, 2006-2010

Figure 4 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 5 Source: CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System The classification scheme can be found at: <http://wonder.cdc.gov/wonder/help/CMF/Urbanization-Methodology.html>. 2006

NCHS Urban-Rural Classification Scheme for Counties, by Deborah D. Ingram and Sheila Franco.

Figure 6 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 7 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figures 8 & 9 Source: Youth Online: High School Youth Risk Behavior Survey (YRBS), 2003-2011

Figure 10 Source: WISQARS Injury Mortality Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 11 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 12 Source: CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System

Figures 13 & 14 Source: HRSA, Title V Information System Multi-Year Report. Some states may have changed their method of calculation.

Figures 15 & 16 Source: National Center for Health Statistics, Multiple Cause-of-Death Data, 2006-2010.

U.S. Census Bureau, Population Division (2012). Intercensal Estimates of the Resident Population by Single Year of Age and Sex for States and the United States (ST-EST00INT-AGESEX): April 1, 2000 to July 1, 2010.

Figure 17 Source: National Center for Health Statistics, Multiple Cause-of-Death Data, 2006-2010.

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About Children's Safety Network

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

In this fact sheet CSN provides a cursory review of the injury morbidity and mortality data available for the state. The figures and tables in this fact sheet can help you understand the state's progress in addressing motor vehicle traffic injuries and suicide. To target and address these and other injury issues, it is critical to understand this data. CSN can assist you in conducting detailed data analyses, utilizing surveillance systems, and undertaking needs assessments. For assistance, contact the Children's Safety Network at csninfo@edc.org.

Connect with the Children's Safety Network

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Need TA? Have Questions? E-mail: csninfo@edc.org

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