

# INJURY

## IN ALABAMA

*A Focus on Prevention*



# INJURY IN ALABAMA: A FOCUS ON PREVENTIOIN

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## INTRODUCTION

**I**njury is a preventable public health problem. Injuries occur in highly predictable patterns with recognizable risk factors among identifiable populations. They are not “accidents,” which are random, uncontrollable, unpredictable events. By preventing and controlling injuries, lives can be saved, disabilities can be prevented and the overall health status of Alabamians can be improved.

Injuries affect everyone regardless of age, gender, race or economic status. There were 3,178 Alabamians who died in 2001 from injuries sustained in a variety of situations, such as motor vehicle crashes, fires, falls and suicide. One out of every 14 deaths in Alabama occurs as a result of injury. Of these deaths, 70% are due to unintentional injuries while 30% are intentional. Injury is the fourth leading cause of death for Alabamians, ranking behind heart disease, cancer and stroke. However, exploring unintentional and intentional injury deaths only reveals part of the picture, for thousands of people sustain injuries and survive. Many of these injuries leave survivors disabled, living with chronic pain and adjusting to profound changes in lifestyle.

Unintentional injury is the number one cause of death for Alabamians age 1 through 34. More children, teenagers and young adults die from unintentional injury than any other cause of death. Motor vehicle crashes account for more than half of all unintentional injuries. Other causes include poisoning, suffocation, falls, fire, drowning and bicycle-related crashes.

Intentional injury, also known as violence, is defined as an act in which there is an intent to harm oneself or another. This is also a leading cause of death, and includes categories such as suicide, youth violence, sexual assault and domestic violence. These incidents have a profound impact on every age, race, and socioeconomic class. Very often, young people are involved as both perpetrators and victims of violence.

Intentional and unintentional injuries result in significant social, economic and personal costs. The associated medical costs, rehabilitation time, loss of productivity and income due to injury are profound. Preventing injuries costs far less than treating them. By developing a plan to prevent injury and death in our state, the associated social, economic and personal costs will be reduced.

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## INTRODUCTION *continued*

*Injury in Alabama: A Focus on Prevention*, identifies some of the significant injury problems affecting our state and suggests strategies for reducing the incidence and severity of these injuries in the future. It does not contain a comprehensive plan for all types of injuries, nor is it the last word on how to prevent and control injuries in Alabama. Rather it is the beginning of what we hope will be a long-term commitment by Alabama's public health, mental health, medical and public safety communities to work with other state and local entities to address injuries, just as we address any other epidemic threatening the lives and health of our citizens.

Led by the Injury Prevention Division at the Alabama Department of Public Health, the plan was developed in conjunction with an Injury Advisory Council, which consisted of representatives from the

- Alabama Chapter National Safety Council
- Alabama Coalition Against Domestic Violence
- Alabama Coalition Against Rape
- Alabama Department of Economic and Community Affairs
- Alabama Department of Education
- Alabama Department of Public Safety
- Alabama Department of Mental Health/Mental Retardation

- Alabama Department of Transportation
- Alabama Department of Human Resources
- Alabama Head Injury Foundation
- Alabama Hospital Association
- Southern Regional Child Advocacy Centers
- University of Alabama at Birmingham Injury Control Research Center
- University of Alabama at Birmingham Center for Injury Sciences
- University of Alabama CARE Research and Development Laboratory and multiple areas within the Alabama Department of Public Health including
- The Alabama Trauma Registry
- Behavioral Risk Factor Surveillance System
- Chronic Disease Prevention
- Child Death Review
- Emergency Medical Services
- Family Health Services
- Pregnancy Risk Assessment Monitoring System
- Vital Statistics

Criteria utilized in selecting injuries to be represented in the plan include National 2010 Healthy People Objectives, Alabama morbidity and mortality data, recommendations of the Injury Advisory Council and feasibility of plan implementation.





# BICYCLE-RELATED INJURIES

# BICYCLE-RELATED INJURIES

## THE PROBLEM:

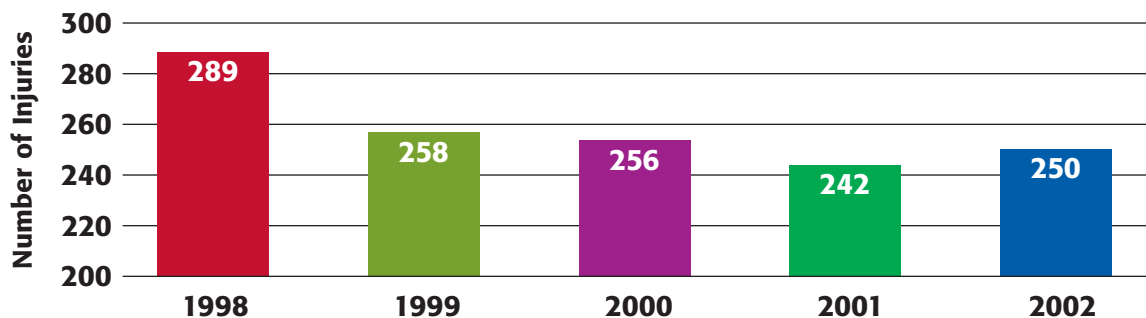
- An estimated 140,000 children are treated each year in emergency departments for head injuries sustained while bicycling.
- 70-80 percent of all fatal bicycle crashes involve head injuries.

Each year over 500,000 people in the United States are injured while riding bicycles and more than 700 people die as

a result of bicycle-related injuries. Nearly 2/3 of all bicycle-related injuries and more than 1/4 of those killed are children between the ages 5 and 15.

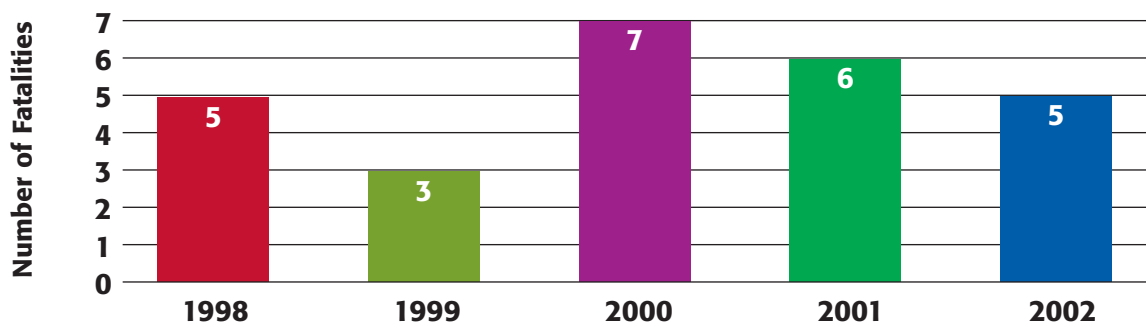
Between 1998 and 2002 in Alabama, 1,295 people were injured and 26 died in bicycle crashes. Children age 14 and under account for 52% of the bicycle crash injuries and 80% of the fatalities that occurred in 2002.

### Unintentional Bicycle-Related Injuries in Alabama (1998-2002)



(Source: CARE database)

### Unintentional Bicycle-Related Fatalities in Alabama (1998-2002)



(Source: CARE database)

Between 1998 and 2002, there were 477 traumatic spinal cord injury (TSCI) and traumatic brain injury (TBI) cases reported in Alabama attributable to bicycle injuries. Males were nearly three times more likely than females to sustain a TSCI or TBI as a result of a bicycle injury (Table 1). Eighty-five percent (402 cases) of the 477 bicycle-related TSCIs and TBIs affected Alabamians between 2 and 17 years of age.

**Table 1: Bicycle Injuries Resulting in TSCI and TBI, Alabama January 1998 - July 2002**

Race/ Ethnicity	Gender		Total
	Female	Male	
Black	45	138	183
White	84	205	289
Other	1	4	5
<b>Total</b>	<b>130</b>	<b>347</b>	<b>477</b>

(Source: Alabama Trauma Registry)

## CAUSES:

- Only 20-25 percent of all bicyclists wear bicycle helmets.

More than 95% of all bicyclists killed in the United States were not wearing helmets. Approximately 25% of children ages 5 through 14 wear bicycle helmets. Once riders enter the teenage years, helmet usage drops to nearly zero. In Alabama, 90% of 853 surveyed youths, 9th through 12th grade, who rode a bicycle in the past 12 months reported that they had never or rarely wore a bicycle helmet. In 1999 adults surveyed about their child's helmet use indicated that 31.9% of Alabama children 5-15 wore a helmet in the past 12 months when riding a bicycle. There was almost a 22% difference in what adults and teens reported on bicycle helmet usage.

## THE COSTS:

- Societal costs in the United States related to bicycle head injuries or death exceed \$8 billion annually.

The costs to society brought about by bicycle-related injuries and deaths are significant. An estimated 140,000 children are treated each year in emergency departments for head injuries sustained by bicycling. Six percent of persons who are treated for bicycle-related injuries require hospitalization. In 2002 the average length of stay in an Alabama hospital for treatment of bicycle-related TSCI and TBI was 2.2 days, though this value ranged from less than one day to 17 days.

## PREVENTION:

- Every dollar spent on bicycle helmets saves society \$30 in indirect medical costs.
- Every bicycle helmet saves \$395 in direct medical costs.

Wearing a helmet greatly reduces the risk of injury in the event of a bicycle crash. Risk for serious head injury can be lowered by as much as 85%; risk for brain injury is reduced by up to 88%; and risk of facial injury is diminished as much as 65%. One way to encourage bicyclists to protect themselves is through legislation. Alabama has a helmet law (1995) which states that anyone under the age of 16 must wear a helmet when riding a bicycle. A first offense to the state law leads to bicycle safety counseling; a second offense results in citation to the parent/guardian; and in the event of a third offense,

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## **BICYCLE-RELATED INJURIES** *continued*

the bicycle is temporarily confiscated. Other offenses result in a \$50 fine. One municipality in Alabama, Homewood, has a law requiring all cyclists of all ages to wear helmets.

Another method to reduce bicycle injuries is to provide safe environments for cyclists by recognizing connections between urban development and quality of life. A national movement to foster livable communities is known as the Smart Growth Initiative. Smart Growth was formed in 1996 by the United States Environmental Protection Agency and several non-profit and government organizations. It was formed in response to increasing community concerns about the need for new ways to grow that boost the economy, protect the environment and enhance community vitality. One of the major principles is to provide a variety of transportation choices including having bicycle paths which would create safer environments for bicyclists to ride and not be in danger. The United States Department of Transportation policy statement in March 2002 stated that bicycle and pedestrian ways shall be established in new construction and reconstruction projects in all urbanized areas, with few exceptions. In response, communities are beginning to implement new approaches to transportation planning.

## **ALABAMA'S STRATEGY FOR PREVENTING INJURY:**

### **GOAL:**

**Reduce the incidence of bicycle-related injuries and fatalities.**

- 1. Increase percentage of young people between 5 and 16 years of age that wear bicycle helmets to 50% by 2010.**
- 2. Promote public awareness that bicycle helmets can help to reduce the severity or eliminate bicycle-related injuries.**
  - a. Develop public service announcements to educate the public on the effectiveness of bicycle helmets to reduce the severity and occurrence of bicycle-related injuries.
  - b. Develop public service announcements to educate the public on the consequences of not wearing a bicycle helmet.
  - c. Collaborate with local and state agencies such as local Metro Planning Organizations or other organizations (i.e. SAFE KIDS) to develop training and educational programs targeting persons 5-16 years of age on the importance of wearing bicycle helmets.
    1. Proper use of helmet and other protective devices.
    2. Helmet giveaways.
    3. Brochures for parents.



4. Educate legislators on the importance of mandating bicycle helmet wear for all cyclists.
5. Reinforce Alabama’s helmet law with public service announcements.
6. Encourage members of the Alabama Chapter of the American Pediatric Association to implement training and awareness activities relative to bicycle safety.

**3. Coordinate with the Smart Growth initiative to design more walkable and bicycle friendly neighborhoods.**

- a. Identify communities who participate in Smart Growth Initiatives.
  1. Develop a directory for the state.
  2. Coordinate efforts to expand to other communities.
- b. Educate local government entities and residential developers on the advantages of bicycle friendly neighborhoods.

**4. Provide bicycle traffic safety training.**

- a. Implement a school program to educate children on the proper way to ride a bicycle in traffic.
  1. Hand signals.
  2. Riding with the flow of traffic.

**5. Increase bicycle tolerance by motor vehicle operators.**

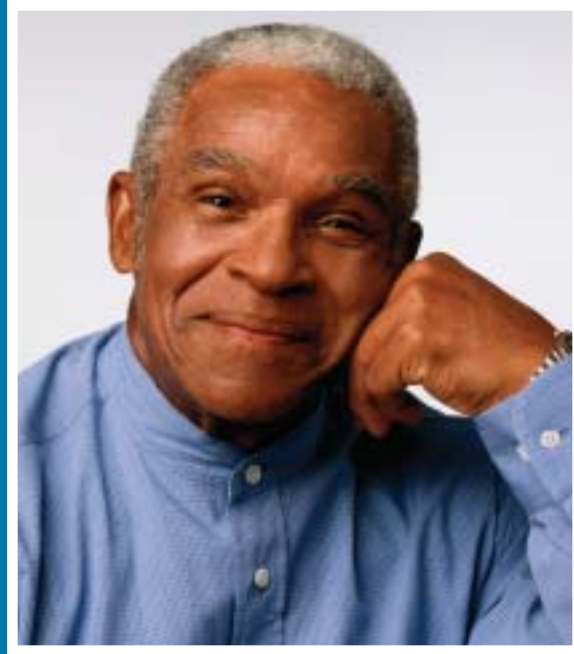
- a. Create a “Share the Road” public education campaign.
  1. Create tools that incorporate multiple forms of media and compelling stories to communicate the message.

2. Design outreach activities to promote bicycle safety for motorists and bicyclists.
3. Encourage local organizations and bicycle advocacy groups to sponsor the campaign in their community.
  - b. Include components on “safe bicycling” and “sharing the road” in driver education programs.

**6. Collaborate with local bicycle clubs to establish a registry of bicycle-related injuries.**

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3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Bicycle-Related Injuries Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/bike>
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# FALLS IN THE ELDERLY

# FALLS IN THE ELDERLY

## THE PROBLEM:

- Falls account for 87% of hip fractures.
- Two-thirds of those who experience a fall will fall again within six months.

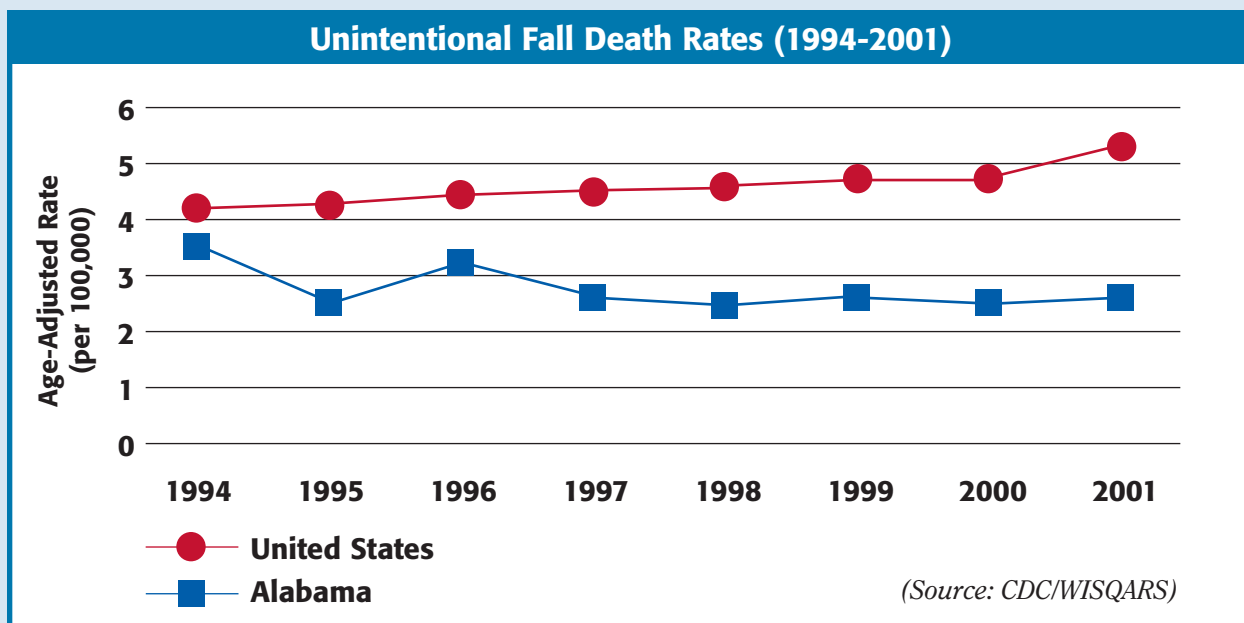
Each year in the United States one in every three adults over 65 years of age sustains a fall. This is the most common cause of injury and hospital admission for trauma among older Americans. In fact, older adults are hospitalized for fall-related injuries five times more often than for injuries due to all other causes.

Not every fall results in a broken bone for those over 65 years of age; however, of all fractures sustained by this population, falls account for 87 percent of them. Hip fractures are the most serious fall-related fractures, resulting in the highest rates of morbidity and mortality. In 1999, about 10,000 people over age 65 died from

fall-related injuries in the United States. Each year about 60% of these fatal falls happen at home, while another 30% occur in public places, and the remaining 10% occur in health care institutions.

As the United States population ages, falls are becoming a greater concern for the public. For example, between 1988 and 1996 the number of Americans over age 65 admitted to hospitals for hip fractures increased almost 50%, from 230,000 to 340,000 admissions over the eight-year period. Year 2000 data reports that 1.6 million seniors were treated in emergency departments for fall-related injuries, while 353,000 were hospitalized. It is projected that the number of hip fractures will exceed 500,000 by 2040. Combining this prediction with an assumed 5% rate of inflation, the total annual cost of hip fractures alone could reach \$240 billion.

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## FALLS IN THE ELDERLY *continued*

- **Falls are a leading cause of traumatic brain injuries.**

Falls are the second leading cause of spinal cord and brain injury among older adults. According to the Alabama Trauma Registry, 3,627 traumatic spinal cord injury (TSCI) and traumatic brain injury (TBI) cases related to falls have been reported among Alabama residents from 1998-2001. Forty-nine percent (1,795 cases) of the 3,627 spinal cord and brain injuries were among Alabamians 60 years of age and older.

- **Every hour an older adult dies as the result of a fall.**

Death as a result of a fall consistently is the second or third leading cause of unintentional injury death among Alabama residents. Between 1994 and 2001, falls accounted for 988 deaths in Alabama (Table 1).

**Table 1. Injury Deaths as a Result of Falls by Year of Death, Alabama 1994-2001**

Year of Death	Number of Deaths	Age-Adjusted Rate
1994	149	3.64
1995	107	2.53
1996	141	3.31
1997	115	2.67
1998	108	2.46
1999	120	2.73
2000	117	2.66
2001	131	2.89

(Source: AL Center for Health Statistics)

From 1990-1998, 74 percent (541 cases) of the 732 deaths were reported among Alabamians 60 years of age or older (Table 2). Falls are the leading cause of death among Alabamians greater than 79 years of age.

**Table 2. Injury Deaths as a Result of Falls by Age Group, Alabama 1990-1998**

Age Group	Number of Deaths	Percent of Deaths
Age <15	7	0.96
Age 15-19	11	1.50
Age 20-29	27	3.69
Age 30-39	37	5.05
Age 40-49	66	9.02
Age 50-59	43	5.87
Age 60-69	91	12.43
Age 70-79	159	21.72
Age >79	291	39.75
<b>Total</b>	<b>732</b>	<b>100.00</b>

\* Percentages may not add up to 100 due to rounding.

(Source: AL Center for Health Statistics)

## THE CAUSES:

Some risk factors that contribute to falls in the elderly include cluttered floors, pets underfoot, a recent change in medication, an adverse reaction to multiple medications, impaired vision or balance, poor lighting, especially in stairways, loose carpeting and lack of supportive equipment in bathrooms.

## PREVENTION:

Falls in the elderly can be prevented. By modifying the home environment and working closely with health care providers, these risk factors can be substantially reduced. Regular exercise, handrails and improved lighting in stairways, non-slip mats, grab bars, vision checks and periodic reviews of medications are examples of steps to reduce the risk of falling. By taking precautions, many falls that occur among older Americans can be prevented, reducing the incidence of injury and death. Falls need not, nor should not, be a normal part of aging.

## ALABAMA'S STRATEGY FOR FALL PREVENTION:

### GOAL:

Reduce the number of deaths and injuries due to falls.

#### **1. Decrease the number of deaths due to falls by 20% to 2.31 deaths per 100,000 people.**

AL Baseline: 2.89 deaths per 100,000 people (CDC, 2001 data)

#### **2. Promote awareness on preventive measures in the home environment.**

- a. Provide preventive information to reduce the risk of falls in bathrooms.
  1. Installation of slip-resistant bathtub and surfaces.
  2. Installation of grab bars in the bathtub.
  3. Installation of a seat in the bathtub.

4. Installation of grab bars on the sides of toilet seats.
5. Installation of raised toilet seats.
- b. Provide preventive information to reduce the risk of falls in the home.
  1. Installation of hand rails on stairs.
  2. Ensuring floors are even.
  3. Ensuring carpet is laid properly and not loose.
  4. Importance of well-lighted hallways and rooms.
  5. Importance of lower bed height.
- c. Develop and provide training to educate older Alabamians and family members on preventive measures to reduce the risk of falls.

#### **3. Develop and implement an educational plan to encourage people at high risk of falls to visit their health care provider every six months.**

- a. Check quality of vision.
- b. Evaluation of physical and mental condition.
- c. Discuss exercise program to improve strength and endurance.
- d. Review of medications to avoid adverse interactions.

#### **4. Develop and implement a plan to educate health care providers about the importance of reviewing adverse interactions of prescriptions for people at high risk for falls.**

#### **5. Promote the need for a fall-related injury surveillance system.**

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## FALLS IN THE ELDERLY *continued*

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# MOTOR VEHICLE CRASHES

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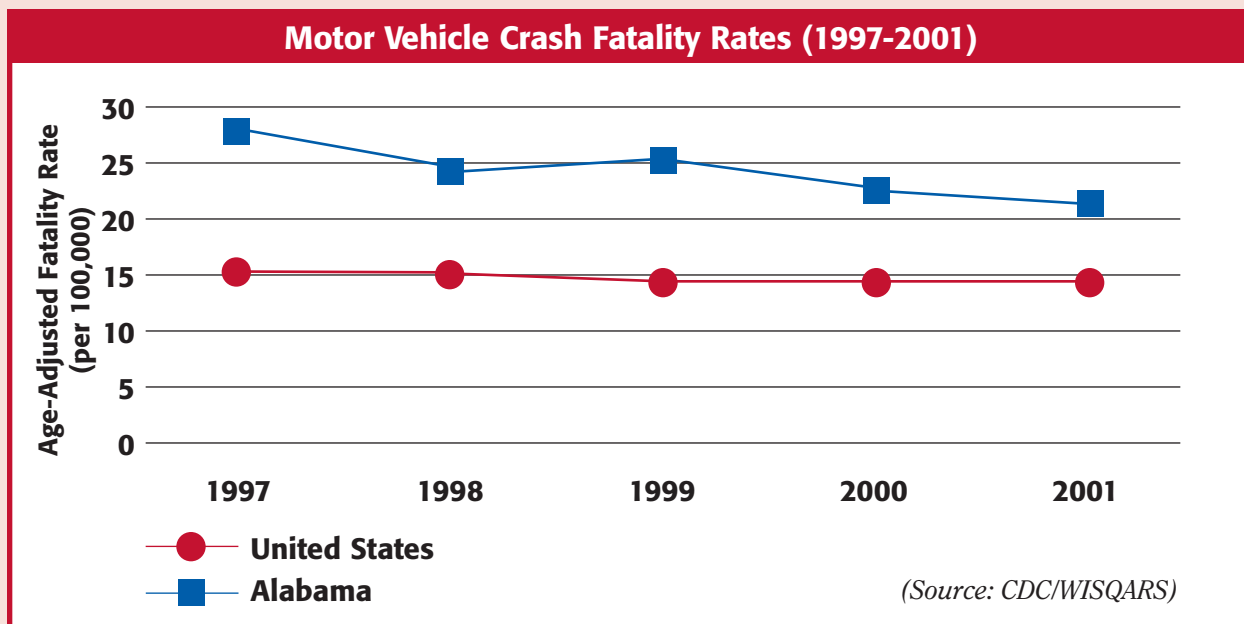
## THE PROBLEM:

- **Nationally, an average of 117 persons died each day in motor vehicle crashes in 2002 – that is one death every 12 minutes.**
- **Motor vehicle crashes are the leading cause of death among Americans from their first birthday up to age 35.**

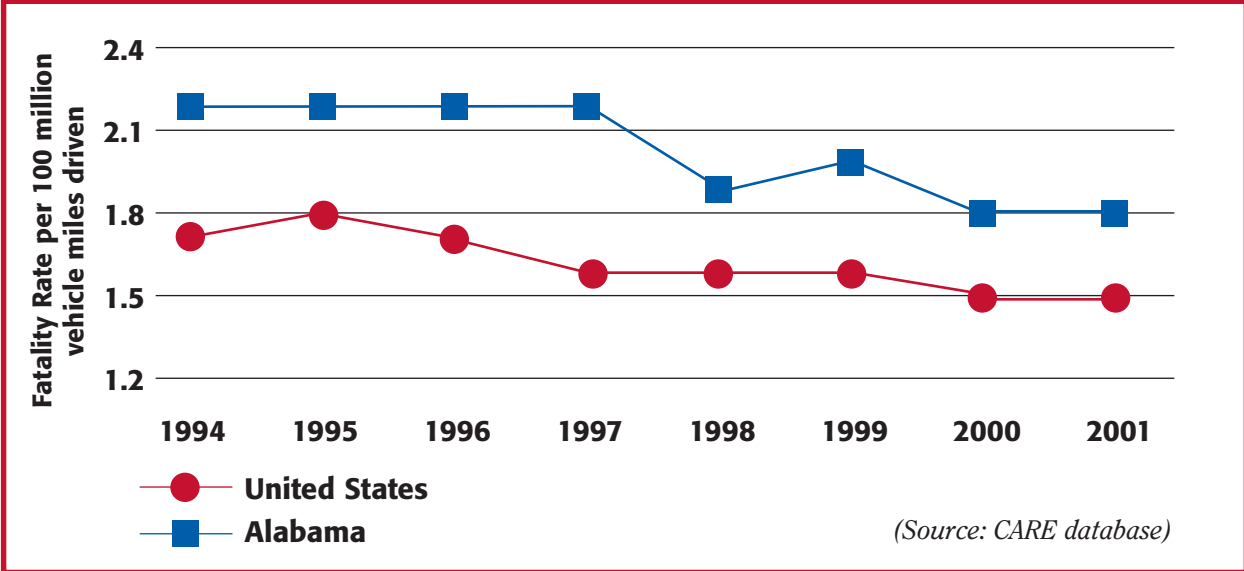
Over 40,000 people die each year in motor vehicle crashes across the United States, while approximately three million people are injured. Motor vehicle crashes are the leading cause of death among American children, teenagers and young adults. Furthermore, every 90 seconds a child is killed or injured in a vehicular crash. In 2001, more than 2,000 children under age 14 died and more than 350,000

sustained injuries while riding in a motor vehicle.

Motor vehicle-related deaths account for half of all unintentional injury fatalities in Alabama, making motor vehicle crashes the number one cause of injury death in this state. In 2001 the age-adjusted fatality rate per 100,000 persons in the United States was 14.82, while in Alabama the rate was 22.56. In 2002, there were 1,038 people killed in Alabama and 44,414 injured as a result of motor vehicle crashes. One Alabamian is injured in a traffic crash every 11.8 minutes, while one dies in a traffic crash every 8.4 hours. In 2001 there were 55 motor vehicle-related deaths in children under 14 years of age in Alabama.



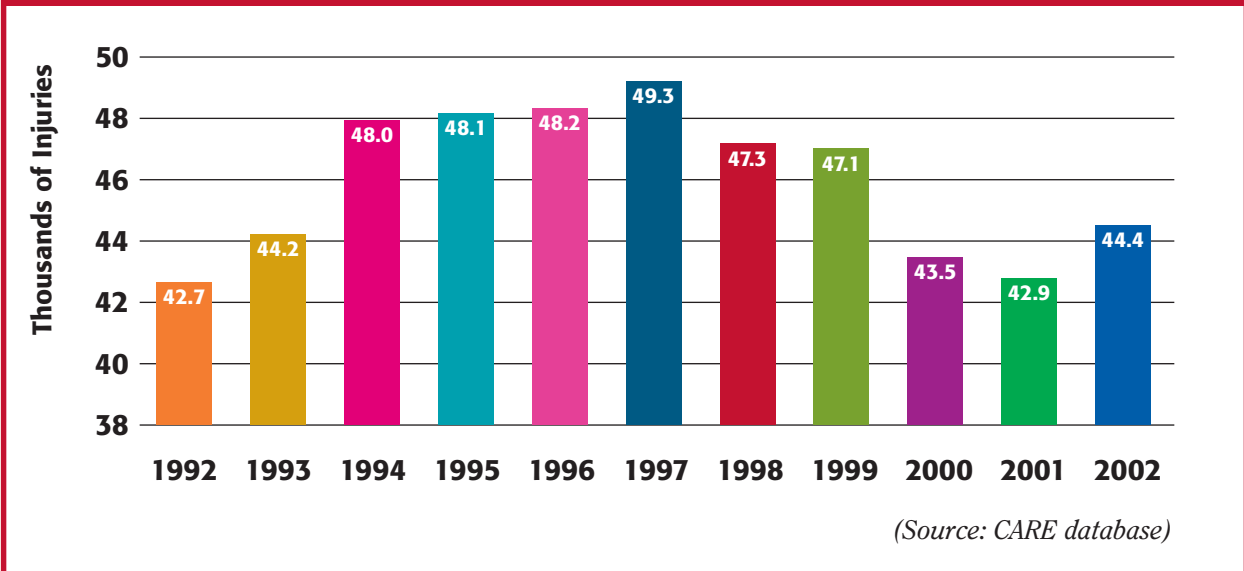
### Motor Vehicle Crash Fatality Rates per Miles Traveled (1994-2001)



Not only are motor vehicle crashes a leading cause of death in the United States, but they also cause disability among survivors, as the leading cause of spinal cord injury and traumatic brain injury for

those under age 65. Of the 3,624 spinal cord and traumatic brain injuries reported in Alabama in 2002, approximately 60% (1,846) were due to motor vehicle crashes.

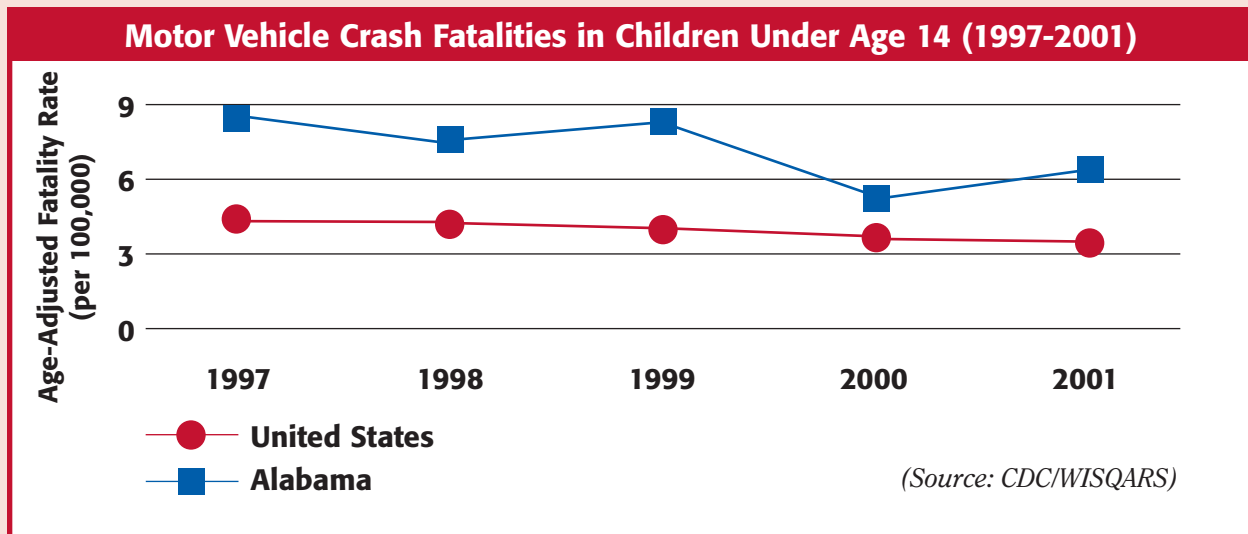
### Motor Vehicle Crash-Related Injuries in Alabama (1992-2002)



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## MOTOR VEHICLE CRASHES *continued*



### PREVENTION:

Each year over half of the fatalities resulting from motor vehicle crashes in Alabama involve people who fall into one of these three categories: children and adults using seat belts and restraints improperly or not at all; drivers impaired by alcohol; and elderly drivers.

Of those children less than 5 years of age killed in motor vehicle crashes each year in the United States, nearly half ride unrestrained; child safety seats would have saved many of these lives. Placing children in age-appropriate restraint systems reduces serious and fatal injuries by more than 50 percent. The appropriate safety seat to use is determined by a child's age and size as well as the vehicle in which it is installed. Rear-facing infant seats should be used to age 1 and up to 20 pounds. Forward-facing toddler seats are used for children up to 40 pounds to about age 4. For children ages 4-8 and 40 pounds,

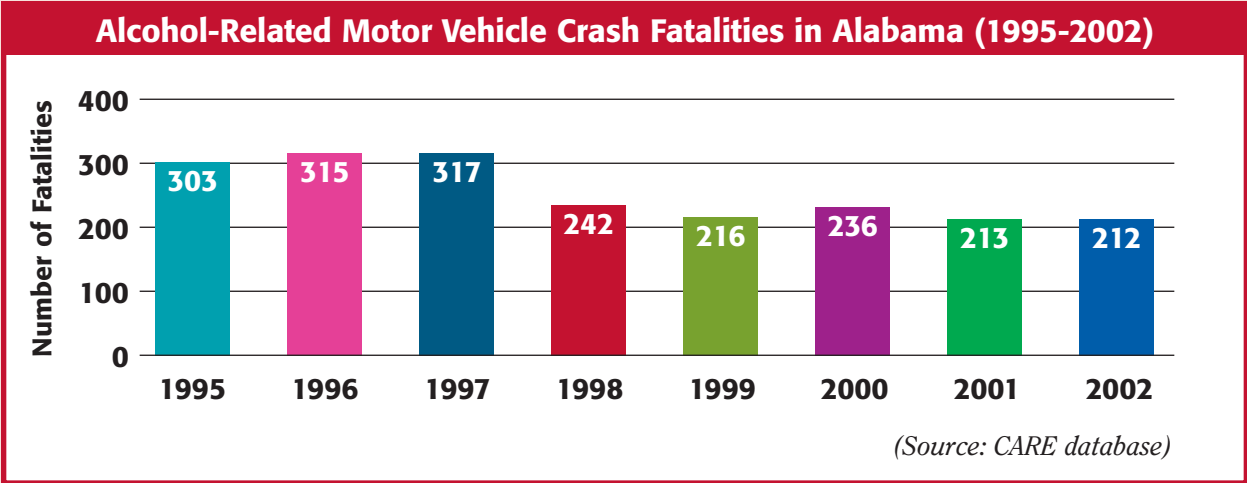
booster seats are recommended, though only 6% nationwide use them. Booster seats raise a child's sitting height to fit a standard lap and shoulder belt. Children should not be restrained in a safety belt alone unless they can sit with their back firmly against the back of the vehicle seat and can touch the floor of the vehicle with knees bent over the seat. All children under 12 years of age are safest when restrained appropriately in the back seat.

- **Alcohol-related motor vehicle crashes represent 41 percent of all traffic-related deaths.**

It is important to also note the impact of alcohol-related motor vehicle crashes in the United States and Alabama. Driving under the influence of alcohol is the greatest single factor in causing traffic fatalities. Nationally, alcohol-related crashes kill someone every 30 minutes and catastrophically injure someone every two minutes. Impaired driving will affect one

in three Americans in a crash during his or her lifetime. In 2001 alone, there were 213 alcohol-related fatalities and 3,103 injuries in Alabama. However, it is

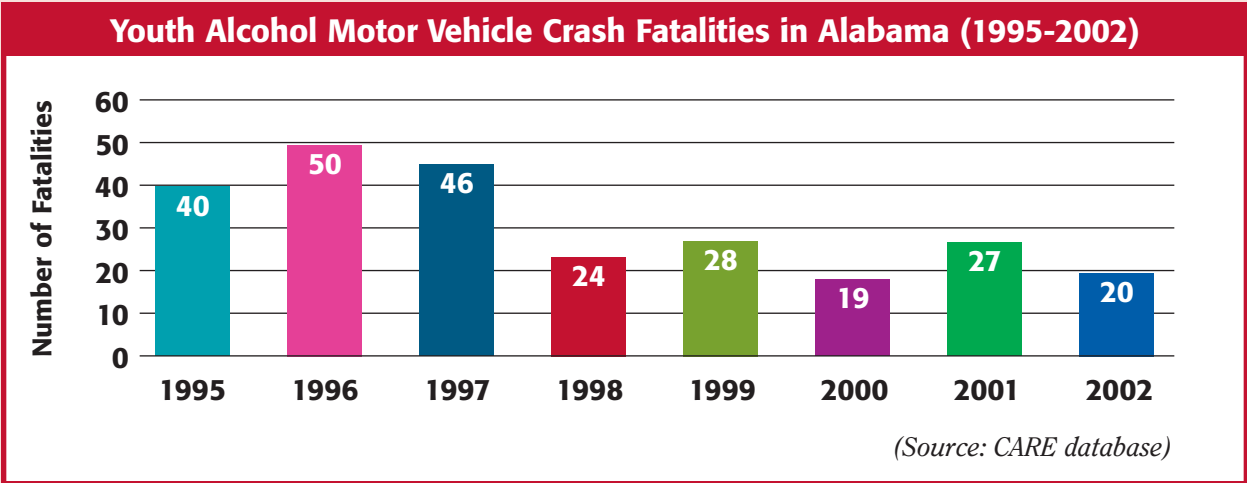
estimated that within the state of Alabama, alcohol-related crashes are underreported by approximately 50%.



- Consistently, more than one in three students reported that in the past month, he or she had ridden with a driver who had been drinking alcohol.**

Drinking and driving behavior among young people did not change significantly between 1991 and 2001. When asking 9th through 12th grade students nationwide if they drove a vehicle after drinking alcohol, the percentage who responded affirmatively ranged between 13% and

17% over the past ten years. Alabama's youth responded 'yes' with a slightly higher difference between 15% and 18%. Furthermore, in a national survey querying whether teens rode in a vehicle driven by someone who had been drinking alcohol, the percentage who answered positively ranged from 30 to 40, while Alabama's youth responded slightly higher with 34% to 43% affirmative answers. Stronger incentives are needed to prevent adolescent drinking and driving.



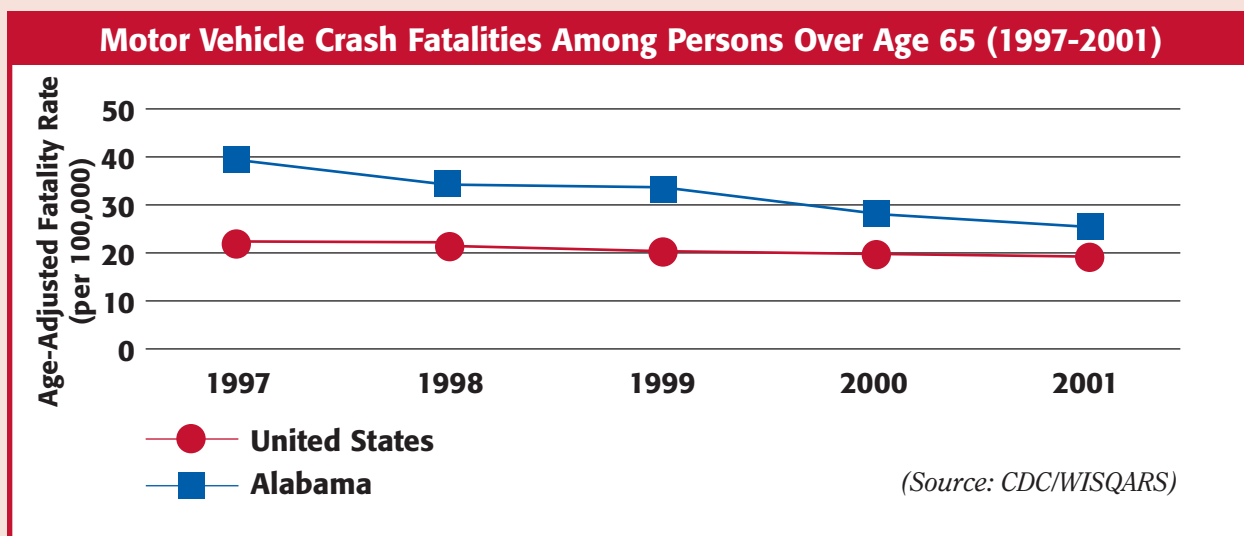
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## MOTOR VEHICLE CRASHES *continued*

- Rates for motor-vehicle related deaths and injuries among older adults are rising.
- Research is needed to determine under what conditions older adults choose to stop driving and under what conditions they should stop driving.

There are more than 25 million people age 65 and older in the United States and the numbers are rising. Between 1990 and 1997, the number of motor vehicle crash deaths in older adults rose 14%; the number of nonfatal injuries rose 19%.

In 2001 among Americans age 65 and older, 7,256 died in motor vehicle crashes (age-adjusted rate 20.46/100,000 people) and another 185,000 suffered non-fatal injuries. There were 153 deaths in Alabamians age 65 and older in 2001 (age-adjusted rate 26.59/100,000 people). The difference in national and Alabama age-adjusted death rates among elderly persons due to motor vehicle crashes is almost 30%. To implement effective programs to reduce injury and death in this population, a better understanding of factors that contribute to these motor vehicle crashes is needed.



- The use of lap/shoulder safety belts reduces the risk of fatal injury to front-seat car occupants by 45 percent.
- Child safety seats reduce the risk of death by about 70% for infants and by about 55% for toddlers ages 1-4.

Alabama adopted a child safety seat law in 1989. The law stipulates the use of a

child restraint system up to 6 years of age. According to observational surveys, 87% of Alabamians used child restraints in 2002. Although this number is encouraging, it is important to realize that up to 85% of car seats are improperly used or installed. Over the past 25 years it is estimated that over 5,000 children in America have been saved by the proper use of child safety



seats or adults belts. Among children under 5 years old, an estimated 269 lives nationwide were saved in 2001 by child restraint use. If everyone used safety seats properly for children under age 5, an additional 138 lives could have been saved.

Alabama adopted a primary safety belt law in 1999, stipulating that each front seat occupant must use a correctly fastened safety belt when the vehicle is in motion. The use of safety belts reduces death and injury in motor vehicle crashes, but not everyone uses them. According to observational surveys, 77% of Alabamians used safety belts in 2003. The usage rate has increased from 58% due to the adoption of the safety belt law and intensive educational and enforcement efforts. In fact, the Alabama Department of Public Safety reported a total of 48,730 safety belt citations by state troopers in 2001.

### **THE COSTS:**

- **The cost of motor vehicle crashes in 2000 totaled \$230.6 billion.**
- **Wearing a seatbelt saves \$50 billion in medical care, lost productivity and other injury-related costs.**

The financial burden on society as a result of motor vehicle crashes is enormous each year. In the year 2000, costs totaled \$230.6 billion, which is equal to approximately an \$820 disbursement to every person living in the United States. The lifetime economic cost to society for each fatality is over \$977,000. Over 80 percent of this amount is attributable to lost workplace and household productivity. Each critically injured survivor costs an average of \$1.1 million, in which medical

costs and lost productivity account for 84 percent of the expenses. In the year 2000 in Alabama alone the estimated economic costs due to motor vehicle crashes was \$2,788 million. This equals 1.2% of the total United States costs of \$230.6 billion and equals \$627 per Alabamian.

By increasing awareness using educational programs, media campaigns such as Click It or Ticket, enforcement and accurate data collection, Alabama can begin to reduce the toll that motor vehicle crashes take on Alabama’s citizens. Current efforts have already succeeded in increasing seat belt and car seat use in our state.

## **ALABAMA’S STRATEGY FOR PREVENTING INJURY:**

### **GOAL:**

**Reduce death and injury related to motor vehicle crashes.**

- 1. Decrease motor vehicle crash fatality rate per 100,000 vehicle miles traveled to 0.8. (2010 National Objective)**  
AL Baseline: 1.8 per 100,000 vehicle miles traveled (2002 FARS/CARE data)
- 2. Increase safety belt use to 92%. (2010 goal)**  
AL Baseline: 77% (2003 Observational Surveys)
  - a. Support increased enforcement of primary seat belt law.

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## **MOTOR VEHICLE CRASHES** *continued*

- b. Continue awareness and enforcement campaigns to educate the public about the importance of safety belt use in saving lives and avoiding injury.
- c. Support strengthening legislation to require occupants in the back seat to wear seat belts.

### **3. Increase child safety seat use to 100%. (2010 goal)**

AL Baseline: 87% (2003 Observational Surveys)

- a. Support increased enforcement of child restraint law.
- b. Encourage expansion of the child restraint laws to include appropriate restraint use for all children under the age of 16.
- c. Continue awareness and enforcement campaigns to educate the public about the importance of selecting and installing the appropriate car seat for children birth to 8 years of age.
  - 1. Infants should be in rear-facing child safety seats until at least 20 pounds and at least 1 year old.
  - 2. Children over 1 year old and between 20 and 40 pounds can be in forward-facing child safety seats, or in rear-facing convertible seats if the child has not reached the maximum rear-facing weight.

- 3. Children ages 4 to 8 (about 40-80 pounds) should be in a booster seat and restrained with lap and shoulder belts every time they ride.
- 4. All children ages 12 and under should ride in the back seat.

### **4. Reduce death and injuries related to motor-vehicle crashes in older adult drivers by 20% to 90 fatalities and 2,059 injuries**

AL Baseline: 112 Fatalities and 2,574 Injuries (2001 CARE)

- a. Support research and data collection to determine conditions that may affect older adult drivers related to motor-vehicle crashes.

### **5. Reduce alcohol-related motor vehicle deaths by 20% to 170 fatalities.**

AL Baseline: 213 Fatalities and 3,103 Injuries (2001 CARE)

- a. Increase the accuracy in the reporting of alcohol/drug crashes.
- b. Increase the enforcement component needed to reduce alcohol/drug crashes.
- c. Support Public Awareness Programs to reduce drinking and driving.

### **6. Promote the establishment of an infrastructure to support more effective data collection and information distribution.**

## References:

1. Alabama Department of Public Health, Injury Prevention Division. Alabama Trauma Registry.
2. Alabama Department of Public Health, Injury Prevention Division. 2003 Observational Survey.
3. Alabama Department of Transportation. Highway Safety Plan.
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Child Passenger Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/factsheets/bike/childpas.htm>
5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
6. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from URL: [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars)
7. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. Available from URL: <http://www.cdc.gov/nccdphp/dash/yrbs/2001/youth01online.htm>
8. Fatality Analysis Reporting System.
9. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
10. National Highway Traffic Safety Administration. Available from URL: <http://www.nhtsa.dot.gov/>
11. National Highway Traffic Safety Administration (NHTSA), Dept. of Transportation (US). Traffic safety facts 2002: Alcohol. Washington (DC). Available from URL: <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSF2002/2002alcfacts.pdf>.
12. National SAFE KIDS Campaign. Available from URL: <http://www.safekids.org>.
13. Stevens JA, Hasbrouck L, Durant TM, Dellinger AM, Batabyal PK, Crosby AE, et al. Surveillance for injuries and violence among older adults. *MMWR Surveillance Summaries* 1999; 48(SS-8):27-50.
14. The University of Alabama College of Engineering, CARE Research and Development Laboratory. *Alabama Traffic Crash Facts* 2002. Tuscaloosa, AL.



# RESIDENTIAL FIRES



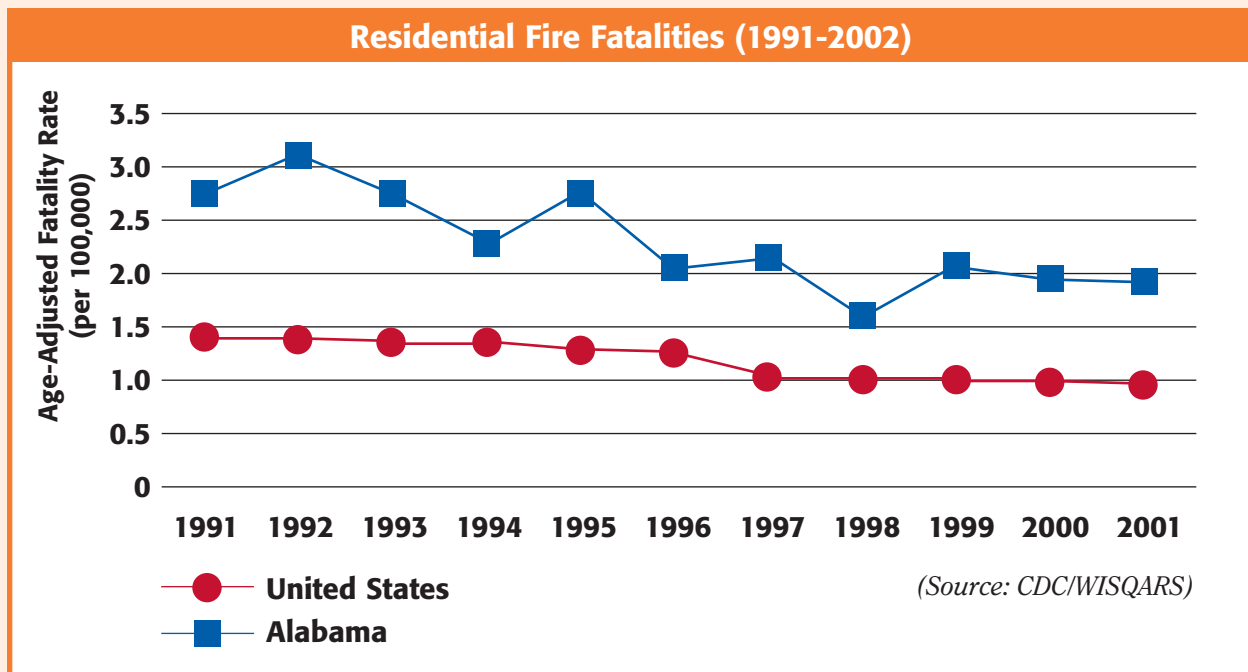
# RESIDENTIAL FIRES

## THE PROBLEM:

- About 85 percent of all fire deaths occur in the home. Every 27 minutes someone is killed or injured in a home fire.
- Residential fires account for 66 percent of all fire-related injuries.

Over 400,000 residential fires nationwide account for approximately

3,000 deaths and 16,000 injuries each year. Residential fires result in direct property damage of roughly \$8.5 billion each year. In Alabama, over a five-year period (1997-2001) more than 400 residential fire fatalities were reported. Alabama's fire fatality rate is consistently two times higher than the national average; in 2001 the age-adjusted rate per 100,000 persons in Alabama was 1.93, while that of the United States was 0.99.



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## RESIDENTIAL FIRES *continued*

### THOSE AT RISK:

- **Groups at greatest risk of suffering from fire injuries and deaths include children ages 5 and under, adults ages 65 and older, minorities and low-income families.**

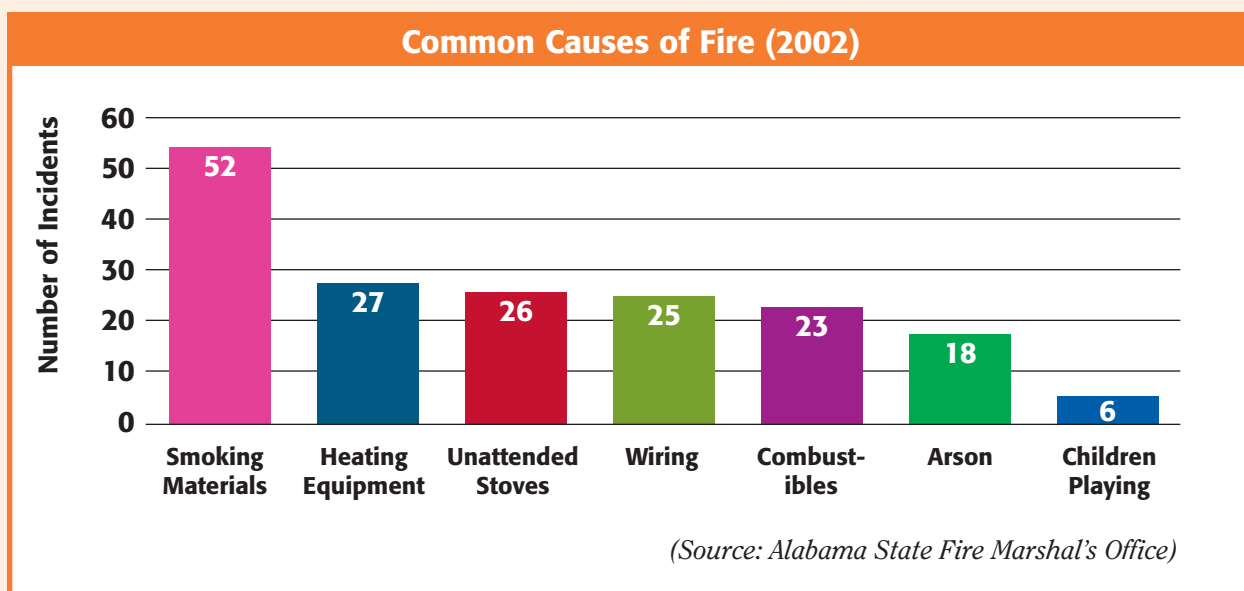
In 2001, 87 unintentional residential fire/flame deaths were reported in Alabama. Forty-eight percent of the fire mortality cases (42 deaths) occurred among Whites. However, the age-adjusted mortality rate among Blacks (4.34 per 100,000) was more than three times the age-adjusted mortality rate among Whites (1.25 per 100,000). Males represented 55 percent of the reported 87 fire mortality cases with an age-adjusted mortality rate of 2.34 per 100,000; females had an age-adjusted mortality rate of 1.56 per 100,000.

Groups at greatest risk of suffering from fire injuries and deaths include

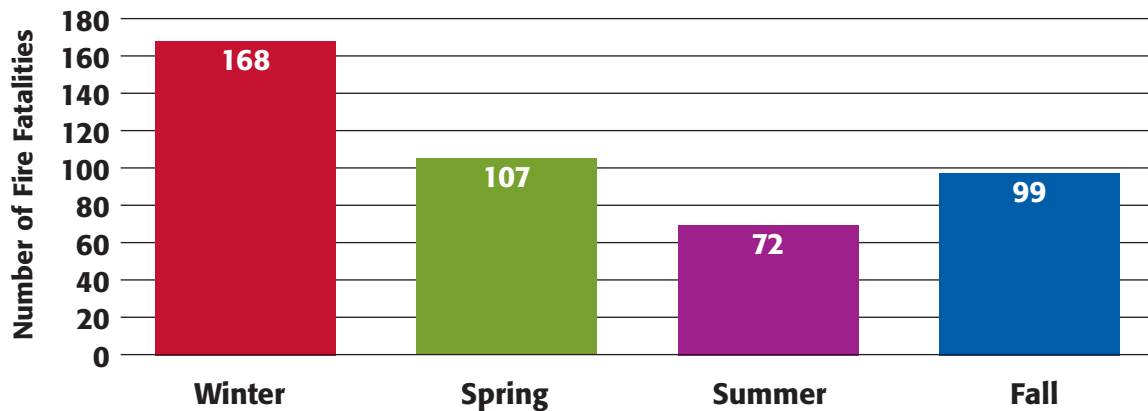
children ages 5 and under, adults ages 65 and older, minorities and low-income families, persons living in rural areas and persons living in manufactured homes. Alabama is primarily a rural state. As such, many communities contain residential units built before 1976, mobile homes and lower income rental units. Furthermore, rural areas are serviced by volunteer fire staff, which often means larger service areas and longer response times.

### THE CAUSES:

Misuse of smoking material, including cigarettes and ashtrays, and heating equipment, such as furnaces, space heaters and fireplaces, continues to account for the vast majority of fire-related deaths and injuries in Alabama. Due to the increased use of heating devices in cold weather, the largest number of fatalities occurs during the winter months.



### Seasonal Variation in Fire Fatalities (1997-2002)



(Source: Alabama State Fire Marshal's Office)

## PREVENTION:

Early detection devices like smoke alarms can reduce home fire fatalities by as much as 50 percent. In a typical home fire, residents have approximately two minutes to escape safely. Working smoke alarms are considered the “first line of defense” against fire damage. Smoke alarm maintenance includes monthly battery checks and yearly battery replacement.

In Alabama it is estimated that 94% of homes have at least one smoke alarm. However, nationally, one in four homes has a non-functioning smoke alarm and many homes need more than one alarm. It is suggested that smoke alarms be placed outside each sleeping area and on every floor of a home. Further recommendations include testing alarms monthly and replacing the battery yearly. In Alabama, only 37% of adults surveyed reported that they or someone else had tested smoke alarms in their home within the past month.

Another major factor in reducing fire fatalities and injuries is establishing a home fire escape plan. According to the

National Fire Protection Association, only 16 percent of American families have developed and practiced an escape plan. Plans should include positioning working smoke alarms near family sleeping areas, identifying easy-to-use exits and establishing a safe meeting place outside the residence. Escape plans should be practiced at least two times per year.

## THE COSTS:

- **\$1 spent on smoke alarms can save \$69 in fire-related costs.**
- **Nationally, structural fires resulted in \$8.5 billion in property damage in 1999.**

The cost of residential fires to society is high. Annually, the largest share of fire losses in the United States is sustained by residential structural fires. In 1999, these fires resulted in property damage exceeding \$8.5 billion. In addition, the costs of medical treatment and rehabilitation for those persons injured in fires are expensive. The prevention of

*Continued next page.*

## RESIDENTIAL FIRES *continued*

these injuries costs far less than treating them: for every one dollar spent on smoke alarms, \$69 can be saved in fire-related costs.

The Alabama Smoke Alarm Initiative (ASAI) is actively working to reduce fire deaths and injuries in Alabama. The initiative is working with fire departments in high-risk areas to provide fire safety education and to install free smoke alarms. High-risk communities are defined as those with small populations, high fire fatality rates and large poverty rates. During the first five years of the project, the ASAI has worked with fire departments in seven counties, installed over 5,000 smoke alarms and saved 130 lives within homes receiving an ASAI smoke alarm.

### ALABAMA'S STRATEGY FOR RESIDENTIAL FIRE PREVENTION:

#### GOAL:

Reduce the number of deaths and injuries due to residential fire.

- 1. Reduce the age-adjusted rate of residential fire deaths to less than 1.2 deaths per 100,000 people.**  
AL baseline: 1.93 deaths per 100,000 people (CDC, 2001 data)
- 2. Increase the use of functioning residential smoke alarms to 100% and have one smoke alarm on every floor.**

### 3. Continue to promote and enhance public fire safety education.

- Promote residential fire safety.
  - Educate on proper use and maintenance of smoke alarms to include checking the batteries and best locations for smoke alarms in the home.
  - Educate about the correct usage of supplemental room heaters and proper maintenance of gas furnaces and gas stoves.
  - Stress the importance of not smoking in bed and keeping lighters out of sight and reach of children.
  - Educate on proper storage of flammable liquids.
  - Educate on setting hot water heaters at 120 degrees.
  - Encourage practicing a fire evacuation plan to include determining two ways out of every room, designating a safe place to meet outside, calling 911 and staying out of the home once you escape.
  - Creating fire escape plans for the elderly, people with special needs, or young children.
  - Increase knowledge on how to respond and to survive a fire if you cannot get out immediately.

- b. Target at risk groups.
  - 1. Collaborate with schools, daycares and head start programs to provide fire safety education for children.
  - 2. Collaborate with senior centers to provide fall and fire safety training.
  - 3. Re-evaluate at risk groups to target with fire safety education on an annual basis.
- c. Serve as a fire safety education resource for other agencies and groups.
  - 1. Provide pamphlets, incentives and activity sheets.
  - 2. Conduct training sessions as needed.

**4. Identify and coordinate with current programs addressing residential fire injuries and deaths.**

- a. Maintain the Alabama Department of Public Health’s Agency Fire Safety meetings and support its mission.
- b. Support SAFE KIDS campaigns that promote fire safety.
- c. Identify other agencies/groups to collaborate with to promote awareness and provide fire safety education.

**5. Promote the need for a quality fire and burn injury data collection system.**

**References:**

1. Alabama Department of Insurance, Alabama State Fire Marshal’s Office.
2. Alabama Department of Public Health, Injury Prevention Division. Alabama Smoke Alarm Initiative.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Fire Deaths and Injuries Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/factsheets/fire.htm>
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Available from URL: [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars).
6. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Available from URL: <http://www.cdc.gov/brfss/index.htm>
7. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
8. National Fire Protection Association Fact Sheets. Available from URL: <http://www.nfpa.org/Research/NFPAFactSheets/NFPAFactSheets.asp>





# INTIMATE PARTNER VIOLENCE

# INTIMATE PARTNER VIOLENCE

## THE PROBLEM:

- **In a national survey, 25% of female participants reported being raped or physically assaulted by an intimate partner.**
- **Nearly two-thirds of women who reported being raped, physically assaulted, and/or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend or date.**

Violence by intimate partners, or domestic violence, is an important public health problem internationally, nationally and in Alabama. It is defined as “actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner”.

In 2001, 20 percent of the 19,873 violent offenses committed in Alabama were domestic violence incidents. Domestic violence was indicated in 4,013 incidents reported. These included 40 homicides, 172 rapes, 3,762 aggravated assaults and 24,625 simple assaults. Seventy-five percent of the domestic violence offenses in Alabama were reported by women, while 55% of victims suffered injuries. Of these injuries 8% were injured with a firearm; 20% were injured with a knife; 41% were injured with fists, feet or hands; and 31% were injured with other dangerous weapons. Though only 80% of Alabama’s domestic violence cases are

reported, the domestic violence rate in this state is one of the highest in the nation.

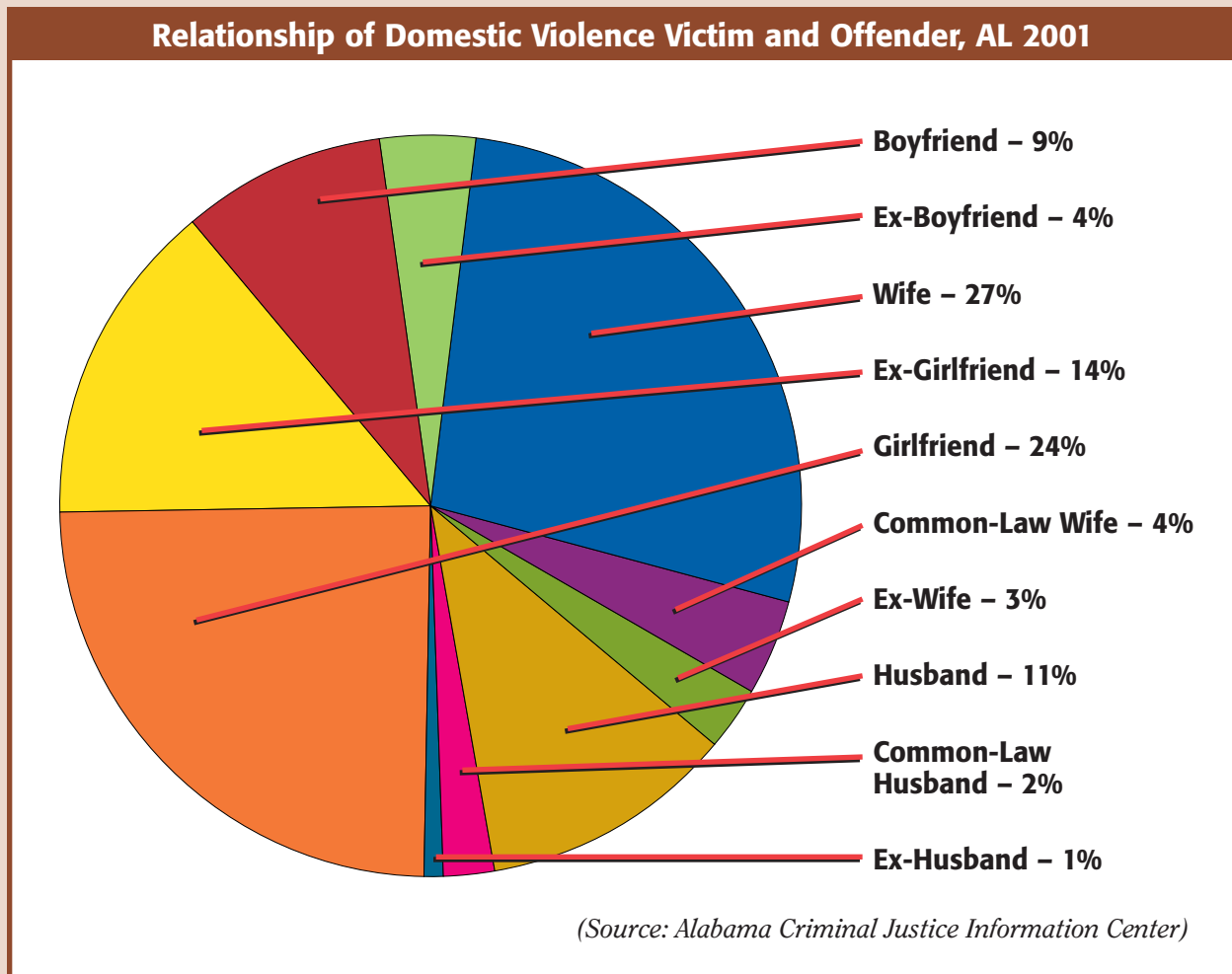
## THOSE AT RISK:

Domestic violence is the leading cause of injury to women. Approximately 1.5 million women and 834,700 men are raped and/or physically assaulted by an intimate partner each year in the United States. More women than men experience intimate partner violence. According to the National Violence Against Women Survey, one out of four U.S. women has been physically assaulted or raped by an intimate partner; one out of every fourteen U.S. men reported such an experience. Women are also more likely than men to be murdered in the context of intimate partner violence. Women ages 20 to 29 years are at greatest risk of being killed by an intimate partner.

Between 1981 and 1998, Alabama’s homicide rate for white females murdered by intimate partners was 1.57 per 100,000; for black females, the rate was 4.70 per 100,000. During the same period, the national rate for female intimate partner homicides was 1.43 per 100,000. In Alabama, 60% of the victims are black; the other 40% are white. In 63% of the offenses, the offenders are black; in 75% of reported incidents, the offenders are male. In 34% of domestic violence incidents, the victim is the wife of the offender, while in another 38%, the victim is the offender’s girlfriend.

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## INTIMATE PARTNER VIOLENCE *continued*



### THE COSTS:

The *World Report on Violence and Health* states that violence against women by intimate partners is a serious and widespread problem in all parts of the world. It describes the consequences as profound, extending beyond the health and happiness of individuals to affect the well-being of entire communities. Its impact

on health, children and the economy are significant. The health care costs of intimate partner rape, physical assault, and stalking exceed \$5.8 billion each year, nearly \$4.1 billion of which is for direct medical and mental health care services. More qualitative and quantitative data are needed to better determine the full magnitude of intimate partner violence and associated human and economic costs.

## PREVENTION:

- **Changing societal and community norms is imperative in the struggle to prevent intimate partner violence.**
- **Collaboration at the state and community level to ensure support of victims while increasing penalties for abusers is needed.**

The *World Report of Violence and Health* reviews methods to prevent intimate partner violence. They include continued support of victims, legal remedies and judicial reforms, treatment for abusers, health service interventions and community-based efforts. All efforts should instill the principle that violence and abuse are not acceptable in our society and will not be tolerated.

In 2002, *A Plan to Address Violence Against Women in Alabama* was created by a variety of agency and community representatives including the Alabama Department of Public Health, Alabama Department of Economic and Community Affairs, Alabama Coalition Against Domestic Violence, Department of Corrections, Administrative Office of Courts, Department of Human Resources, Board of Pardons and Paroles, Court of Criminal Appeals, Alabama Department of Mental Health/Mental Retardation, the Attorney General's Office, Department of Youth Services, members of the faith community, health care professionals, judges and attorneys. The plan outlines recommendations for addressing domestic violence in every area of society including legislation, law enforcement, prosecution, the judicial system, health care professionals, youth prevention and

intervention activities, victim services, and community response. This collaboration is a foundation with which to begin a community-based effort to change societal norms and address violence.

## ALABAMA'S STRATEGY FOR INTIMATE PARTNER VIOLENCE PREVENTION:

### GOAL:

**Reduce injuries and deaths due to intimate partner violence.**

#### **1. Disseminate and implement the Alabama Violence Against Women Plan.**

- a. Support law enforcement, prosecution and judicial response recommendations.
- b. Coordinate community initiatives to strengthen safety networks.

#### **2. Support Primary Prevention of Intimate Partner Violence.**

- a. Evaluate and disseminate intervention programs so that evidence-based initiatives are available to Alabama communities.
- b. Support youth education and empowerment programs.
- c. Support integration of resources to address all violence including bullying, sexual violence and youth violence.

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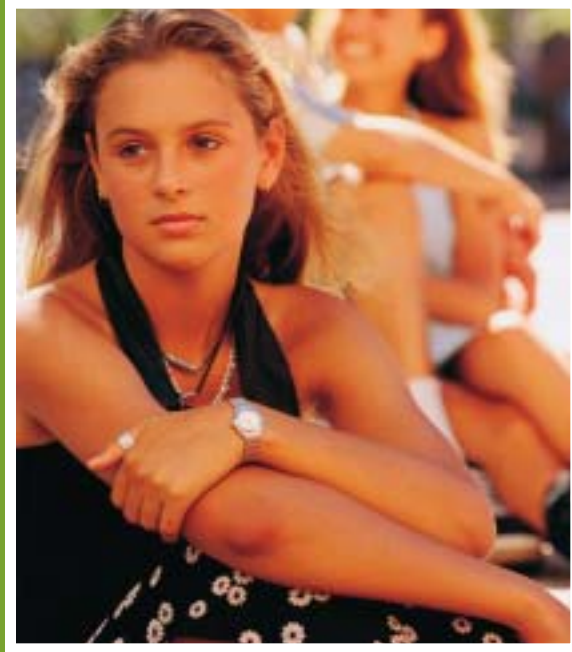
## INTIMATE PARTNER VIOLENCE *continued*

- 3. Increase public awareness that intimate partner violence is a significant public health problem that can be prevented.**
- 4. Support development of a comprehensive surveillance system to accurately measure the impact of intimate partner violence on our state.**

### References:

1. Alabama Criminal Justice Information Center, Statistical Analysis Center. Crime in Alabama 2002. Available from URL: <http://acjic.state.al.us/SAC/>
2. Alabama Department of Public Health, Injury Prevention Division. Alabama's Violence Against Women State Plan 2002.
3. Centers for Disease Control and Prevention. CDC Surveillance Summaries, October 12, 2001. MMWR 2001:50(No. SS-3).
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Intimate Partner Violence Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm>
5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
6. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
7. National Institute of Justice. The Criminalization of Domestic Violence: Promises and Limits. January 1996.
8. U.S. Department of Justice. National Violence Against Women Survey: Full Report of the Prevalence, Incidence and Consequences of Violence Against Women. November 2000.
9. World Health Organization. World Report on Violence and Health. Geneva 2002.





# SEXUAL ASSAULT

# SEXUAL ASSAULT

## THE PROBLEM:

- **According to the National Violence Against Women Survey, 1 in 6 women will experience rape or attempted rape during her lifetime.**
- **More than half (54%) of female rape victims are younger than age 18 when they experience their first attempted or completed rape.**

Each year in the United States, approximately 683,000 sexual assaults are committed. Only 16% of rape victims report the offense to police. Both females and males experience sexual assault and intimate partner violence; however, male victimization of females is more common. The National Violence Against Women Survey (2000) estimates that 1 in 7 women and 1 in 48 men will report being raped in their lifetime.

Sexual violence is defined as a sex act completed or attempted against a victim's will or when a victim is unable to consent due to age, illness, disability, or the influence of alcohol or other drugs. It may involve actual or threatened physical force, use of guns or other weapons, coercion, intimidation or pressure. Incidents included in this category include rape and attempted rape, child molestation, incest and sexual harassment. Assailants who commit these terrifying and brutal crimes can be strangers, acquaintances, friends, dates or family members, including spouses.

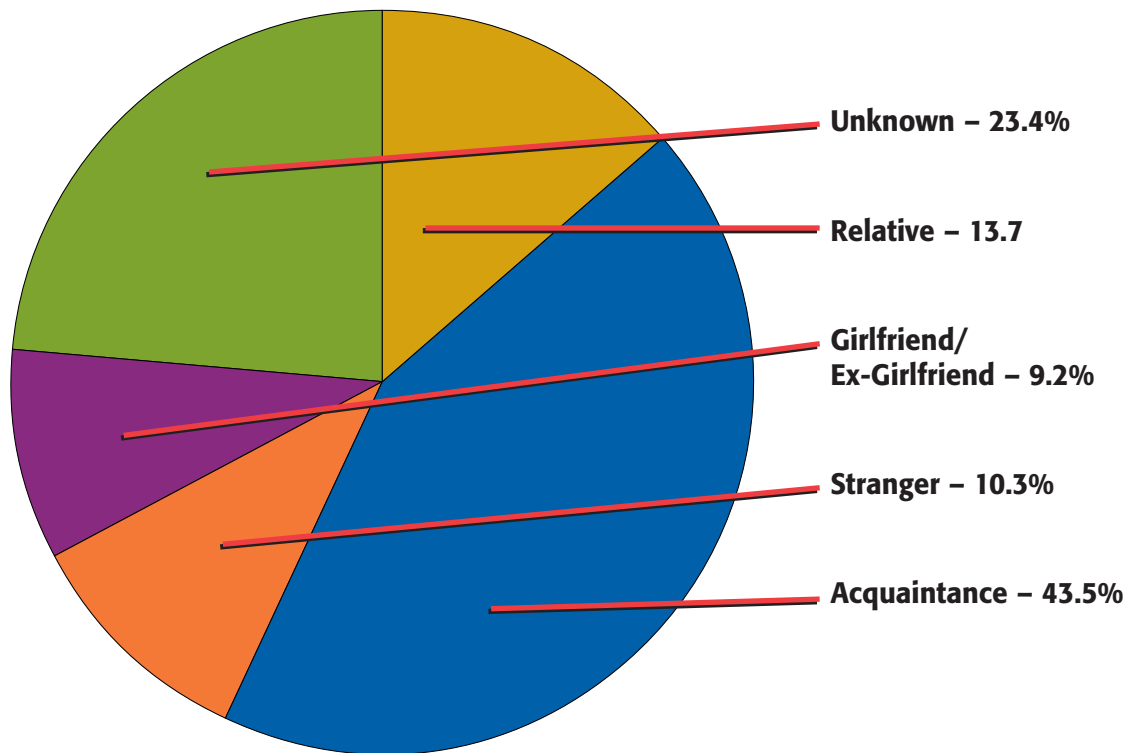
The consequences of sexual assault vary and can continue after the actual assault. They include pregnancy and gynecological complications, sexually transmitted diseases, mental health problems, and suicidal behavior. Furthermore, victims often experience anxiety, chronic headaches, fatigue, sleep disturbances, recurrent nausea, decreased appetite, eating disorders, and sexual dysfunction following these traumatic events. As a result, sexual assault may more than double the risk of substance abuse.

## THOSE AT RISK:

- **In Alabama, 69% of rapes are committed by someone the victim knows.**

In 2002, 1,567 Alabama women reported being raped, averaging 4.3 rapes per day. Of these victims, 49% were juveniles, persons under the age of 17. In Alabama, 69% of rape victims knew or were related to the perpetrator. Perpetrators were reported as being a relative, acquaintance, stranger, present or former girlfriend or unknown. Seventy percent of the offenders and victims were of the same race. Approximately 36% of rapes were committed by white males, while 47% were committed by black males.

## Relationship of Sexual Assault Victim and Offender, AL 2002



(Source: Alabama Criminal Justice Information Center)

### PREVENTION:

- **Changing societal norms and community tolerance of sexual assault is needed to prevent sexual violence.**
- **Collaborating at the state and community level to prevent future perpetrators while providing support and protection to victims is necessary.**

Sexual violence can profoundly affect the social well-being of victims, as individuals may be stigmatized and ostracized by their families and others. Sexual violence often goes unreported because of embarrassment, denial or fear of retaliation. Of those victims that are forced to have sex, 73% fail to recognize

their experience as rape. Myths regarding flirty behavior, inappropriate clothing, the ability to resist and the perceived rights of dating partners, reflect social norms that tolerate sexual violence. Changing societal norms to be intolerant of sexual violence is the key to preventing sexual violence.

The *World Report on Violence and Health* recommends individual approaches, developmental approaches, health care responses, community-based prevention campaigns, and legal/policy response to reduce sexual violence. Other recommendations include greater attention to primary prevention through communities and schools.

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## SEXUAL ASSAULT *continued*

In 2002, *A Plan to Address Violence Against Women in Alabama* was created by a variety of agency and community representatives including the Department of Public Health, Alabama Department of Economic and Community Affairs, Alabama Coalition Against Rape, Alabama Coalition Against Domestic Violence, Department of Corrections, Administrative Office of Courts, Department of Human Resources, Board of Pardons and Paroles, Court of Criminal Appeals, Alabama Department of Mental Health/Mental Retardation, Attorney General's Office, Department of Youth Services, ministries, health care professionals, judges and attorneys. The plan outlines recommendations for addressing sexual assault in every area of society including legislation, law enforcement, prosecution, the judicial system, health care professionals, youth prevention and intervention activities, victim's services, and community response. This collaboration is a foundation with which to begin a community-based effort to change societal norms and address violence.

## ALABAMA'S STRATEGY FOR SEXUAL ASSAULT PREVENTION:

### GOAL:

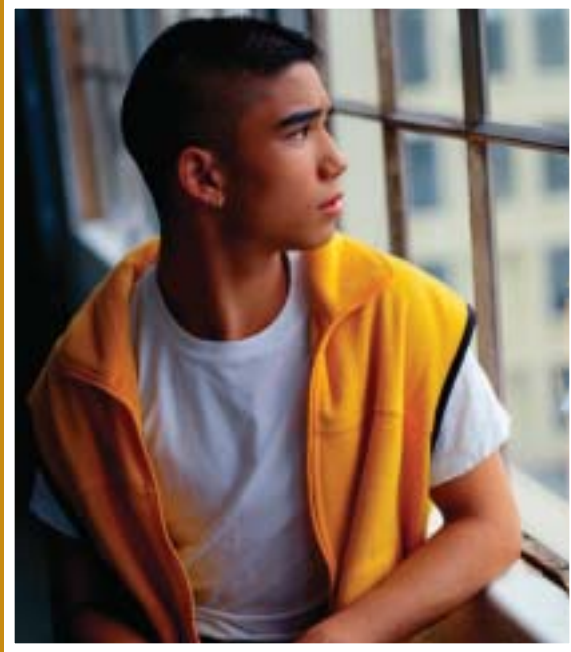
To reduce sexual assault in Alabama.

- 1. Disseminate and implement the Alabama Violence Against Women Plan.**
  - a. Support law enforcement, prosecution and judicial response recommendations.
  - b. Coordinate community initiatives to strengthen safety networks.
- 2. Support primary prevention of sexual assault.**
- 3. Increase public awareness that sexual assault is a public health problem.**
- 4. Promote awareness of services available to victims of rape/sexual assault.**
  - a. Rape Crisis Centers services including hotlines, counseling, and medical facilities.
  - b. Criminal justice system services including advocates and legal support.
  - c. Family support groups.
- 5. Support development of a comprehensive surveillance system to accurately measure the impact of sexual assault on our state.**

**References:**

1. Alabama Criminal Justice Information Center. Crime in Alabama 2002. Available from URL: <http://acjic.state.al.us/SAC/>
2. Alabama Department of Public Health, Injury Prevention Division. Alabama's Violence Against Women State Plan 2002.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Sexual Violence Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/factsheets/svfacts.htm>
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
5. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
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7. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Criminal Victimization in the United States. A National Crime Victimization Survey, 2001. January 2003.
8. World Health Organization. World Report on Violence and Health. Geneva 2002.





# SUICIDE

# SUICIDE

## THE PROBLEM:

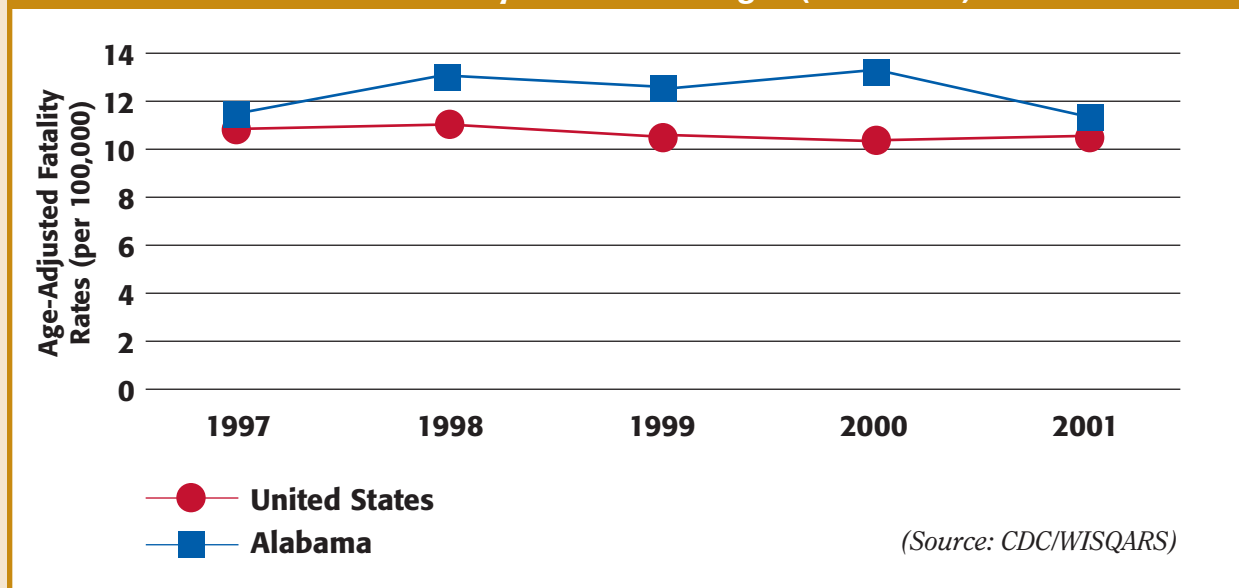
- **86 people commit suicide each day in the United States and over 1,500 attempt suicide.**
- **Suicide is the second leading cause of death among Americans aged 25-34.**

Nearly 30,000 individuals die as a result of suicide each year and another 650,000 receive emergency care after attempting to take their own lives. For young people ages 10 to 24, suicide is the third leading cause of death in the United States. It is the second leading cause of death among Americans ages 25 to 34. For pre-teens (10 to 14 year-olds) the rate of suicide has nearly doubled in the past two decades.

Across all ages, suicide is the 11th leading cause of death in the United States.

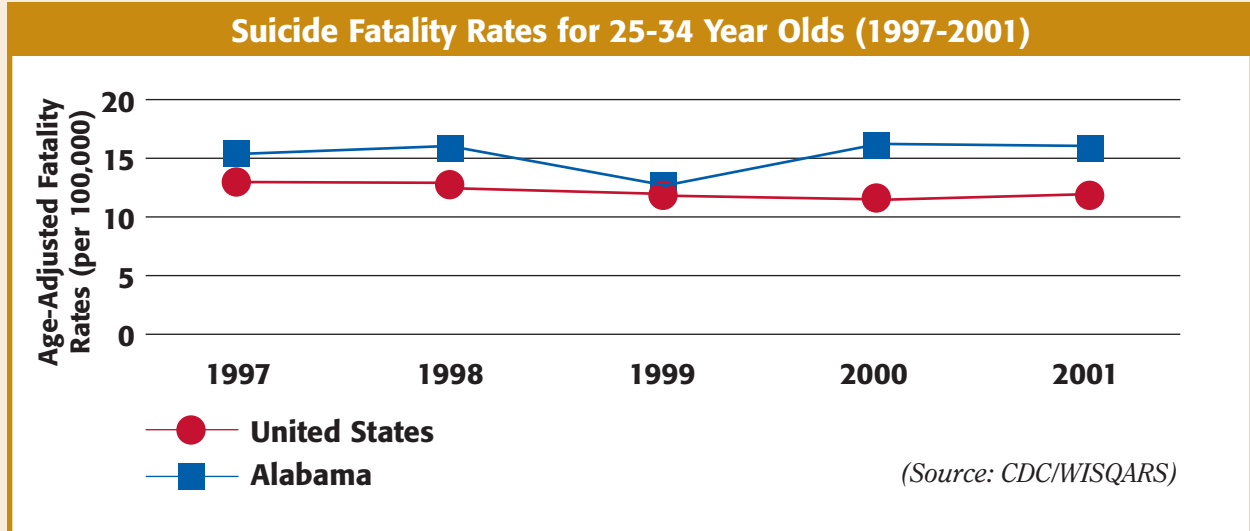
Suicide is the second leading cause of death due to injury in Alabama, second only to motor vehicle crashes. Over 500 suicides are committed in the state each year. Alabama's age-adjusted fatality rate in 2001 was 11.34 deaths per 100,000 people, higher than the United States age-adjusted fatality rate of 10.69 deaths per 100,000 people. For 15 to 24 year-olds, the age-adjusted fatality rate for Alabama in 2001 was 10.13 deaths per 100,000 compared to 9.88 deaths per 100,000 in the U.S. For 25 to 34 year-olds, Alabama's rate is significantly higher at 15.46 deaths per 100,000 compared to a national rate of 12.73 deaths per 100,000.

**Suicide Fatality Rates for All Ages (1997-2001)**



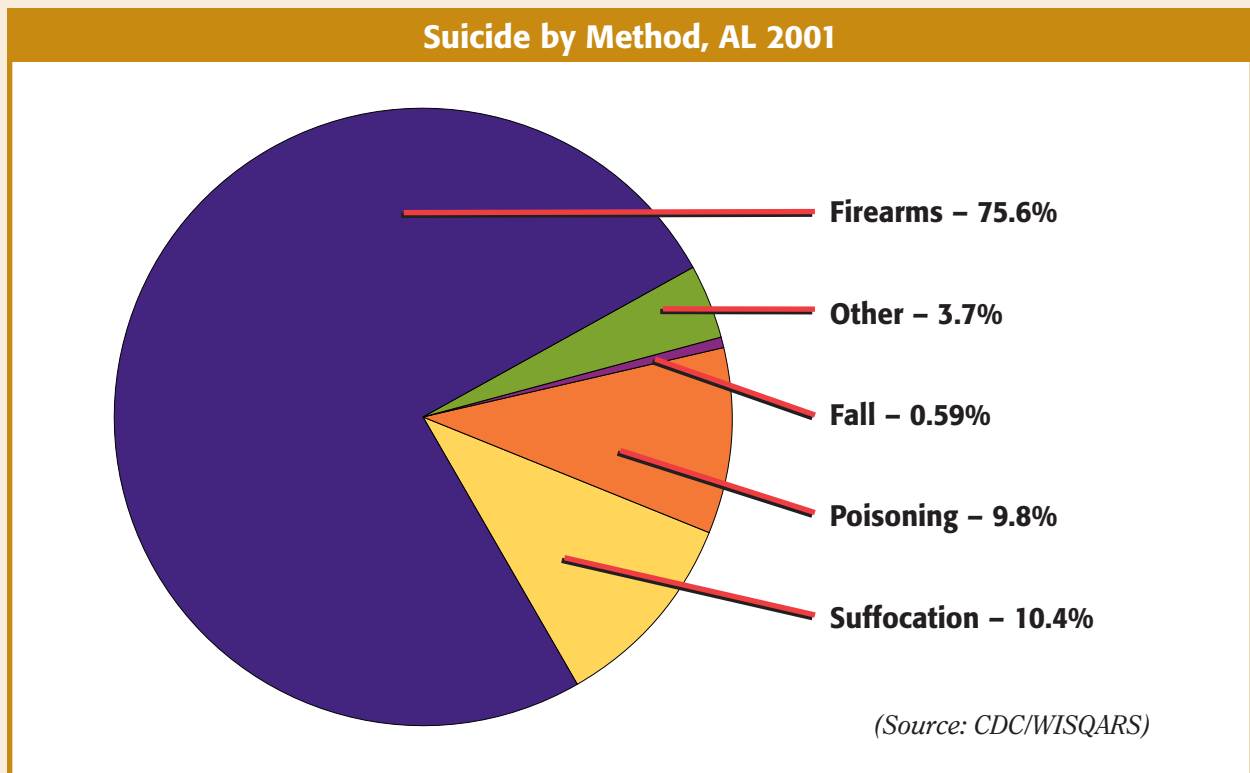
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**SUICIDE** *continued*



The method most commonly used in suicide deaths in Alabama is firearms. In 2001, 55% of suicides in the United States were committed using a firearm; while in

Alabama 75.6% of suicides were committed using a firearm. Suffocation and poisoning are the next most common methods of suicide.



## THOSE AT RISK:

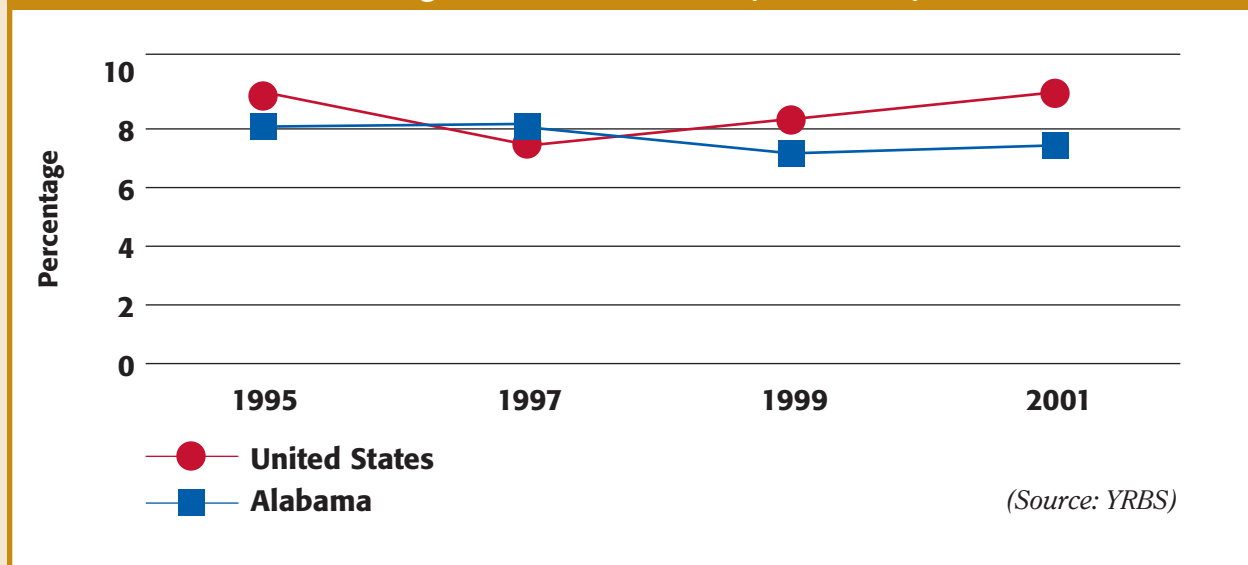
- **One young person dies from suicide every two hours.**
- **Depressive symptoms occur in up to 80% of people who commit suicide.**

Suicide behavior has several complex risk factors which interact with one another. They include psychiatric, biological, social and environmental factors. Depression plays a major role in suicide and is thought to be involved in approximately 65-90% of all suicides with psychiatric pathologies. Studies have revealed that up to 80% of people who committed suicide had several depressive symptoms.

It is the 8th leading cause of death for men and the 19th leading cause of death for women. White females attempt suicide more often than males; however, males are at least four times as likely to die from suicide. White males account for nearly 80% of all cases.

The Youth Risk Behavior Survey (YRBS) conducted by CDC provides important information on attempted suicide in young people. It has consistently shown that a large number of youth in grades 9 through 12 consider or attempt suicide. In 2001, 7.8% of Alabama students reported attempting suicide within twelve months of the survey. Another 12% had created a plan about how they would attempt suicide and 2.2% were treated by a doctor or nurse due to their attempted suicide.

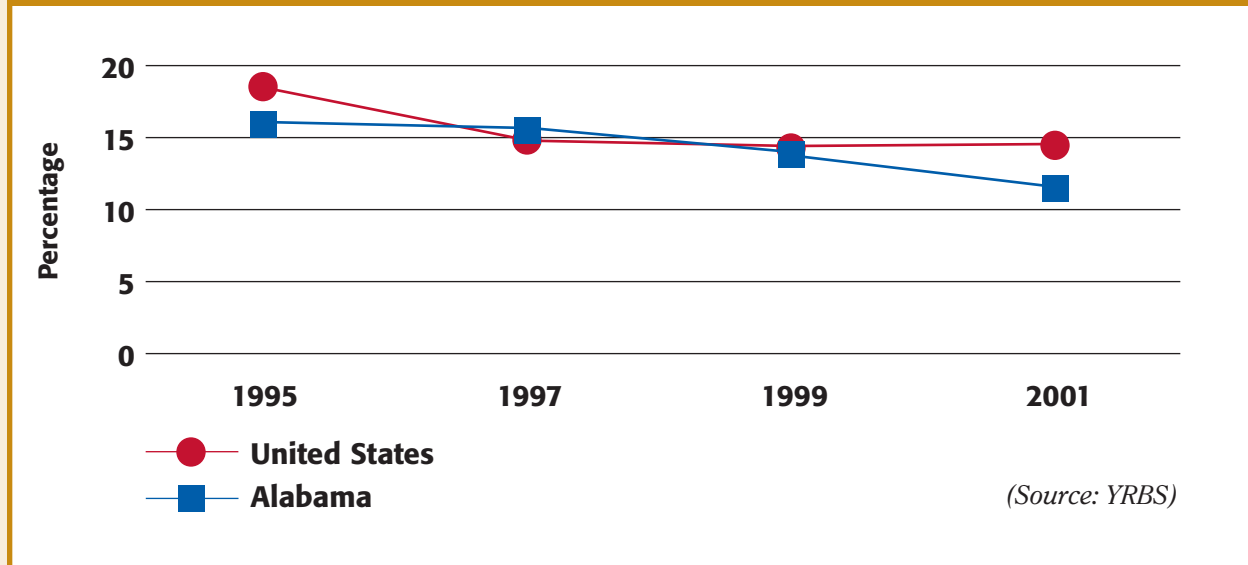
**Percentage of Students Who Actually Attempted Suicide One or More Times During the Past 12 Months (1995-2001)**



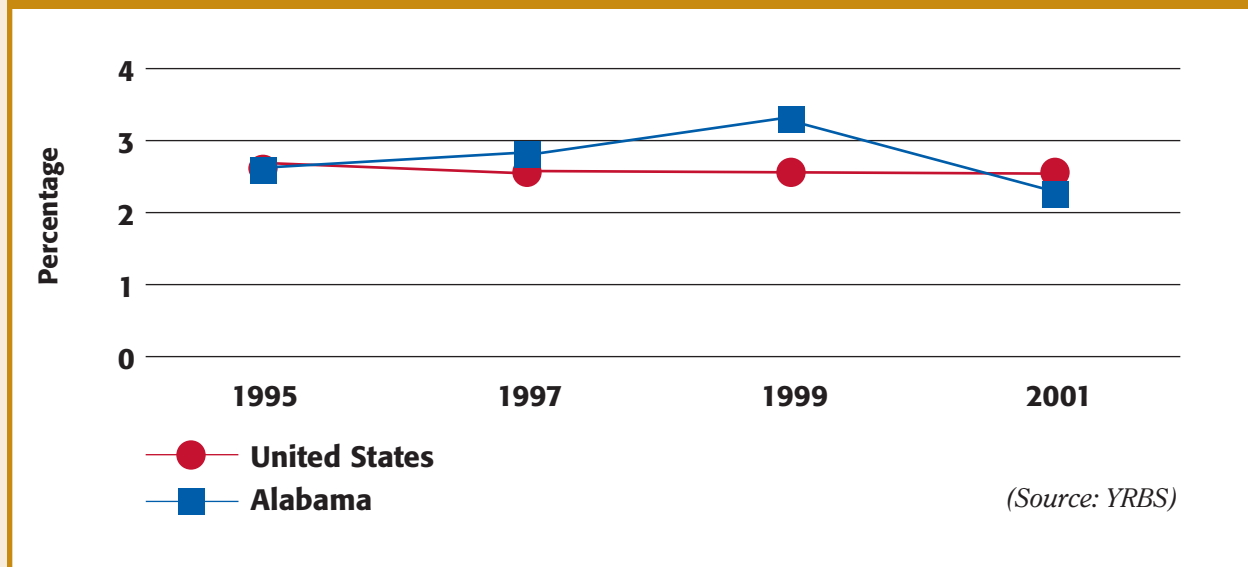
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## SUICIDE *continued*

**Percentage of Students Who Made a Plan About How They Would Attempt Suicide During the Past 12 Months (1995-2001)**



**Percentage of Students Whose Attempted Suicide During the Past 12 Months Resulted in an Injury, Poisoning or Overdose that had to be Treated by a Doctor or Nurse (1995-2001)**





## **COST:**

Suicide is a major cause of death in the nation and also contributes to disability and suffering. Suicide is a serious public health problem that affects not only those who attempt or succeed in suicide but also the emotional trauma of family and friends left behind. The cost of suicide to society is high, as medical expenses, work-related losses, years of potential life lost and quality of life costs are estimated to be in the billions.

## **PREVENTION:**

- **Suicide is a serious public health problem that is preventable.**

In an effort to address suicide on a national level, the 1999 *“Surgeon General’s Call to Action to Prevent Suicide”* and related 2001 *“National Strategy for Suicide Prevention: Goals and Objectives for Action”* outline goals and methods to prevent the loss of life and suffering that suicide causes. The reports recognize that mental and substance abuse disorders are the greatest risk for suicidal behavior. As a result, the report suggests an important approach for preventing suicide is by addressing the problems of undetected and undertreated mental and substance abuse disorders. This approach is further supported by *“The President’s New Freedom Commission on Mental Health”* released in 2003.

The *National Strategy to Prevent Suicide* provides 11 goals. They are to:

- 1) promote awareness that suicide is a public health problem that is preventable,
- 2) develop broad-based support for suicide prevention,
- 3) develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services,
- 4) develop and implement suicide prevention programs,
- 5) promote efforts to reduce access to lethal means and methods of self-harm,
- 6) implement training for recognition of at-risk behavior and delivery of effective treatment,
- 7) develop and promote effective clinical and professional practices,
- 8) improve access to and community linkages with mental health and substance abuse services,
- 9) improve reporting and portrayals of suicide behavior, mental illness, and substance abuse in the entertainment and news media,
- 10) promote and support research on suicide and suicide prevention and,
- 11) improve and expand surveillance systems.

*Continued next page.*

## SUICIDE *continued*

The *World Report on Violence and Health* recognizes suicide as a very serious global public health problem. It cites not only the deaths from suicide, but also the people who survive attempts and require serious medical attention. Further, for every person that commits suicide, family and friends left behind are profoundly affected emotionally, socially and economically. The report makes several recommendations for reducing suicidal behavior which include the need for better data and continued research to understand risk factors, protective factors and effective interventions; better psychiatric treatment; environmental changes which restrict access to methods of suicide; and strengthening community-based efforts. It is estimated that there are 16 suicide attempts for every suicide completed. With preventive efforts like those mentioned in the National Strategy to Prevent Suicide and recognition of suicide as a public health problem from the World Health Organization, the 16 people who attempt suicide may not turn into the one who completes the process.

## ALABAMA'S STRATEGY FOR SUICIDE PREVENTION:

### GOAL:

To reduce injuries and deaths due to suicide.

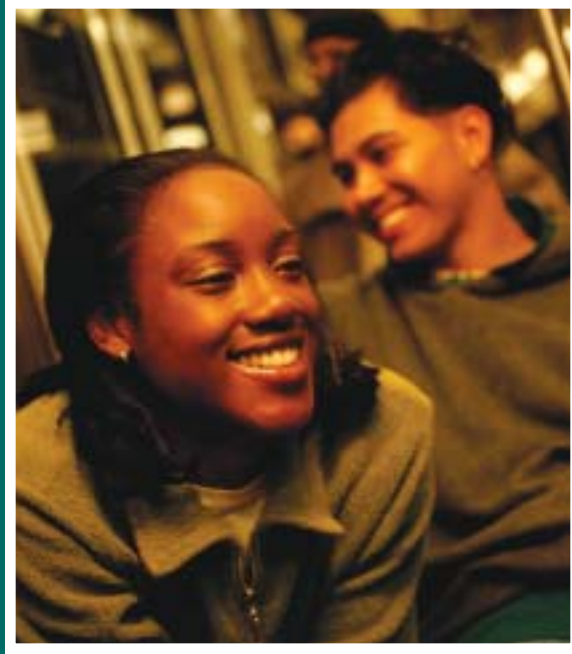
- 1. Support the development of a comprehensive multi-disciplinary task force to develop a suicide prevention plan.**
- 2. Support the development and implementation of a statewide suicide prevention plan which follows the “Surgeon General’s Call to Action to Prevent Suicide” and related “National Strategy for Suicide Prevention.”**
  - a. Address the 11 goals outlined in the “National Strategy for Suicide Prevention”.
    1. Promote awareness that suicide is a public health problem that is preventable.
    2. Develop broad-based support for suicide prevention.
    3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

4. Develop and implement suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Improve access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicide behavior, mental illness and substance abuse in the entertainment and news media.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

**3. Support the development of a comprehensive surveillance system to accurately measure the impact of suicide on our state.**

**Suicide References:**

1. Alabama Department of Public Health, Center for Health Statistics.
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Suicide in the United States Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/factsheets/suifacts.htm>
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from URL: [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars).
5. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. Available from URL: <http://www.cdc.gov/nccdphp/dash/yrbs/2001/youth01online.htm>
6. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
7. National Strategy for Suicide Prevention: Goals and Objectives for Action. DHHS. Rockville, MD, 2001
8. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. DHHS. Rockville, MD, 2003.
9. The Surgeon General's Call to Action to Prevent Suicide. U.S. Public Health Service. Washington, DC, 1999.
10. World Health Organization. *World Report on Violence and Health*. Geneva 2002.



# YOUTH VIOLENCE

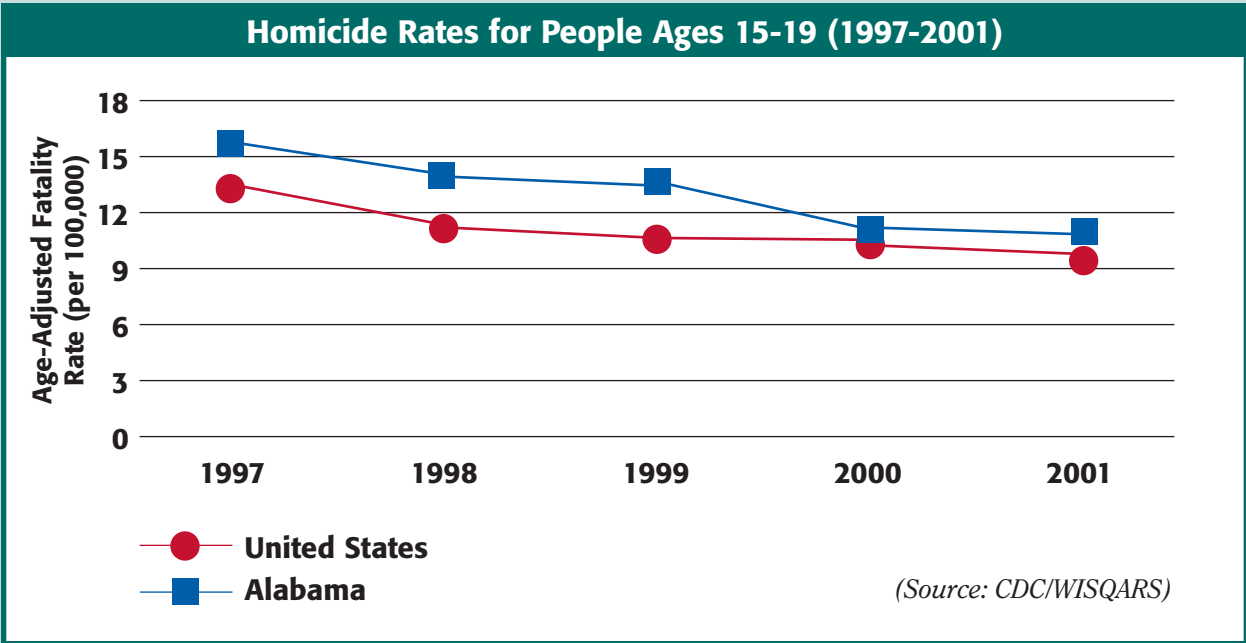
# YOUTH VIOLENCE

## THE PROBLEM:

- Homicide is the second leading cause of death for young people ages 15 to 24.
- In 1999, 4,998 youths ages 15 to 24 were murdered - an average of 14 per day.

Violent injury and death disproportionately affect children, adolescents and young adults in the United

States. Some 1,899 youth ages 15-19 were killed by homicide and more than 300,000 youth ages 15-19 were injured as a result of violence in the year 2001. Approximately 1 in 28 of these injuries required hospitalization. In Alabama, 36 youth ages 15-19 were killed by homicide with an age-adjusted rate of 11.31 deaths per 100,000 compared to 9.37 deaths per 100,000 nationally.



- In 1999, 82% of homicide victims 15 to 19 years old were killed with firearms.
- 28% of the fatal injuries happened inside the school building; 36% occurred outdoors on school property; and 35% occurred off campus.

In a survey of 9th through 12th grade students across the United States, more than one-third of respondents in 2001 reported being in a physical fight in the past 12 months; 4% were injured seriously enough in a physical fight to require medical treatment by a doctor or nurse and 6.4% of high school students surveyed

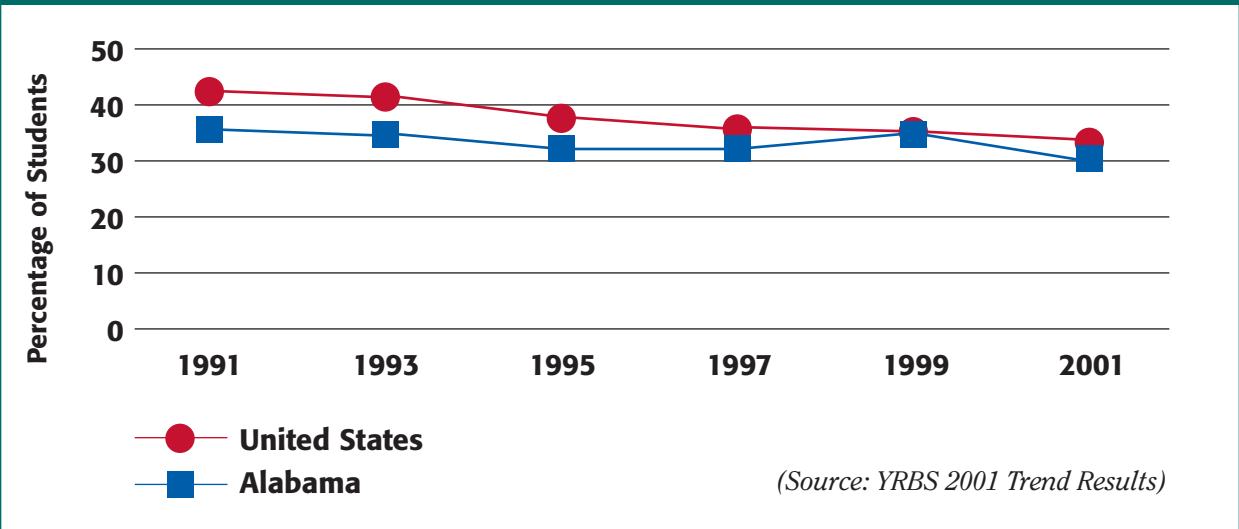
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## YOUTH VIOLENCE *continued*

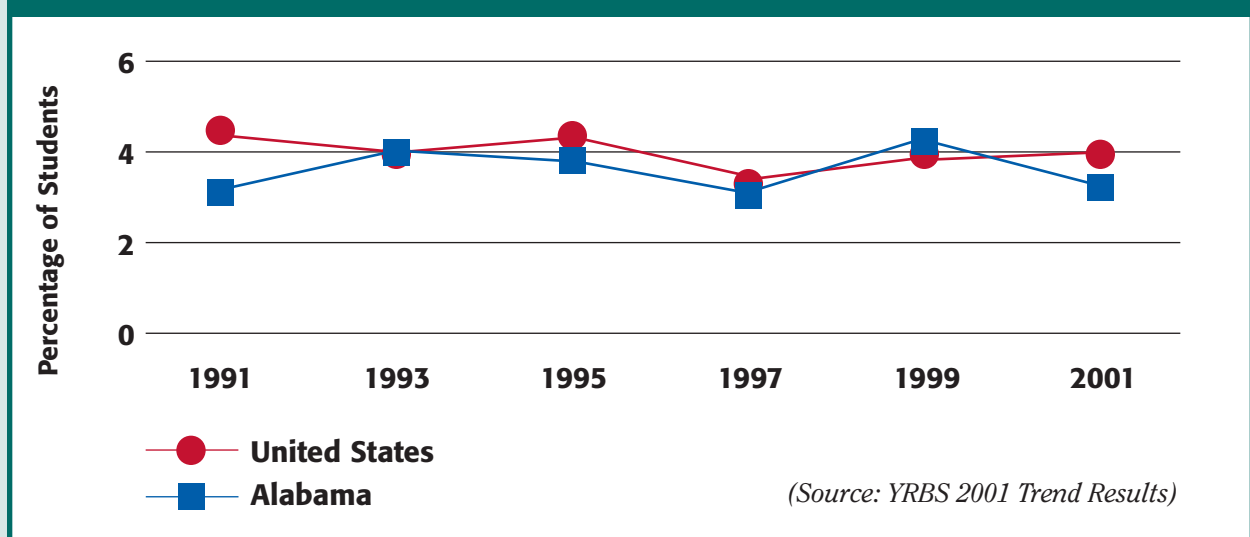
had carried a weapon during the preceding 30 days. These percentages are close to how Alabama students responded to the survey. Thirty percent of Alabama high school students reported being in a physical fight in the past 12 months,

3.6% were injured seriously enough in a physical fight to require medical treatment by a doctor or nurse and 7.4% of Alabama high school students surveyed had carried a weapon during the preceding 30 days.

**Students in a Physical Fight One or More Times in the Past 12 Months (1991-2001)**



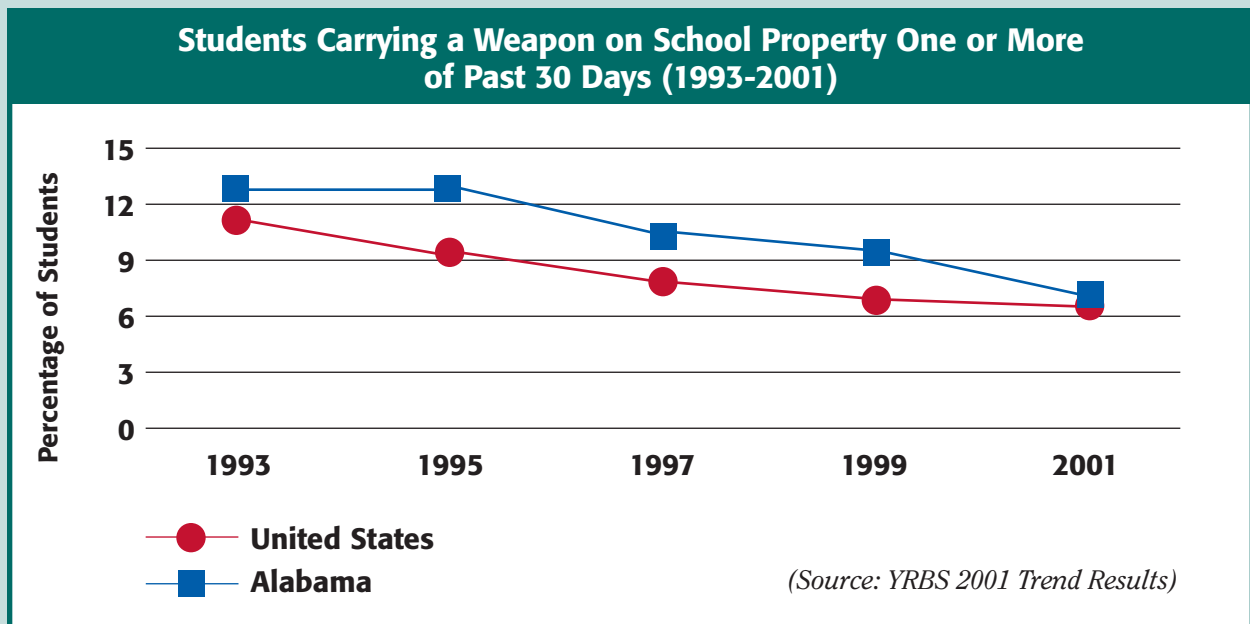
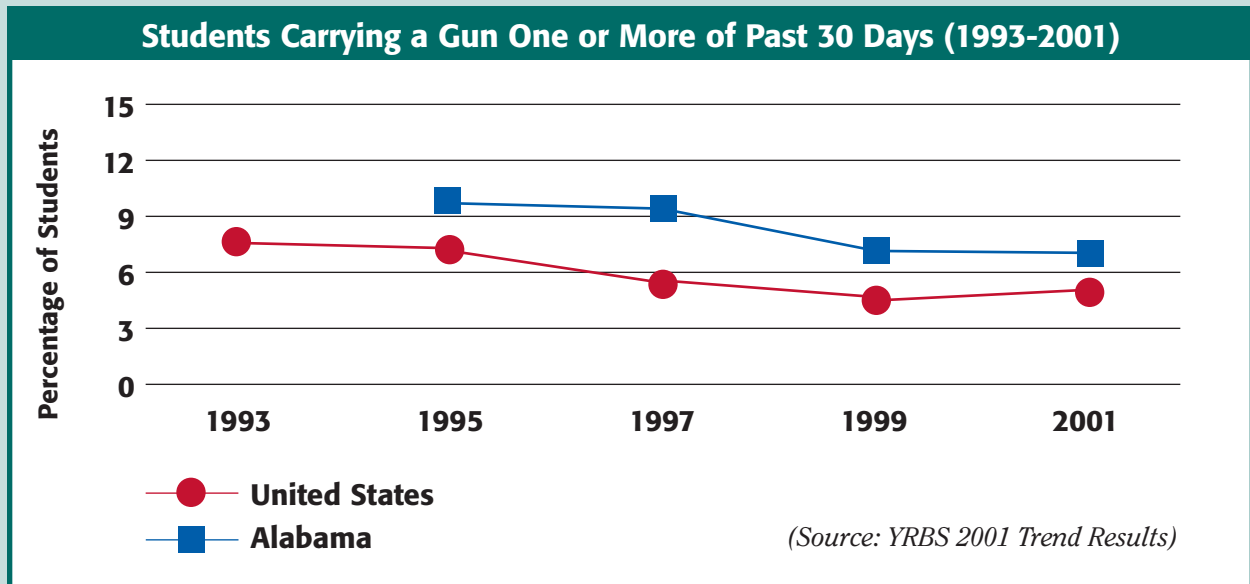
**Students Injured in a Physical Fight and Treated by Medical Personnel One or More Times in the Past 12 Months (1991-2001)**





Most school-associated violent deaths occur around the start of the school day, during the lunch period, or the end of the school day. Research indicates that rates of school-associated homicide events are

higher near the beginning of both the spring and fall semesters and gradually decline during the course of each semester. Most young homicide victims are killed with guns.



*Continued next page.*

## YOUTH VIOLENCE *continued*

The Alabama School Incident Report (SIR) was developed in 1997 by a task force composed of local school and selected State Department of Education personnel. This program provides the framework for all Alabama public schools and school systems to collect school safety and discipline information in a uniform manner. Offenses tracked and reported are violations of the law or represent a serious breach of local board of education policy. Included are those offenses considered severe enough to be reported to local law enforcement or which resulted in a student being suspended out of school, expelled or placed in an alternative program. During the 2002-2003 school year, there were 39 reports of handgun possession and 2 homicides.

**Statewide Annual School Incident Report (2002-2003 school year)**  
*(Note: Total Incidents include victims and perpetrators)*

Type of Incident	Total Incidents	Grades
Fighting	19,916	K-12
Harassment	3,488	K-12
Homicide	2	10-12
Sexual Harassment	881	K-12
Threats/Intimidation	2,731	K-12
Handgun Possession	39	K-12
Handgun Use	3	K-12
Knife Possession	615	K-12
Knife Use	7	K-12

The Parents' Resource Institute for Drug Education (PRIDE) survey is a voluntary survey that is administered to students in grades 6-12. Since 1982 more than 7,600 school systems in 46 states have used the PRIDE questionnaire. That equates to more than 7.5 million students. It is administered by teachers in the classroom setting. The questionnaire not only explores the types and extent of drug use within the school, it also touches upon drug use outside of the school setting. It further delves into the prevalence, or lack thereof, of positive reinforcers in each child's life. It also asks the student to answer questions concerning violence, safety, and suicide. The truly valuable aspect of the program is that the data gleaned from the surveys are returned to school systems on a very comprehensive CD that not only displays the raw data, it also shows multiple linkages in that data. Consequently, individual schools can see how closely drug use and skipping class or violence and participation in extracurricular activities are correlated. Then the schools can tailor their at risk programs to address their particular needs based on data collected from only their students.

In April 1999, the State of Alabama implemented a statewide school safety hotline so that Alabama's students, parents and concerned citizens may report their school safety-related information and concerns on an anonymous basis 24 hours a day. This statewide hotline, 1-888-SAV-KIDS, is operated by the Alabama Department of Public Safety's

Missing and Exploited Children's Unit. By September 2002, over 2,800 calls had been received and 21% of the calls involved possible threats which were referred to local law enforcement, school or mental health office for further investigation and action. Only 2% have involved imminent threat which were referred to the necessary office for immediate action, and 1% involved drug threats at or near school grounds and were referred to local law enforcement. Almost 75% involved suggestions to improve school safety, miscellaneous calls from media, general complaints, hang ups and some just wanting to talk.

## PREVENTION:

- **Youth violence can be reduced and prevented.**
- **Effective interventions must be disseminated and adopted by local and state authorities, community-based organizations and private sector partners.**

*Youth Violence: A Report of the Surgeon General*, released in 2001, is a report that summarizes research regarding youth violence and, based on the research, recommends action steps. The report concludes that youth violence can be reduced and prevented. It states that the most important finding is that the public already has the knowledge and the tools to reduce or prevent much of the most serious youth violence. It calls for the use of systematic research-based approaches and cites a number of prevention programs that have been shown to work. Courses of action recommended include continued efforts at reducing gun use by

youths, improving public awareness of effective programs and disseminating model programs in the community.

Currently, Alabama has implemented a comprehensive plan which promotes safety and emergency response. The "Alabama Safe Schools Initiative" is a comprehensive plan that provides training and resources to Alabama schools. The initiative is a joint effort by the State of Alabama Office of the Attorney General, Office of the Governor, Department of Public Safety and Department of Education. It is comprised of five parts:

- 1) The production and distribution of standardized Alabama "School Emergency" crisis notebooks,
- 2) Statewide School Safety Hotline,
- 3) Statewide trainings,
- 4) A public service announcement "Prevent School Violence" marketing campaign,
- 5) Development of "Safe Schools for Alabama's Children: An Educator's Guide".

Alabama is also one of five states that received funding in 2001 from the Centers for Disease Control and Prevention to study the causes of youth violence. The University of Alabama at Birmingham, recipient of the funding, has established the Comprehensive Youth Violence Center (CYVC). Studies conducted at the CYVC will produce innovative intervention programs directed towards reduction in violent behavior and related health and social problems in many youths.

Violence is a significant public health issue which impacts the health and well-being of our youth. It cuts across

*Continued next page.*

## **YOUTH VIOLENCE** *continued*

all geographic and socio-economic boundaries. It has devastating and costly effects on individuals, families, communities, and society. Addressing individual and social factors that increase the probability of violence during adolescence and young adulthood such as individual, family, peer/school and neighborhood is a first step toward preventing violence.

### **ALABAMA'S STRATEGY TO REDUCE YOUTH VIOLENCE:**

#### **GOAL:**

**Reduce injuries and deaths due to youth violence.**

#### **1. Support data collection and analysis.**

- a. Support administration of the Parents' Resource Institute for Drug Education (PRIDE) Survey through the Alabama Department of Education to identify the risk factors and protective factors involved in youth violence in Alabama.
- b. Continue to support administration and analysis of the Youth Risk Behavior Survey (YRBS).
- c. Continue to support administration and analysis of the Alabama School Incident Report (SIR).

#### **2. Promote education on youth violence.**

- a. Support comprehensive school violence prevention curriculum in grades K-12.
- b. Support programs that conduct anti-bullying, conflict resolution and mediation activities for youth.
- c. Support ongoing effort of the Alabama Department of Education to provide proactive youth development and counseling services.
- d. Support statewide communication campaign to heighten public awareness and individual and community responsibility for preventing youth violence.

#### **3. Improve public awareness of effective interventions.**

- a. Support use of research-based approaches to reducing youth violence.
- b. Disseminate information about effective prevention programs.

#### **4. Provide a forum for individual groups and public and private sector agencies for addressing various types of youth violence.**

#### **5. Support development of state reporting of crime information and violence surveillance.**

## References:

1. Alabama Department of Education, Data Collection. School Incidence Report.
2. Alabama Department of Education, Prevention and Support Services. PRIDE Survey.
3. Alabama Department of Public Safety, Missing and Exploited Children's Unit. Statewide School Safety Hotline.
4. Anderson M, Kaufman J, Simon TR, Barrios L, Paulozzi L, Ryan G, Hammond R, Modzeleski W, Feucht T, Potter L, and School-Associated Violent Deaths Study Group. "School-Associated Violent Deaths in the United States, 1994-1999." JAMA 2001; 286: 2695-2702.
5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: 2001.
6. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: URL: [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars).
7. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Youth Violence Fact Sheet. Available from URL: <http://www.cdc.gov/ncipc/dvp/youth/youth.htm>.
8. Healthy People 2010: Objectives for Improving Health, Injury and Violence Prevention. Washington, DC, November 2000.
9. State of Alabama Office of the Attorney General, Office of the Governor, Department of Public Safety and Department of Education. Alabama Safe Schools Initiative. Available from URL: [www.ago.state.al.us/schools](http://www.ago.state.al.us/schools).
10. University of Alabama at Birmingham, Comprehensive Youth Violence Center. Available from URL: <http://www.uab.edu/youthhealth/cyvc.html>.
11. Youth Violence: A Report of the Surgeon General. U.S. Public Health Service. Rockville, MD, 2001.
12. World Health Organization. World Report on Violence and Health. Geneva 2002.



## ACKNOWLEDGEMENTS

Many thanks to the members of the Injury Advisory Council who assisted in the development of the Injury Prevention Plan.

Johnny P. Ward  
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Montgomery, AL 36104  
334-206-5300  
800-252-1818

This publication was supported by  
cooperative agreement #U17/CCU419368-  
04 from the National Center for Injury  
Prevention and Control, Centers for  
Disease Control and Prevention (CDC). Its  
contents are solely the responsibility of the  
authors and do not necessarily represent  
the official views of the CDC.

## INJURY PREVENTION RESOURCES

### Bicycle Safety

- American Academy of Pediatrics  
Publications Department  
141 Northwest Point Boulevard  
Box 927  
Elk Grove Village, IL 60009-0927  
800-433-9016 (phone)  
[www.aap.org](http://www.aap.org)

Materials include *Physician's Resource Guide for Bicycle Safety Education*; "Bicycle Safety Camp," which is a videotape for elementary school students concerning the importance of wearing helmets and other safety issues while riding bicycles; and bicycle safety sheets from the Injury Prevention Program. The safety sheets cover such topics as encouraging children to wear helmets, myths and facts about bicycle safety, choosing the right size bicycle for a child, and child passengers on adults' bicycles.

- American Trauma Society  
8903 Presidential Parkway  
Suite 512  
Upper Marlboro, MD 20722-2656  
800-556-7890 (phone)  
[www.amtrauma.org](http://www.amtrauma.org)
- National Parent Teachers Association (PTA)  
330 North Wabash Avenue  
Suite 2100  
Chicago, IL 60611-3690  
312-670-6782 (phone)  
[www.pta.org](http://www.pta.org)

Materials include a guide, *Bike Injury/Bike Rodeos*, which lists bicycle safety resources and provides guidelines to help local PTAs

organize bicycle rodeos and promote bicycle safety.

- National SAFE KIDS Campaign  
111 Michigan Ave NW  
Washington, DC 20010  
202-884-4993 (phone)  
[www.safekids.org](http://www.safekids.org)

Materials include SAFE KIDS Cycle Smart, a guide for community bicycle safety programs and resource materials list; a kit for medical professionals regarding bicycle helmets and injury prevention; a teacher's guide on bicycle helmets; a brochure for parents; a bicycle helmet poster; a traffic safety magazine for children; public service announcements for television; and a chart of legislation mandating bicycle helmet use.

### Fall Safety

- Centers for Disease Control and Prevention, National Center for Injury Control and Prevention  
Mailstop K65  
4770 Buford Highway NE  
Atlanta, GA 30341-3724  
770-488-1506 (phone)  
770-488-1667 (fax)  
[www.cdc.gov](http://www.cdc.gov)

*Tool Kit to Prevent Senior Falls* has current technical information and materials about falls and fall-related injuries that can be used on an individual basis or incorporated into health promotion activities aimed at reducing falls among older adults. Included are fact sheets, graphs, brochures, health education material and a home assessment checklist. Available from <http://www.cdc.gov/ncipc/pub-res/toolkit/toolkit.htm>



- “Remembering When™: A Fire and Fall Prevention Program for Older Adults”  
[www.nfpa.org](http://www.nfpa.org)  
“Remembering When™ – A Fire and Fall Prevention Program for Older Adults” was developed by the NFPA Center for High-Risk Outreach and the Centers for Disease Control and Prevention (CDC) to help older adults live safely at home for as long as possible. *Remembering When™* is centered around 16 key safety messages – eight fire prevention and eight fall prevention – developed by experts and practitioners from national and local safety organizations as well as through focus group testing in the high-fire-risk states of Alaska, Arkansas, Mississippi, and cities of Cleveland and Atlanta. A power point presentation for *Remembering When™* is available on the website.

## Fire and Burns

- National Fire Protection Agency  
Risk Watch, Sparky the Fire Dog, fact sheets  
NFPA (National Fire Protection Association)  
1 Batterymarch Park  
Quincy, MA 02169-7471 USA  
617-770-3000 (phone)  
617-770-0700 (fax)  
[www.nfpa.org](http://www.nfpa.org)

The mission of the international nonprofit NFPA is to reduce the worldwide burden of fire and other hazards on the quality of life by providing and advocating scientifically-based consensus codes and standards, research, training and education.

- United States Fire Administration  
16825 South Seton Avenue  
Emmitsburg, MD 21727  
301-447-1000 (phone)  
301-447-1052 (fax)  
[www.usfa.fema.gov](http://www.usfa.fema.gov)

Materials include fact sheets on various fire safety issues, kids page, publications and fire safety facts.

- Burn Prevention Foundation  
5000 Tilghman, Suite 215  
Allentown, PA 18104  
610-481-9810 (phone)  
800-207-3090 (toll-free)  
[www.burnprevention.org](http://www.burnprevention.org)

The mission of the Burn Prevention Foundation is to provide burn injury prevention education to and advocacy for those at greatest risk. Our primary service area is in Eastern Pennsylvania, although many of our programs and products are utilized worldwide.

## Motor Vehicle

- National Highway Traffic Safety Administration  
888-DASH-2-DOT (toll-free hotline)  
888-327-4236  
[www.nhtsa.dot.gov](http://www.nhtsa.dot.gov)

Resources include information about Buckle Up America, impaired driving, recalls, injury prevention, safety seats, traffic safety digest, crash statistics, etc.

- National SAFE KIDS Campaign  
111 Michigan Ave NW  
Washington, DC 20010  
202-884-4993 (phone)  
[www.safekids.org](http://www.safekids.org)

SAFE KIDS is dedicated solely to the prevention of unintentional childhood injury- the number one killer of children ages 14 and under. Resources include safety checklists on multiple injury areas including motor vehicle, fire, poisoning, bicycling and playground safety.

*Continued next page.*

## INJURY PREVENTION RESOURCES *continued*

- Children’s Safety Network National Injury & Violence Prevention Resource Center Education Development Center, Inc.  
55 Chapel Street  
Newton, MA 02458-1060  
617-969-7100 X2722 (phone)  
617-969-9186 (fax)  
e-mail: [csn@edc.org](mailto:csn@edc.org)  
[www.childrensafetynetwork.org](http://www.childrensafetynetwork.org)

Resources include power point presentations on traffic safety, child passenger safety education materials. The center also has information regarding bullying, general child injury and suicide prevention.

### Domestic Violence

- Alabama Coalition Against Domestic Violence  
P.O. Box 4762  
Montgomery, AL 36101  
334-832-4842 (phone)  
334-832-4803 (fax)  
800-650-6522 (toll-free hotline)  
email: [acadv@acadv.org](mailto:acadv@acadv.org)  
  
The Alabama Coalition Against Domestic Violence is a nonprofit organization dedicated to working toward a peaceful society where domestic violence no longer exists. The Coalition was organized in 1978 as a network of shelters for battered women and their children, and organizations and individuals concerned about the issue of domestic violence. The ACADV serves domestic violence victims throughout the state through its 18-member shelter programs and 24-hour crisis line for domestic violence.
- National Coalition Against Domestic Violence  
[www.ncadv.org](http://www.ncadv.org)  
  
NCADV offers a variety of other publications, posters, t-shirts, pins, bumper stickers and other promotional and educational items that can be used for training, recognition and awareness activities. Contact NCADV for a full publication and product catalogue.
- National Domestic Violence Hotline  
PO Box 161810  
Austin, Texas 78716  
800-799-SAFE (7233)  
800-787-3224 (TTY)  
512-453-8541 (fax)  
[www.ndvh.org](http://www.ndvh.org)  
  
The hotline provides crisis intervention, information about domestic violence and referrals to local service providers to victims of domestic violence and those calling on their behalf.
- National Violence Against Women Prevention Research Center  
843-792-2945 (phone)  
[www.vawprevention.org](http://www.vawprevention.org)  
  
The NVAWPRC serves as a clearinghouse for prevention strategies and keeps researchers and practitioners aware of training opportunities, policy decisions, and recent research findings. The NVAWPRC website also offers the latest research on violence against women as a resource to everyone involved in the field of violence prevention so they can better do their work.



## Sexual Assault

- Alabama Coalition Against Rape (ACAR)  
P.O. Box 4091  
Montgomery, AL 36102  
334-264-0123 (phone)  
334-264-0128 (fax)  
800-656-HOPE (toll-free)  
[www.acar.org](http://www.acar.org)

ACAR was founded in 1995. ACAR, comprised of 15 member rape crisis centers across the state, conducts prevention activities and empowers centers to facilitate consistent and compassionate care of victims of sexual violence and their families. ACAR's mission is to end sexual violence and improve the treatment of sexual violence survivors in the state of Alabama.

- FaithTrust Institute, formerly Center for the Prevention of Sexual and Domestic Violence  
2400 N 45th Street #10  
Seattle, WA 98103  
206-634-1903 (phone)  
206-634-0115 (fax)  
[www.cpsdv.org](http://www.cpsdv.org)

Their tagline is "Working together to end sexual and domestic violence". FaithTrust Institute provides training and educational resources for clergy, lay leaders, seminary faculty, chaplains, policy makers of religious institutions, and community advocates on the faith aspects of sexual and domestic violence.

- National Sexual Violence Resource Center  
123 North Enola Drive  
Enola, PA 17025  
877-739-3895 (toll-free)  
717-909-0710 (phone)  
717-909-0714 (fax)  
717-909-0715 (TTY)  
[www.NSVRC.org](http://www.NSVRC.org)

The National Sexual Violence Resource Center (NSVRC) is a comprehensive collection and distribution center for information, statistics, and resources related to sexual violence. It serves as a resource for state, territory, and tribal anti-sexual assault coalitions, rape crisis centers, allied organizations, community projects, policy-makers, government entities, media, educators, health care providers and others working to address and eliminate sexual assault.

## Suicide

- The American Association of Suicidology (AAS)  
4201 Connecticut Avenue, NW Suite 408  
Washington, DC 20008  
202-237-2280 (phone)  
202-237-2282 (fax)  
[www.suicidology.org](http://www.suicidology.org)

AAS is dedicated to the understanding and prevention of suicide. AAS promotes research, public awareness programs, education and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide and publishes directories of members, suicide prevention centers and support groups.

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## INJURY PREVENTION RESOURCES *continued*

- The American Foundation for Suicide Prevention (AFSP)  
120 Wall Street, 22nd Floor  
New York, NY 10005  
212-363-3500 (phone)  
212-363-6237 (fax)  
888-333-AFSP (toll-free)  
[www.afsp.org](http://www.afsp.org)  

AFSP is dedicated to advancing our knowledge of suicide and our ability to prevent it. The foundation's activities include supporting research projects that help further the understanding and treatment of depression and the prevention of suicide; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of problems of depression and suicide and the need for research, prevention and treatment; and supporting programs for suicide survivor treatment, research and education.
- National Suicide Prevention Training Center  
55 Chapel Street  
Newton, MA 02458-1060  
617-618-2418 (phone)  
617-969-9186 (fax)  
[www.ncspt.org](http://www.ncspt.org)  

An internet-based workshop on locating and using existing data systems for suicide prevention. This is a joint project of EDC, Inc. and the Harvard Injury Control Research Center.
- Suicide Prevention Advocacy Network (SPAN)  
5034 Odin's Way  
Marietta, GA 30068  
888-649-1366 (phone)  
770-642-1419 (fax)  
[www.spanusa.org](http://www.spanusa.org)  

SPAN, a nonprofit organization is dedicated to the creation of an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government and public service to achieve the goal of significantly reducing the national rate of suicide by the year 2010.
- Light For Life Foundation International Yellow Ribbon Suicide Prevention Program  
P.O. Box 644  
Westminster, CO 80036-0644  
303-429-3530 (phone)  
303-426-4496 (fax)  
[www.yellowribbon.org](http://www.yellowribbon.org)  

The Yellow Ribbon cards empower youth, giving them permission and a way to ask for help. Seminars and presentations that teach awareness and suicide prevention skills are available. The Yellow Ribbon Program has chapters around the country to provide support services to prevent suicide. The program provides information on suicide, survivors support groups and task forces and coalitions around the country.



- Office of the Surgeon General  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201  
202-205-0463 (fax)  
[www.surgeongeneral.gov](http://www.surgeongeneral.gov)

The Surgeon General's Office has issued The Surgeon General's Call to Action to Prevent Suicide and accompanying fact sheets. Additional information on the Healthy People 2000 and 2010 Objectives are available from the office and through the website. The website also has links to the Surgeon General's publications and a special section for kids, parents and teachers.

## Youth Violence

- National Parent Teachers Association  
1090 Vermont Ave. NW, Suite 1200  
Washington, D.C. 20005-4905  
202-289-6790 (phone)  
202-289-6791 (fax)  
888-425-5537 (hotline)  
[www.pta.org/programs/crisis](http://www.pta.org/programs/crisis)

Violence, Kids, Crisis, What You Can Do  
Resources include a community violence prevention kit, checklists and safety tips.

- Keep Schools Safe  
34 Main St.  
Amherst, NH 03060  
603-478-0555 (phone)  
[www.keepschoolssafe.org](http://www.keepschoolssafe.org)

School safety and security resources available for students, parents, teachers, and school administrators. Information is available regarding bullying, gangs, hazing, incidents, memorials and statistics.

- Alabama Safe Schools Initiative  
11 South Union Street  
Montgomery, AL 36130  
[www.ago.state.al.us/schools](http://www.ago.state.al.us/schools)

The Attorney General's Office is pleased to offer this site as a resource for educators, parents and students. This site is a “one-stop-shop” for school safety information in Alabama. In an on-going effort, we will provide you with the latest links, downloads and other resources on school safety. The “**Alabama Safe Schools Initiative**” is a comprehensive plan that provides to Alabama schools training and resources promoting safety and emergency response. The initiative is a joint effort by the Office of the Attorney General, in conjunction with the Office of the Governor, the Alabama Department of Public Safety, and the Alabama Department of Education.

- National Youth Violence Prevention Resource Center  
P.O. Box 6003  
Rockville, MD 20849-6003  
1-866-SAFEYOUTH (phone)  
1-866-723-3968  
[www.safeyouth.org](http://www.safeyouth.org)

The National Youth Violence Prevention Resource Center Hotline offers information on youth violence and referrals to organizations providing youth violence prevention and intervention services.



Bureau of Health Promotion and Chronic Disease • Injury Prevention Division

201 Monroe Street, Suite 900, Montgomery, Alabama 36104

(800) 252-1818 • (334) 206-5300

[www.adph.org/injuryprevention](http://www.adph.org/injuryprevention)

Published in 2004.

Informational material in alternative formats will be made available upon request.