

Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

Statewide Needs Assessment for the State of Alabama

Introduction

Maternal, Infant, and Early Childhood Home Visiting Needs Assessment Methods Overview

The purpose of this assessment is threefold: 1) to identify at-risk communities in Alabama based on a set of indicators and criteria outlined in the federal legislation; 2) to identify home visiting resources for families in Alabama with children from birth to 5 years; and 3) to determine the gaps related to areas of greatest risk, i.e. need and the location of home visiting programs in Alabama. The Alabama Department of Children's Affairs (DCA) serves as the lead agency for this project and collaborates with the Alabama Department of Public Health (ADPH), the Children's Trust Fund (CTF), existing home visitation programs, and other relevant state agencies. Each of these agencies and programs as well as a representative from the Fort Rucker Army Base's Family Advocacy Program is represented on the Home Visiting Needs Assessment Advisory Committee (HVNAC). The HVNAC has provided information and guidance throughout the needs assessment process. Identification of "communities" with at-risk profiles utilized secondary data from the Alabama Center for Vital Statistics, U.S. Census Bureau, Centers for Disease Control and Prevention, and other sources. "At-risk" was measured using a series of indicators, including population characteristics; health outcomes; health factors, such as health care utilization; health behaviors; socioeconomic factors; and educational factors. All of these indicators are reflective of those outlined in the ACA Maternal, Infant, and Early Childhood Visiting Program legislation.

Based on those indicators and others deemed appropriate by a panel of experts in child and family health in Alabama, a composite risk score was calculated for each county and mapped using ArcGIS. Existing needs assessments from programs conducting home visiting services or those agencies or entities that have useful data related to the needs of children and families were identified and reviewed for relevant information. Some of these assessments, such as the Title V assessments, were useful for some state level information, but most of these assessments did not have the county level data we were seeking. Surveys of home visiting providers and parents, and focus groups of parents, key agency personnel and home visiting providers were conducted and data analyzed to provide a measure of program quality and to further identify resources and gaps. Existing home visiting program models in the State and related resources have also been mapped. The simultaneous mapping of available resources and communities/counties within the State that are considered "at-risk" presents a visual representation of the areas in the State with the greatest need and the fewest resources. The communities or counties that are in the "gap areas" are those areas that the State will focus on for development of future home visiting programs. Details of this process and supporting documentation follow.

Overview of Alabama/Coordination with Other Statewide Needs Assessments and Reports

The well-being of children in Alabama has typically been less assured than that of the nation as a whole. According to the 2010 Kids Count overall rankings of child well-being, Alabama (AL) is 47th in the nation. The *Kids Count* overall rankings of child well-being are a composite of 10 key indicators, each one with higher values for Alabama relative to the United States (2007 and 2008 data): percent low-birthweight babies (US 8.2%, AL 10.4%); infant mortality (US 6.7/1,000, AL 9.9/1,000); child death rate (US 19/100,000, AL 23/100,000); teen death rate (US 62/100,000, AL 93/100,000); teen birth rate (43/1,000, AL 54/1,000); percent of teens not in school and not high school graduates (US 6%, AL 8%); percent of teen not attending school and not working (US 8%, AL 10%); percent of children living in families where no parent has full-time, year-round employment (US 27%, AL 30%); percent of children in poverty (US 18%, AL 22%); and percent of children in single-parent families (US 32%, AL 36%). Further, five of the eight indicators compared to 2000 data are “getting worse” in Alabama. These are percent low-birthweight babies (7% increase); infant mortality (5% increase); teen death rate (1% increase); percent of children in poverty (5% increase); and percent of children in single-parent families (3% increase) (Annie E. Casey, 2010). These factors, individually, in addition to Alabama’s overall ranking support the conclusion that the entire state is generally at high risk for poor outcomes related to child well-being.

During the process of this needs assessment, several other statewide needs assessments and annual reports were reviewed, specifically for information that adds to the discussion of Alabama in general or that furthers the understanding of risk for poor outcomes related to child well-being. Excerpts and, in some cases, summary information from the sources reviewed is provided below.

2005-2010 Title V Maternal and Child Health Needs Assessment and Block Grant- 2011 Application/2009 Report

Total Population

Alabama’s estimated population in 2008 was 4.7 million. Comparing 2008 to 2000, the state’s population had increased by 4.8%, whereas the nation’s population had increased by 8.0%. In Alabama and in the nation, 7% of residents were under 5 years of age (6.7% in Alabama and 6.9% in the US); and 24% were under 18 years of age (24.1% in Alabama and 24.3% in the US). Compared to the nation, Alabama residents were slightly more likely to be 65 years of age or older (13.8% versus 12.8%).

Geography

According to the US Census 2000, population density was higher in Alabama than in the nation (87.6 persons per square mile versus 79.6 persons per square mile.) However, population density may be skewed by a few densely populated areas, and therefore does not adequately describe the State’s geography. Many of Alabama’s 67

counties are largely rural. Specifically, according to the US Census 2000, 50 (75%) of the State's 67 counties were more than 50% rural, and 37 (55%) of its 67 counties were more than 75% rural.

Demographics

In 2008, compared to the US, Alabama residents were less likely to be White, more likely to be Black, less likely to be Asian, and less likely to be Latino. Combining race and ethnicity, Alabama residents were slightly more likely to be White non-Latino than were US residents. Comparing 2008 to 2000, the number of 0-24 year-old Alabama residents increased among the total population and among Whites, Asians, Hawaiians or Pacific Islanders, and persons of two or more races. The most striking increases were in the number of Asians (up by 26%) and the number of persons who were of two or more races (up by 51%). Conversely, the number of Black 0-24 year-old residents and the number of American Indian or Native Alaskan 0-24 year-old residents declined slightly.

Further, 4.3% of Alabama residents age 0-24 years were Latino, up from 2.5% in 2000. The percentage of White, non-Latino residents was 61.5%, down from 63.4% in 2000. A similar decrease was noted for the percentage of Black, non-Latino residents, 31.1% compared to 31.7% in 2000. Finally, 3.1% of residents were Other, Non-Latino, up from 2.4% in 2000.

In 2008, there were 64,345 live births to Alabama residents: an increase of 1.9% relative to 2000. Of those, 8.2% were Latino (up from 3.1% in 2000); 59.2% were White, non-Latino (down from 63.4% in 2000); 30.7% were Black, non-Latino (down from 32.3% in 2000); and 1.8% were other, non-Latino (up from 1.1% in 2000). The pregnancy rate among 18-19 year-old females has increased. The percentage of infants whose mother had received inadequate prenatal care has increased. Also, the risk of infant death increased in 2005-07 relative to 2002-04 and racial gaps in infant mortality have persisted.

Unemployment

According to the US Bureau of Labor Statistics, in December 2009, the unemployment rate was higher in Alabama than in the nation with a rate of 11.0% in Alabama (preliminary) and 10.0% in the US. This was in contrast to reports from 2001 through 2008 where Alabama's unemployment rate was below the nation's rate. According to the University of Alabama's Center for Business and Economic Research (CBER), Alabama entered the current recession later than the nation, but the decline has been steeper. In addition, though 2010 is expected to be a year of recovery for Alabama's economy, CBER expects Alabama's rate of improvement may be slower than the nation's.

Poverty

The prevalence of poverty has been higher in Alabama than in the nation and has been higher among children and youth than among adults. According to the 2006-2008 American Community Survey (ACS), the percentage of people living below the federal

poverty level, according to age, were as follows: persons aged 17 years or younger – US 18.2%, AL 22.9%; persons aged 18-64 years – US 11.8%, AL 14.6%; persons aged 65 years or older – US 9.8%, AL 12.2%. According to the US Census 2000, Alabamians were notably more likely than US residents to be living below 100% of the FPL (16.5% of Alabama residents versus 13.0% of US residents). Figure 1 provides illustration of various poverty measures at the county level. Included are overall poverty, poverty among children under age 5, families, and the location quotient, a comparison of relative poverty between state and county.

Education

According to the US Census 2000, Alabamians had less formal education than did US residents as a whole. Comparing persons aged 25 years or older in Alabama to those in the nation, Alabamians were slightly less likely to be high school graduates (75.3% versus 80.4%) and notably less likely to have a bachelor's degree (19.0% versus 24.4%).

Teen Death

For 15-24 year-old Alabama residents, the all-cause death rate has increased. The drug- and alcohol-related death rate has increased in 15-24 year-old White, non-Latino males. The homicide/legal intervention death rate has increased in 15-24 year-old Black, non-Latino males.

Household Structure

The following findings on household structure are from two different sources: the 2006-2008 ACS and the National Survey of Children's Health (NSCH), 2007. Findings from the two sources collectively show that: Alabama children and youth were more likely to live in single-parent households than US children and youth; the lower the household income, the more likely the child was to live in a household with no father present; compared to privately-insured children, publicly-insured children and uninsured children were more likely to live in a household with no father present; and Black, non-Latino children were more likely than White, non-Latino children to live in a household with no father present.

Foster Home Care

According to the 2006-2008 ACS, 1,116,004 children and youth aged 17 years or younger were living in Alabama households, and 1.7% of these individuals was either a foster child or unrelated to the householder. This finding was similar to the corresponding percentage for US children and youth (1.8%).

Per the Alabama Department of Human Resources, in August 2008 there were 5,894 children and youth enrolled in foster care. Most (5,791, or 98%) of these enrollees were 19 years of age or younger, few (98, or 1.7%) were 20 years of age, and (5, or 0.1%) were 22 years or older. Of those in foster homes, 50% were White, 48% were Black, and 0.6% were of another race. About 4% of the foster home enrollees were Latino.

Receipt of Public Assistance

Compared to US children, Alabama children and youth are more likely to live in households that had received public assistance in the last 12 months. Specifically, the 2006-2008 ACS reports the percentage of children and youth aged 17 years or younger who were living in households with Supplemental Security Income, cash public assistance income, or Food Stamp benefits. This survey reports that 24% of Alabama children and 19% of US children, were living in households receiving public assistance.

Crime

Unless stated otherwise, information presented here about crime is reported in or derived from Crime in Alabama 2008, a report produced by the Alabama Criminal Justice Information Center. The basis of the report is the Unified Crime Reporting System and arrest data.

In 2008, the crime rate for the state was 4,330.4/100,000 inhabitants (or about four crime reports per 100 persons). Comparing 2008 with 2007, there was a 3.7% increase in Part I Offenses (homicide, rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, and arson). Of the 33,349 Part I arrests made in Alabama in 2008, 14% were of juveniles ages 17 years or younger. About 4.6% of arrests for Part II Offenses (anything not classified as a Part I Offense, i.e. non-aggravated assault, disorderly conduct, drug offenses, violation of liquor laws) were juveniles.

In summary, of all arrests made in Alabama in 2008, 14% of Part I Arrests and 5% of Part II Arrests were of juveniles age 17 years or younger. A 2008 juvenile crime arrest rate for Alabama can be calculated by combining the actual number of juveniles arrested for either offense and then dividing that number by the estimated number of 10-17 year-old Alabama residents in 2008. It is estimated that the juvenile crime arrest rate in Alabama in 2008 was 2,721 arrests per 100,000 juveniles (or 2.7 arrests per 100 juveniles). Considering juveniles as victims of crime, of the 342 homicide victims in 2008, 28 were juveniles, and seven of the juvenile victims were under 5 years of age. About one-third (32%) of the 1,524 rape victims were adolescent females from 13-16 years of age.

Safety and Supportiveness of Neighborhoods

The National Survey of Children's Health (NSCH) asked how often the respondent felt that the child was safe in the household's community or neighborhood. For Alabama children and youth aged 17 years or younger, most respondents (88.1%) felt that the child was usually or always safe in the neighborhood. About 9% felt that the child was sometimes safe in the neighborhood, and 3% felt that the child was never safe in the neighborhood. These responses were similar to those for the nation. However, in both Alabama and the nation, respondents for White, non-Latino children and youth were more likely than those for other racial/ethnic groups to feel that the child was usually or always safe in the neighborhood.

The NSCH classified children based on the respondent's perception about whether the child lived in a supportive neighborhood. For 0-17 year-old children and youth, 85.4% of Alabama residents said that the child's neighborhood was supportive, similar to the corresponding finding for the nation – 83.2%. The responses differed significantly between Black non-Latinos and White non-Latinos. Specifically, 79% of respondents for Black, non-Latino children and youth, versus 89.5% of respondents for White, non-Latino children and youth, felt that the child's neighborhood was supportive. The same pattern occurred in the US, where 71% of respondents for Black, non-Latino children and youth, versus 88.8% of respondents for White, non-Latino children and youth, felt that the child's neighborhood was supportive.

Alabama's Title V Program Ten Priority Needs

The ten priority needs selected by Alabama's Title V program illustrate opportunities for collaboration, coordination, and partnership with current and to-be-developed home visiting efforts in the state. These needs are:

1. Increase access to culturally competent care coordination services for Children and Youth with Special Health Care Needs (CYSHCN), including transition planning as appropriate.
2. Promote access to a medical home and to basic health care for children, youth, and women of childbearing age.
3. Promote positive youth development to reduce high risk behaviors in adolescents.
4. Reduce the prevalence of obesity among children, youth, and women of childbearing age.
5. Reduce the prevalence of violent behavior, including homicide and suicide, committed by or against children, youth, and women.
6. Reduce infant mortality, especially among African Americans.
7. Increase family and youth participation in CYSHCN policy-making through support services and education/training.
8. Promote access to community-based services for CYSHCN and families (including respite care, recreational opportunities, transportation, child care, and school-based services) through education, awareness, advocacy, and linking families with local resources.
9. Promote access to a dental home and to preventive and restorative dental care for children, youth, and women of childbearing age.
10. Promote access to mental health services for children, youth, and women of childbearing age.

Alabama 2008-2009 Head Start Needs Assessment

The state-level, comprehensive Head Start Needs Assessment, as mandated by the National Office of Head Start, is focused on coordination of services, and alignment of services, curricula, and assessments utilized in Head Start programs in tandem with the *Child Outcomes Framework* and *State Early Learning Standards*, as appropriate. Alabama's report was used to provide direction for the development and implementation of a required strategic plan that will guide the Alabama Head Start State Collaboration

Office (HSSCO) to support Head Start grantees in meeting requirements of the Head Start Act. Specifically, Head Start grantees must develop strategies to ensure coordination, collaboration, transition services, and alignment with Local Education Agencies (LEAs) for K-12 education and other agencies. Additionally, the results of the report informed the Alabama Head Start Collaboration Office of the status of collaboration in the national priority areas. The Alabama Head Start Needs Assessment (AHSNA) was conducted to determine the degree of ease or difficulty encountered by Head Start programs in forging relationships with partnering agencies.

The AHSNA included a survey containing 148 Likert-type items and 21 open-ended questions based on gathering information related to the ten priority areas: Health Care, Services for Children Experiencing Homelessness, Family/Child Assistance, Child Care, Family Literacy Services, Children with Disabilities and their Families, Community Services, Partnerships with Local Education Agencies, Head Start Transition, and Alignment with K-12, and Professional Development. The survey was completed by Head Start and Migrant and Seasonal Head Start program staff. Results document the level of relationship-building and the level of difficulty experienced by Head Start programs in their collaboration efforts. The use of the term relationship-building refers to the levels of cooperation, coordination or collaboration with service providers. The scale values of the Likert-type items were determined as follows: (1) Scale assessing relationship: 1 = No Working Relationship, 2 = Cooperation, 3 = Coordination, and 4 = Collaboration; (2) Scale measuring difficulty: 1 = Not at all Difficult, 2 = Somewhat Difficult, 3 = Difficult, 4 = Extremely Difficult. Direct excerpts from the key findings are presented below.

- Grantees indicated they were at the level of “Coordination” in their relationship-building efforts with other health care services providers. However, grantees indicated the highest score for relationship-building in local agencies providing mental health prevention and treatment. *Head Start programs indicated the lowest relationship-building score in working with home visiting providers.*
- Asked specifically about providing services to children experiencing homelessness, most respondents reported their lowest level of relationship-building in the area of working with the local McKinney-Vento liaison, and similarly low level of relationship-building in working with Title I Directors. Grantees reported the highest score for relationship-building with local agencies serving families experiencing homelessness.
- An overwhelming majority of grantees indicated the highest level of relationship-building in working with TANF agencies, and child welfare agencies, while the lowest level of relationship-building was among Children’s Trust agencies.
- When asked about their relationships with child care agencies, respondents reported the highest level of relationship-building with child care resource and referral agencies. Conversely, the level of relationship-building was lowest in the area of state and regional/planning committees that address child care issues.
- Regarding family literacy services, grantees indicated the highest level of relationship-building with public/private sources that provide book donations or

funding for books, while the level of relationship-building was lowest in the area of working with Even Start.

- Most grantees indicated the highest level of relationship-building with Part C Early Intervention providers – at the level of “Collaboration”, with the lowest level of relationship-building in the area of university/community college programs and services related to children with disabilities.
- In the area of community services, respondents reported the highest level of relationship-building with providers of child abuse prevention/treatment services, and the lowest level of relationship-building was with other agencies in the area of law enforcement.
- When asked specifically about their partnerships with local education agencies, grantees indicated a relationship-building level of “Collaboration” (41.9%), which suggests good progress toward the goal of forging a collaborative relationship.
- In the area of Head Start transition and alignment with K-12, grantees indicated a level of relationship-building of “Collaboration.” This score indicated a very high perception of partnership development between Head Start and K-12 programs.
- In the area of professional development, grantees reported the highest level of relationship-building with institutions of higher education that were community colleges or vocational and trade schools. The lowest level of relationship-building was related to online courses/programs where 25.8% of grantees indicated a level of “No Working Relationship” with service providers.

Nine overall recommendations (with suggested activities) were made to increase relationship-building efforts of Head Start programs. These, along with the finding in one area of the lowest relationship-building score in working with home visiting providers may offer opportunities for collaboration with current and to-be-developed home-visiting efforts in Alabama.

Community-Based Child Abuse Prevention 2011 Annual Report and Application,
Alabama Department of Child Abuse and Neglect Prevention/ Children's Trust Fund

The Alabama Department of Child Abuse and Neglect Prevention/Children's Trust Fund (ADCANP/CTF) was renamed during the 2006 legislative session. As a state entity, ADCANP/CTF was created 27 years ago by legislation with the mission to prevent child abuse and neglect throughout the state. The annual report covers a network of Community-Based Child Abuse Prevention (CBCAP) supported projects administered through ADCANP/CTF for the fiscal year 2009. The CBCAP Program consists of 9 projects located statewide. These programs are composed of community-based programs that include program types such as *home visitation*, parent education and support, respite, and fatherhood. The report describes leadership activities, actions to advocate for systemic changes, prevention plan efforts, collaboration and coordination, outreach activities for special populations and cultural competence, plans for parent leadership and family involvement, plans for support, training, technical assistance and evaluation assistance, and public awareness and education activities.

The purpose of the ADCANP/CTF network is to support the development, operation and expansion of community based programs by providing on-going technical support, training, advocacy, networking and funding opportunities. The larger network of grantees funded by ADCANP/CTF includes 128 organizations and 170 programs that specifically address child abuse and neglect prevention. Some of these programs solely or partially provide home visiting services.

ADCANP/CTF maintains a list of standards to be used to measure initial levels of operation from fiscal management to a service delivery perspective. These standards are currently used in formatting the networking group of high quality family resource centers across the state. The network of family resource centers is composed of 11 member sites and several associate and provisional sites that also receive ADCANP/CTF funding. ADCANP/CTF funded programs will continue to expand and enhance its network of community-based prevention programs by integrating a continuum of family centered and holistic preventive services for children and families throughout Alabama.

During fiscal year 2009, 2,319 individuals (including children and adults) and 2,923 families were participants in direct services. Also, 70,840 individuals received public awareness/education. Finally, 331 individuals received training.

Through review of unmet needs in the state, ADCANP/CTF has the flexibility to expand existing programs and identify new programs anytime during the grant year. Fiscal Year 2011 funding will be used to continue to define and expand a statewide network for children and families in collaboration with local and state departments. In addition, ADCANP/CTF encourages expansion in respite care/voucher services and the development of family resource and support programs in under-served areas of the state. These plans may offer opportunities for collaboration with current and to-be-developed home-visiting efforts in Alabama.

Children's Policy Councils (2009 Needs Assessment Update Summary)

Each year, the Alabama Department of Children's Affairs works with all sixty-seven of the state's County Children's Policy Councils to complete a Needs Assessment. Once the needs are identified, action plans are made and work begins. The Needs Assessment process was changed last year to follow a results accountability model. Realizing that a year is not enough time to effect the changes desired, the decision was made to make the 2009 Needs Assessment an update of the work begun last year. The 2009 Alabama Children's Needs Assessment Update reflects the effort at the county level to insure that children and families have access to needed services and programs. Each county considered ten results for Alabama's children, highlighting accomplishments and selecting results for focused activity. The results, presented in the weighted rank order for the state as a whole, are listed below. Comments describing the results are also presented and are primarily direct excerpts from the update summary.

1. *Families are Strong and Stable.* A family is the basic unit found in communities everywhere and the stronger the family, the stronger the foundation of the community. A strong and stable family promotes social harmony and instills positive values in children, making it more likely that they will grow into responsible citizens.
2. *Children are Healthy.* Creating a healthy environment for children to live, play, and grow. Mentioning childhood obesity, juvenile diabetes, substance abuse, low birth weight babies, and teen pregnancy, communities recognize the cumulative effects of choices and habits.
3. *Children are Successful in School.* Students who have gained self confidence and believe themselves capable of learning may find the success that eludes the less confident students. (tie)

Children Stay Out of Trouble. Communities recognize the need to protect, guide, and direct their young people so that they will have the tools they need to stay out of trouble. Keeping children from getting into trouble is much better than helping them once they are already there. (tie)

5. *Children are Safe.* Providing a safe environment for children so that they will not only grow, but also thrive.
6. *Children are Ready for School.* Being ready for school is more a matter of social, mental and physical readiness for classroom learning rather than a function of age. Additionally, schools and parents must be ready as well, providing the support and tools necessary for children to experience success in school. Many county CPCs realize that children who are not ready for school are the ones who often fall behind academically, are more likely to stay behind, never catch up, and drop out.
7. *Children Transition Successfully to Adulthood.* The demands and responsibilities of navigating the complexities of an adult world can be difficult for those who have been prepared. When no measures have been taken to insure that the transition goes as smoothly as possible, it can be overwhelming for the young person. Communities recognize the essential stability and support needed to make the passage from adolescence to adulthood a positive experience.
8. *Families are Hopeful and Positively Engaged in Their Children's Development.* A family's protective factors can be its greatest asset for children. It is those families who remain hopeful and engaged in their children's development who have the best chance of building a better future for the children.
9. *Communities are Safe, Engaged and Supportive.* It is a community effort to provide the appropriate environment for its children to develop physically, mentally, socially, and emotionally.

10. *Communities are Thriving.* Communities that thrive have hope, optimism, and a positive belief in the future. They have the capacity to be open-minded and not only allow, but invite, people to be exactly who they are and embrace the contributions of each individual.

These results and associated action plans may offer opportunities for local collaboration with current and to-be-developed home-visiting efforts in Alabama.

Alabama Coalition Against Domestic Violence 2010 Annual Report

The Alabama Coalition Against Domestic Violence (ACADV) 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. ACADV is a statewide network of community-based programs providing shelter, support, and advocacy to victims of domestic violence and their children.

ACADV serves domestic violence victims throughout the state through its 19 member shelter programs and 24-hour crisis line for domestic violence. It serves member shelter programs by providing technical assistance; coordinating state certification standards for shelter programs; training all shelter program staff who provide direct services to victims; gathering and analyzing service statistics from all member programs; assisting in the development of Coordinated Community Councils providing a community-wide response to domestic violence issues; coordinating communication efforts of the shelter member programs; and coordinating the cooperative work between shelters and Department of Human Resources.

ACADV also offers statewide planning, educational, and technical assistance on issues of domestic violence, and provides training for a variety of groups statewide. These include volunteers and staff workers in domestic violence, medical personnel, legal advocates and attorneys, law enforcement officials, judicial system personnel, perpetrator intervention personnel, child welfare and public assistance workers, other service agencies, and the faith community.

It is estimated that about 2.3 million people each year in the US are raped and/or physically assaulted by a current or former spouse, boyfriend or girlfriend. Women who were physically assaulted by an intimate partner averaged 6.9 physical assaults per year by the same partner. About 37% of women seeking injury-related treatment in hospital emergency rooms were there because of injuries inflicted by a current or former spouse or intimate partner. Girls and young women between the ages of 16 and 24 years experience the highest rate of non-fatal intimate partner violence. The costs of intimate partner violence annually exceed \$5.8 billion, including \$4.1 billion in direct healthcare expenses, \$900 million in lost productivity, and \$900 million in lifetime earnings.

Activities of Alabama domestic violence programs were recorded as a part of a September 2009 24-hour census survey. Alabama results for that one day follow:

- 834 victims served
- 187 hotline calls answered
- 787 educated in prevention and education trainings
- 76 unmet requests for services in one day
 - Programs were unable to provide services for many reasons
 - 33% reported not enough funding for needed programs and services
 - 33% reported not enough specialized services
 - 22% reported not enough staff
 - 17% reported no available beds or funding for hotels
 - 11% reported limited funding for translators, bilingual staff, or accessible equipment

In 2009 in Alabama, hands, fists, or feet were used as a weapon in 48% of the offenses. There were 34 domestic violence (DV) homicides, 1,615 DV aggravated assaults, and 29,940 DV domestic simple assaults (data from the Alabama Criminal Justice Information Center Domestic Violence Statistical Analysis Report 2008 – the latest data available). Between October 2008 and September 2009, ACADV served 1,828 adult and 1,650 child victims in shelters, provided outreach and out-of-shelter services to 10,440 adult victims, and received 16,562 crisis hotline calls. The goals, projects, and initiatives of ACADV may offer opportunities for state and local collaborations with current and to-be-determined home-visiting efforts in Alabama.

Overall, these existing needs assessments portray Alabama as a small state facing numerous challenges that could negatively impact children and their families. A number of the needs assessments reviewed above suggest that there are opportunities for cooperation and collaboration at the community level where new home visiting efforts may be targeted.

Section 1. Statewide Data Report

This statewide data report uses the most recent data to serve as a baseline to which at-risk communities are to be compared. Table 1 provides data related to each of the indicators as outlined in Appendix A of the Supplemental Information Request. Although we reviewed the Title V and other needs assessments, many of the indicators

were not available in those documents. Information from CAPTA and Head Start needs assessments were largely qualitative and those data were not specifically applicable to this section. Therefore we utilized supplementary documents and resources to complement the information. Unless otherwise specified, information about measures, sources, and years are included in Table 2 along with the explanation of the composite score. Importantly, in some cases more recent data were available at the state-level or the methods for collecting the data were slightly different. Therefore comparisons with national data should be considered with caution. Where appropriate and available, confidence intervals were reported for estimates.

As noted in the background section, Alabama is a state of that ranks as one of the lowest in relation to many health, social, educational, and other outcomes. Most of the indicators included below were higher (worse) than the national average. For example, the national average for low birth weight in 2006 was 8.3 %. In Alabama, the rate was 10.6 %. However, reported use of substances including alcohol, marijuana, and illicit drugs were lower compared to the national averages reported in the SAMSHA Data Reports.

Section 2. Unit Selected as Community

Overall Approach to the Identification of At-Risk Communities in Alabama

The State has defined “communities” as counties, primarily because of the availability of appropriate data elements at that level. Both quantitative and qualitative data have been utilized for measurement of the data elements. Based on the ecological model, our goal was to examine elements of society and community that affect child health and development outcomes. Table 2 provides the factors and associated measures and data sources utilized in the determination of at-risk communities in Alabama. Many of these, including low birth weight, infant mortality, and poverty are known to be highly related to each other. All data were analyzed at the county level, except in a few instances in which data were only available on a regional level. A composite score was given to each county based on these indicators and counties were ranked according to the composite score. The County Health Rankings project, a component of Mobilizing Action Toward Community Health (MATCH), a joint project between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute (<http://www.countyhealthrankings.org/about-project/ranking-methods>), as well as other research efforts (Goldenhagen, et al., 2005) specifically related to child health, have utilized specific methods to create composite scores. These and other methods from the research literature were explored. A detailed description of the process used to create our county rankings and levels of risk follows.

Creation of weighted composite score

To identify communities at-risk, we created a composite score for each of the 67 counties in the state. The composite score consists of indicators that are included in the Supplemental Information Request, other measures of child health and well-being (County Health Rankings, America’s Children, Goldenhagen et al), and indicators that family and child health experts in Alabama (HVNAC) deemed appropriate and relevant to the identification of at-risk communities. The composite score includes specific indicators and measures in 5 different areas: Family and Social Environment; Economic Circumstances; Physical Environment and Safety; Health Behaviors; Education; and Health and Health Care. Table 2 presents each area with its specific measures, definitions, data sources, and years of data utilized. Table 2 includes all of the indicators required in Appendix A; however, others were added.

To create the composite measure, we gathered data from these sources (noted in Table 1) on the chosen indicators. In addition to these indicators of risk, we also included the percent of children under age 5 as compared to the total number of children under age 5 in the State. Our goal in including this measure was to consider counties with the highest density of children under age 5. We calculated quintiles for each indicator, except for those related to substance abuse (binge alcohol use, marijuana use, nonmedical use of prescription drugs, and illicit drugs) as these measures were only available for the 4 Mental Health regions. If a county had an indicator that fell in the 5th quintile (ranked either highest or lowest depending upon the indicator) it received a

score of 1. Substance abuse measures in the top quartile received a score of 1. Other quintiles or quartiles received a score of 0.

As part of our survey process and seeking stakeholder input, we then asked our HVNAC to rank the agreed upon indicators on a scale of 1-7, with 1 being “not at all important” to 7 being “the most critical”. We utilized the average score of these rankings as the weight for the given indicator. Weights are included in Table 1 as well. For example, the HVNAC gave single parent households a score of 4.00. Counties that did not fall into the top quintile for this indicator maintain a score of zero for that indicator. Counties that were in the top quintile for this indicator received a score of 4. We followed this procedure for each indicator and summed the results. Table 3 provides the list of counties with the highest weighted composite scores as well as population information about each county.

Figure 2 provides the geographic location of the at-risk counties. Notably 10 of the 13 counties are in the Black Belt region of the state. The “Black Belt” is a crescent-shaped region reaching from Texas to Virginia and is named for its rich, dark-colored soil. Nineteen Alabama counties, mainly located in the southwestern part of the State, are located in the Black Belt. Alabama’s Black Belt includes some of the poorest counties in the US. In addition to high rates of poverty, the area has declining populations, low density settlement, high unemployment, and poor access to education and medical care.

Section 3. Data Report For Each At-Risk Community in the State (n=13)

The following section provides information on each of the at-risk communities for Alabama. When possible, we tried to utilize the same data source for the state level indicator as for the county or community level indicator. However, in most cases county-level data were not available from the Title V or other needs assessments. These needs assessments were reviewed for relevant information and data were included in this section if appropriate. Data related to substance abuse is reported at the regional level. Also presented in the text is information related to resources specific to home visiting for the county.

Ten of the thirteen counties identified as at-risk are located in Alabama's Black Belt. Many of these at-risk counties are among the counties with the highest overall and under 5 poverty rates. Most counties have less than 1% of the total state population residing in them (see Table 2). As part of the composite score we considered the proportion of children less than age 5 in the county relative to the state 0-5 population. The at-risk indicators in these counties outweighed the small numbers of children in these counties. Description of high rates of these indicators is relative to state-level data. Poverty is a common thread between all of these counties; however, the issues related to their at-risk nature are slightly different. In the brief descriptions of each at-risk county we did not include information related to substance abuse as that is covered in-depth in following sections. Figures 3 and 4 illustrate the locations of existing home visiting programs (Fig 3) and other community resources (Fig 4).

Greene County (Table 4a)

Greene County is located in the Black Belt region of the state. Less than 1% (0.178) of the 0-5 population for the state of Alabama lives in Greene County. Almost 80% of the population is non-white. The majority of the population is over the age of 15. Most indicators for this county are higher than the state average. However, due to the small number of births the infant mortality rate is unstable. Greene County has 1 Family Resource Center and 1 Head Start program.

Dallas County (Table 4b)

Dallas County is located in the Black Belt region of the state. Slightly more than 1% (1.04) of the 0-5 population for the state of Alabama lives in Dallas County. Almost 70% of the population is non-white. The majority of the population is between 15 and 64

years of age. Marked by high rates of low birth weight, poverty, crime, domestic violence, high school dropouts, teen pregnancy rates, unmarried mothers, low 3rd grade SAT scores, and less than adequate prenatal care, this county has one Family Resource Center, 2 mental health centers, 4 Head Start programs, and 1 HIPPY program.

Barbour County (Table 4c)

Barbour County is also located in the Black Belt region of the state. Less than 1% (0.59) of the 0-5 population for the state of Alabama lives in Barbour County. About 5% of the total population within the county is less than 5 years of age. About 42% of the population is between 15 and 44 years of age. Slightly less than half of the population is non-white. Marked by high rates of low birth weight, poverty, unemployment, domestic violence, high school dropouts, unmarried mothers, low 3rd grade SAT scores, and less than adequate prenatal care, this county has one Family Resource Center, 1 Head Start program, and 1 HIPPY program.

Macon County (Table 4d)

Macon County is also located in the Black Belt region of the state. Less than 1% (0.33) of the 0-5 population for the state of Alabama lives in Macon County. Slightly more than 5% of the total population within the county is less than 5 years of age. About 44% of the population is between 15 and 44 years of age. About 85% of the population is non-white. Marked by high rates of most indicators, including low birth weight, poverty, unemployment, domestic violence, high school dropouts, unmarried mothers, low 3rd grade SAT scores, and less than adequate prenatal care, this county has one Mental Health Center, 6 Head Start programs, and 1 HIPPY program.

Sumter County (Table 4e)

Sumter County is another high-risk county located in the Black Belt region of the state. Less than 1% (0.25) of the 0-5 population for the state of Alabama lives in Sumter County. Slightly more than 5% of the total population within the county is less than 5 years of age. About 41% of the population is between 15 and 44 years of age. Almost 75% of the population is non-white. Marked by high rates of poverty, crime, unemployment, high school dropouts, teen pregnancies, unmarried mothers, and low 3rd grade SAT scores, this county has 2 Family Resource Centers, 1 Mental Health Center, 6 Head Start programs, and no known home visiting programs.

Perry County (Table 4f)

Perry County, also located in the Black Belt region of the state, has less than 1% (0.25) of the 0-5 population for the state of Alabama. Slightly more than 7% of the total county population is less than 5 years of age; about 38% of the population is between 15 and 44 years; and almost 70% is non-white. Marked by high rates of infant mortality, poverty, unemployment, teen pregnancies, unmarried mothers, low 3rd grade SAT scores, and less than adequate prenatal care; this county has 2 Family Resource Centers, 1 Mental Health Center, 2 Head Start programs, and 1 HIPPIY program.

Russell County (Table 4g)

Russell County is one of three at-risk counties not located in the Black Belt region of the state. Its eastern border is Georgia. Slightly more than 1% (1.10) of the 0-5 population in the state lives in this county. Almost 7% of the total population is less than 5 years of age; about 38% is between 15 and 44 years; and more than 44% of the population is non-white. Marked by high rates of infant mortality, poverty, crime, domestic violence, high school dropouts, unemployment, and child maltreatment; this county has 1 Family Resource Centers, 3 Mental Health Centers, 2 Head Start programs, and no known home visiting programs.

Wilcox County (Table 4h)

Wilcox County is in the Black Belt region. Less than 1% (0.28) of the 0-5 population for the state lives in Wilcox County. More than 7% of the total population within the county is less than 5 years of age; about 36% of the population is between 15 and 44 years of age; and almost 73% of the population is non-white. Marked by high rates of low birth weight, poverty, high school dropouts, unemployment, teen pregnancy, low SAT scores, and less than adequate prenatal care utilization; this county has 1 Family Resource Center, 1 Mental Health Center, and no known home visiting programs.

Bullock County (Table 4i)

Bullock County is also in the Black Belt region of the state. Less than 1% (0.28) of the 0-5 population in Alabama lives in Bullock County. Slightly more than 7% of the total population is less than 5 years of age; about 44 % of the population is between 15 and 44 years of age; and almost 72% of the population is non-white. Marked by high rates of low birth weight, poverty, high school dropouts, unemployment, teen pregnancy, unmarried mothers, undereducated mothers, low SAT scores, and less than adequate prenatal care utilization; this county has 1 Head Start program and no known home visiting programs.

Conecuh County (Table 4j)

Conecuh County is another high-risk county located in the Black Belt region. Less than 1% (0.25) of the 0-5 population in the state lives in Conecuh County. Almost 6% of the total population within the county is less than 5 years of age; slightly more than 36% of the population is between 15 and 44 years; and about 44% of the population is non-white. Marked by high rates of low birth weight, poverty, high school dropouts, unemployment, unmarried mothers, undereducated mothers, low SAT scores, and less than adequate prenatal care utilization; this county has 1 Head Start program and 1 HIPPY program.

Tuscaloosa County (Table 4k)

Tuscaloosa County is one of three at-risk counties not located in the Black Belt region of the state. It is the at-risk county with the highest population. Almost 2% (1.6) of the 0-5 population for the state of Alabama lives in Tuscaloosa County; almost 6% of the total population within the county is less than 5 years of age; slightly more than 46% of the population is between 15 and 44 years; and more than 33% of the population is non-white. Marked by high rates of infant mortality, poverty, crime, juvenile crime, domestic violence, high school dropouts, low SAT scores, and less than adequate prenatal care utilization; this county has 2 Family Resource Centers, 9 Mental Health Centers, 3 Head Start Programs, and 1 HIPPY program.

Chambers County (Table 4l)

Chambers County is one of three at-risk counties not located in the Black Belt region of the state. Less than 1% (0.65) of the 0-5 population for the state lives in the county; about 6% of the total county population is under 5 years; just over 37% of the population is between 15 and 44 years of age; and more than 39% of the population is non-white. Marked by high rates of poverty, juvenile crime, domestic violence, high school dropouts, unemployment, births to unmarried mothers, and low SAT scores; this county has 1 Family Resource Center, 3 Head Start Programs, and 1 Parents as Teachers program.

Lowndes County (Table 4m)

The last of the ten high-risk counties located in the Black Belt region is Lowndes County. Less than 1% (0.27) of the 0-5 population of the state resides in Lowndes County. About 7% of the total population is less than 5 years of age; almost 40% of the

population is between 15 and 44 years; and more than 70% of the population is non-white. Marked by high rates of low birth weight, poverty, high school dropouts, unemployment, child maltreatment, births to unmarried mothers, low SAT scores, and less than adequate prenatal care; this county has 1 Family Resource Center, 3 Head Start Programs, and 1 HIPPY program.

Section 4. Quality and Capacity of Existing Programs in At-Risk Communities

The following section provides information about existing home visiting programs in the state. Figure 3 shows the location of the five nationally recognized models by county.

Capacity

The following programs are totally or partially supported by state funds in Alabama:

1. Program Name: Home Instruction for Parents of Preschool Youngsters (HIPPY)*

Model Used: HIPPY Model

Services Provided: 30 weeks of home visits with lessons to assist parents with school readiness. Group meetings reinforce lessons learned in the home. Children can be enrolled for up to three years. Children are tested for school readiness.

Intended Recipient: Parents of 3, 4, or 5 year-old educationally and financially at-risk children

Targeted Goals/Outcomes: To teach parents the skills they need to assure their children enter school knowing letters, shapes colors, increased vocabulary, and a wide variety of school readiness skills

Demographic Characteristics of Those Served: Reflect the characteristics of families in the communities in which the programs are located – typically low income

Number of Individuals Served: 1512 families with 1601 children

Geographic Area Served: 26 counties (2 emerging sites) spread across the 67 counties of Alabama. One HIPPY program is located in 7 of the 13 communities identified as high-risk through this needs assessment.

*Data from 2008-09 program year

2. Program Name: Parents as Teachers (PAT)*

Model Used: Parents as Teachers

Services Provided: 1. Personal Visits-- At least monthly visits to each family during its program year - completed more than once a month to each family with program-defined high needs.

2. Group Meetings--At least monthly group meetings.

3. Screening--All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year. Developmental screening includes

screening in the areas of language, intellectual, social-emotional, and motor development through the use of instruments approved by the PAT National Center. 4.Resource Referral--The program links with organizations that advocate for and support the families and children that the program serves.

Intended Recipient: Infants and young children (birth-5 years) and their parents

Targeted Goals/Outcomes: The program's goals include increasing parent knowledge of early childhood development and improving parenting practices; providing early detection of developmental delays and health issues; preventing child abuse and neglect; and increasing children's school readiness and school success.

Demographic Characteristics of Those Served: Families are assessed for need on a variety of factors (for example, teen mom, child with disability, recent death in the family, low income). According to 2008-2009 data, 70 % of PAT families were characterized by high needs (5 or more risk factors) and approximately 40 % of PAT families represented minority populations.

Number of Individuals Served: 1,069

Geographic Area Served: PAT is available in 17 locations; 13 of these locations are in rural areas or small towns, the remaining locations are in urban areas; 10 programs target specific geographic areas. One of the PAT programs is located in one of the counties we have identified as high-risk.

*Data based on reports from 16 of 17 programs in 2009-2010 Annual Alabama report.

4. Program Name: Nurse-Family Partnership*

Model Used: Nurse-Family Partnership

Services Provided: Nurse-Family Partnership is a free, voluntary program that partners first-time moms with nurse home visitors. When enrolled in the program, a specially trained nurse visits the expectant mother throughout pregnancy and until the baby turns two years old. During these visits, a nurse offers the knowledge and support needed to confidently create a better life for the baby and mother.

Intended Recipient: Low-income pregnant first-time mothers

Targeted Goals/Outcomes: 1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances; 2. Improve child health and development by helping parents provide responsible and competent care; and 3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Demographic Characteristics of Those Served: primarily low-income, first-time pregnant teens who live in Montgomery County

Number of Individuals Served: 100

Geographic Area Served: One program in Montgomery, Alabama and surrounding area in central Alabama. This county was not included in our high-risk county group as identified in this needs assessment.

* Data were from 2009 statewide survey and websites.

5. Program Name: Healthy Families America*

Model Used: Healthy Families

Services Provided: Voluntary home visiting model that initiates services prenatally or at birth and incorporates a comprehensive approach to meeting the families' needs if additional services are needed. Offer services to families for 3-5 years duration.

Intended Recipient: Program is designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. Families are identified through the use of a standardized assessment tool to systematically identify families who are most in need of particular services.

Targeted Goals/Outcomes: 1. To systematically reach out to parents to offer resources and support; 2. To cultivate the growth of nurturing, responsive, parent-child relationships; 3. To promote healthy childhood growth and development; and 4. To build the foundations for strong family functioning

Demographic Characteristics of Those Served: First-time parents who are Medicaid-eligible and live in Madison County.

Number of Individuals Served: 76

Geographic Area Served: Madison County and Huntsville City in north central Alabama. These areas were not included in the high-risk areas identified by this needs assessment.

* Data were from 2009 statewide survey and websites.

There are several other smaller programs in the state utilizing a variety of curricula, such as Baby TALK. Very little information is available on these programs, thus, they were not included in the home visitation resources available in the state.

Table 5 lists each of the high-risk communities identified through the above process of creating risk scores for each county in the state. For each county we have shown what home visiting programs are currently in that county and how many children those programs served. We used the percent of children under 5 living in families below the

FPL as a proxy for general risk in those counties and lastly we show what percent of the >5 year olds the home visiting programs are currently serving. To further understand the relationship between resources and need, we have included a map (See Figure 4) that shows the high-risk communities, existing home visiting programs, Head Start programs, and Family Resource centers. Notable but not included on this map each county has a health department. Additionally 25 other Early Head Start programs exist but Figure 4 only includes the home visiting Early Head Start program. The need is great and the resources, especially home visiting programs are few or non-existing in our identified communities at risk. None of the major military installations in Alabama were in the high-risk areas. As noted, a representative from the Family Advocacy Program at one of these installations served on the HVNAC, but did not participate in our survey or focus group. Additional information may need to be gathered prior to final decisions regarding the geographic placement of additional home visiting programs and services. As Table 5 clearly shows there is virtually no duplication, but there are great gaps in early childhood home visitation services in the identified communities.

Quality of Existing Home Visiting Programs

In addition, to using information from state level agencies that collected various pieces of data to describe home visiting programs in the state, we asked parents who previously had participated in a home visiting program and some parents who had not participated what is their perception of home visiting in Alabama. Further we conducted five focus groups to add to our understanding of the strengths and challenges inherent in the current home visiting programs in Alabama. Focus group participants included two groups of parents who currently were or previously had received home visiting services, a group of parents who had not received home visiting services, a key agency personnel group, and a home visiting provider group.

Survey/ Focus Groups of Parents Who Have Participated in Home Visiting Programs

Participants: One hundred twenty parents who previously participated in a home visiting program completed this survey.

Rating their Experience: When asked to rate their home visiting experience on a scale of 1 to 10 with 1 being the worst and 10 being the best, the majority of respondents indicated a score of 10 (78.2%) or 9 (10.1%). This was also a major theme in the focus groups for parents who have received home visiting services.

Positive Aspects of Home Visiting: More than half of respondents also indicated that the best things about home visiting programs included services being delivered in the home (61.3%), the home visitor/parent educator (60.5%), and the lessons the home visitor taught the parent (55.5%). Other parents and caregivers indicated that the lessons the home visitor taught the child (36.1%) and other reasons (7.6%), such as getting the child ready for school and having someone to talk to, were the best things about the program. The focus groups identified that parents consider home visiting to be very beneficial to their child(ren), a “safe, comfortable, and convenient place to talk”, and a cost-free “support system.”

What Would You Change: Most parents reported that they would not change anything (78%), while others would like to have more visits each week/month (11%), or thought the program should be longer (10.2%). Few respondents listed other reasons (2.5%), such as the need for better communication and harder lessons, as well as the time of day the home visitor came (1.7%), and changing the program curricula (1.7%) as being issues to change. Some parents felt that there is a need to better delineate the differences between home visiting and the Department of Human Resources to establish greater trust for those newly or not yet receiving home visiting services. Overall, most parents considered the home visiting programs to be a great, helpful resource for themselves and their child(ren).

Survey/ Focus Group of Parents Who Have Not Participated in Home Visiting Programs

Participants: Seventy-three parents who had never participated in a home visiting program completed this survey.

Why Haven't Participated: Most parents indicated that they had never been asked to participate (69.7%). Other respondents indicated that their child(ren) were not the right age (16.7%), and other reasons (16.7%), such as not wanting to participate or not having child(ren). Few respondents indicated having the opportunity but choosing not to participate (6.1%), the possibility of not being able to afford the program (6.1%), and the lack of program availability in their area of the state (3%) as being reasons for not participating.

Would You Participate: Half of parents indicated that they would participate in a home visiting program if asked, while the other half indicated that they either would not (25.8%) or were not sure (25.8%). The focus group identified that additional factors that determine participation in home visiting are parents' difficulty identifying home visiting services in certain areas and lack of knowledge about what home visiting services are available in their areas. Some parents voiced that they would not be interested in receiving home visiting services because it would be insulting to have someone judge them, their parenting skills, and the way they raise their child(ren).

Desired Results: About half of parents listed improvement of parenting skills (53.3%) and learning how to teach their child what he/she needs before school (43.3%) as being important. Some parents indicated learning about community resources for their family (38.3%), and having someone to talk to about their child(ren) (31.7%) as being desired results. One quarter of respondents indicated other more general reasons for participating in home visiting such as learning as much as possible, to have an "extended support system," or to have a "refresher course" on parenting.

Thoughts About Home Visiting: In listing other thoughts about home visiting, many parents stated that these services should be available to all families (regardless of income or disability) and that more parents should be informed and made aware of the home visiting programs that are available. Participants believe that the stigma/mistrust

surrounding home visiting will need to be resolved for more caregivers to want to take advantage of the services. Numerous parents believe that home visiting is a good model because it allows children to receive services in an environment in which children and parents are comfortable. Some parents stated that participation in these programs would help parents to better care for their child(ren), intervene early to better prepare them for entering school, and improve the overall health and wellbeing of families.

Challenges: The overwhelming message regarding the home visiting services was that they are a very positive approach to delivering early childhood supports and services. For those parents who had no experience with home visiting, the fear that a home visitor would judge them, or report them to DHR or other authorities was a fairly common theme. Even some families who had experience with home visiting indicated that they were leery initially of what home visiting is intended to do. This general fear of strangers prodding into a family's business and mistrust of some types of authority, especially in the rural south, will need to be carefully considered in moving forward with expansion of home visiting services in Alabama.

Summary: Based on the level of risk that is prevalent in many Alabama counties/communities and the particular risks faced in the communities we have identified through this needs assessment, the need for early childhood supports and services is great. Further, the dearth of resources in many of our targeted counties intensifies the risk for intergenerational poverty and the associated potential for poor outcomes for young children and their families. These targeted communities are not being identified for the first time as communities in great need. By providing services to fill the resource gaps for young children and their families there is an opportunity to improve the outcomes for the next generation of Alabamians in these mainly rural communities.

Section 5. Substance Abuse Treatment and Counseling

Based on information in the 2009 Annual Report of the Alabama Department of Mental Health (ADMH), Substance Abuse and Treatment Division, federal studies indicate that more than 300,000 Alabama citizens are in need of intensive outpatient substance use disorder treatment every year. With currently available resources, ADMH is able to provide services for approximately 25,000 citizens yearly. On any given day, there are more than 600 individuals who have been assessed to need treatment, yet remain on a waiting list for services. Table 6 presents data related to the need but lack of receipt of treatment for both alcohol and illicit drug use in the past year. These data are only available at the Mental Health region level and are reported as such in the table. County-level information was available and reported regarding the number of families in the county served by the Alabama Department of Mental Health Division of Substance Abuse Services. Based on available data, we were able to identify resources within both mental health centers and Family Resource Centers located within each county (if applicable) that provides services related to substance abuse.

Region 2 has the highest percent estimate of those needing but not receiving alcohol treatment. Region 3 has the highest percent estimate of need for illicit drug use treatment. It is important to note that although data on substance abuse was included for the composite score for at-risk communities, it is difficult to assess real need at the county level. Further examination of these issues must be included in the Updated State Plan.

Ten of the thirteen at-risk counties are in Mental Health Service Region 3. Programs and services were identified through resources from Alabama Department of Mental Health and the Family Resource Center information. We were not able to identify any resources related to substance abuse in Bullock and Conecuh counties. However, there are neighboring counties not identified as at-risk that have multiple provider sources and resources. We will examine transportation issues and other access issues further.

Section 6. Summary

Findings of Home Visiting Needs Assessment

Upon examination of the key indicators contained in the Supplemental Information Request and other materials related to the Statewide Needs Assessment for the state of Alabama and comparing Alabama's rankings and ratings compared to other states and the US as a whole, a picture begins to emerge of a small (4.7 million people), mostly rural, resource-poor state with a few population centers in which resources are more readily available. With Alabama's overall ranking of 47th in the nation in the Kids Count 2010 measure of child well-being, it is clear that many children are living in environments within and outside the home that are less than ideal for optimal health and development.

Data Issues

In searching for data sources for the mandated indicators as well as the state-selected indicators, it became clear that the smallest geographic unit for which we were likely to receive or retrieve data related to the risk indicators was the county level. We were able to obtain county level data for all our indicators except the substance abuse indicators, which were reported only by the four state mental health regions. Substance abuse services data were available at the county level. Additional data for towns or other geographic designations would be helpful to further define the most advantageous location for future resources, especially home visiting resources.

Identification of risk becomes a particular challenge in counties with larger populations with resources. Figure 5 illustrates this issue for Jefferson County, which is not an at-risk county but is the most populous county in the state. Risk indicators produce a moderate composite score for this county. However, when considering resources, the distinction between urban and rural may create disparities not measurable at the county level. Madison, Mobile, and Montgomery counties are similar.

High-risk Communities and Home Visiting

The methods for the initial identification and prioritization of communities/counties regarding their risk status are described in Section 2. Throughout this needs assessment we used quantitative data if they were available to apply objective criteria to the indicator being measured. We also recognize that home visiting occurs within the cultural context of the state and the communities within the state. Thus, we wanted to assure that the voices of all the stakeholders were heard and incorporated into this assessment. In calculating the final composite scores to determine at-risk communities, we also took into account the knowledge and experience of our stakeholder Home Visiting Needs Assessment Advisory Committee. Members of the HVNAC rated the importance of various indicator items and these scores were applied to the composite county risk scores to create the final weighted composite score for each county. Thirteen of the sixty-seven counties were ranked in the highest quintile based on their scores on the indicators of risk and the weights.

Gaps in Services in High-Risk Communities

A common definition of a need is the difference between an ideal or desired state and the current or existing state. Thus, to further determine need in the identified high risk communities, we located and mapped various resources. As can be seen in Figure 2, the high-risk communities are located in the southern half of the state and the majority of the resources are located in the northern half of the state or near the urban centers of Huntsville in the north, Mobile in the south, and Birmingham in central Alabama. If we look at home visiting resources alone, as is shown in Table 5, five of the thirteen at-risk communities have no home visiting services at all and the others only have one program that serves small proportions of the potential population in need. Similarly, in relation to other resources, such as Family Resource Centers, Head Start and Early Head Start Programs, and Mental Health Centers there is an uneven distribution of those resources. Some counties/communities have only a Family Resource Center and a Head Start Program (Greene County) or only a Head Start program (Bullock County). Further, these 13 communities have only about 5% of the total population of the state, yet they have about 9% of the total child population under the age of 5.

How will State Address the Needs

It is likely that Alabama will take a multi-county approach to addressing the gaps in home visiting services in the high-risk communities/counties identified. The counties cluster in three groups with Tuscaloosa, Green and Sumter in one group; Perry, Dallas, Wilcox, Lowndes and Conecuh in a second group and Chambers, Macon, Bullock, Russell, and Barbour in the third group. Planning meetings will need to be held with key leaders in the early childhood, mental health, and public health interest areas to develop an infrastructure and leadership for the expanded home visiting effort. Once the structure is in place for the administration and supervision of the programs, the implementation stage can begin. The State plans to apply for federal grant monies to assist in the planning and implementation of this expanded home visiting effort in Alabama.

Figure 1. Poverty Information for Alabama by County

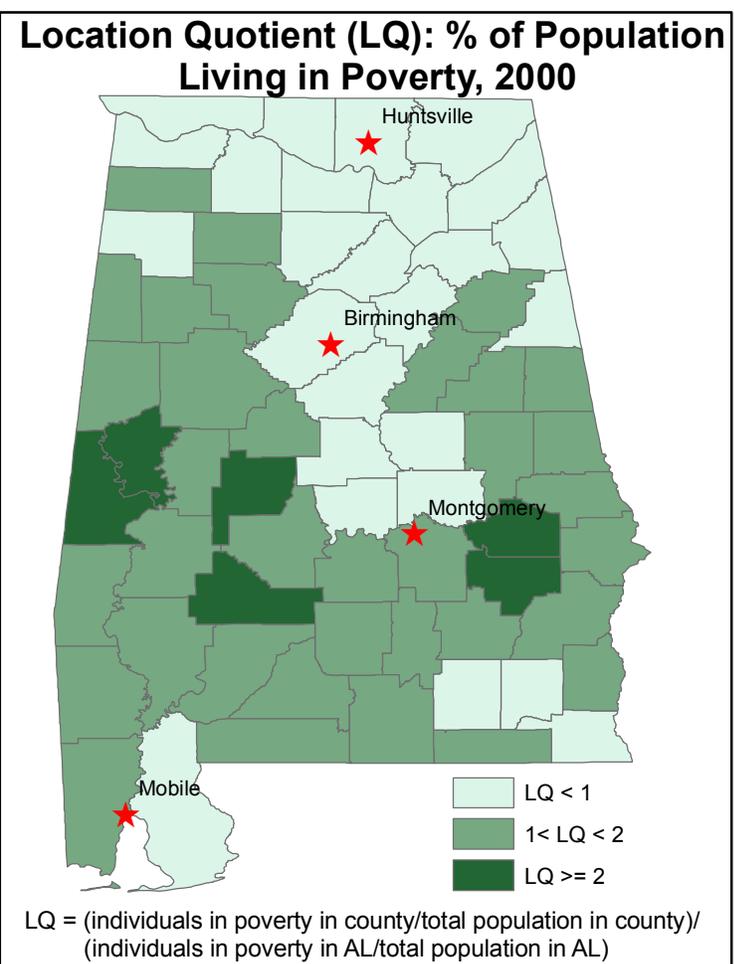
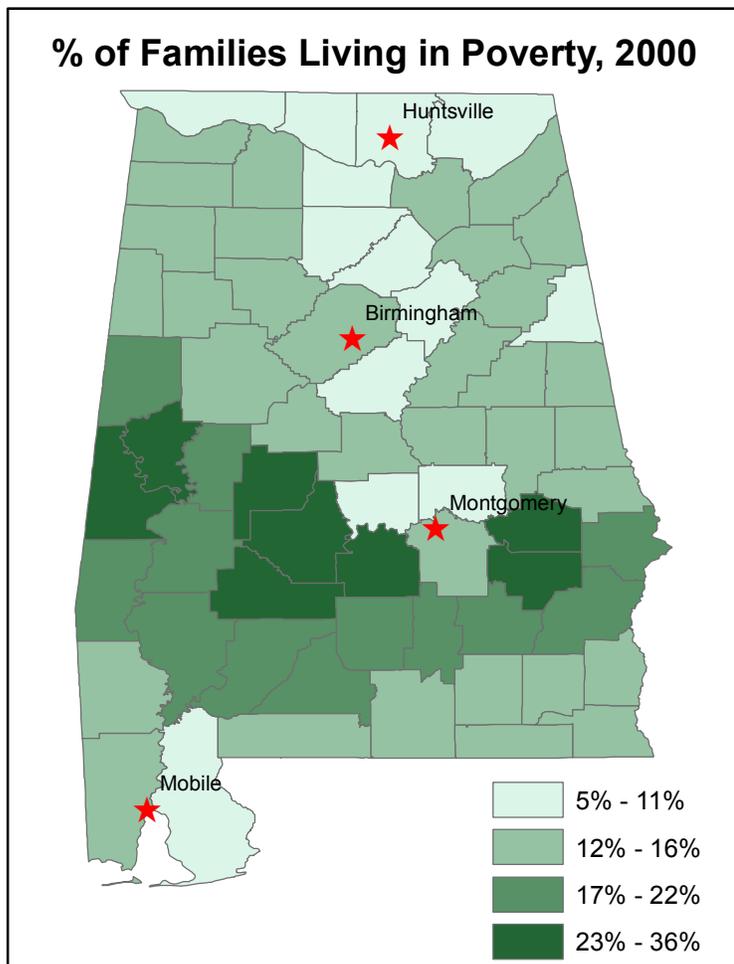
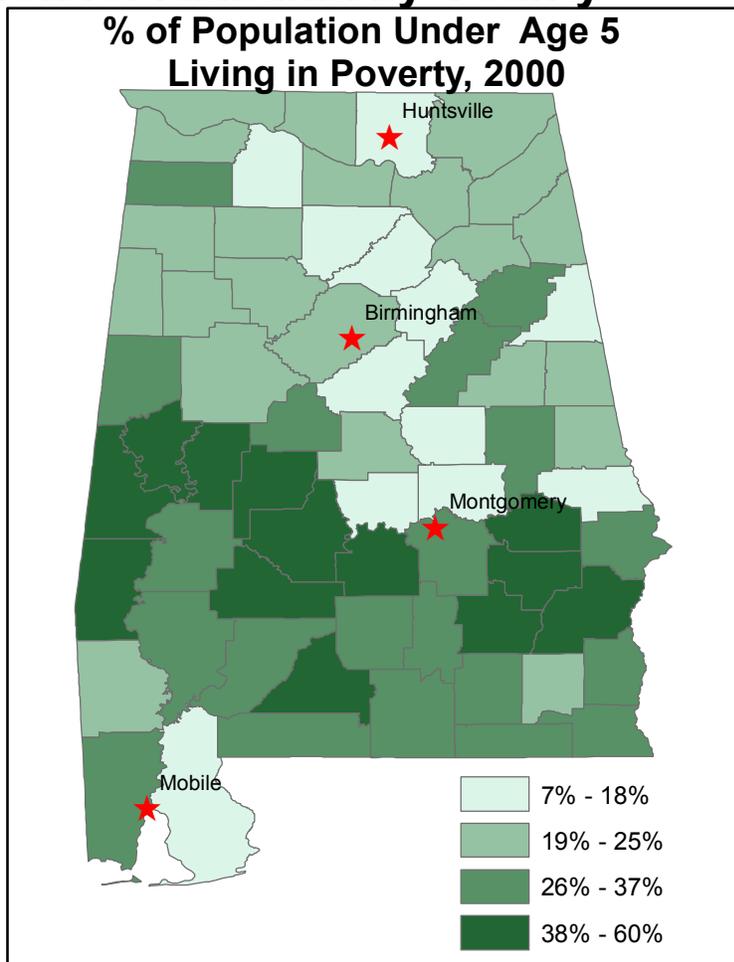
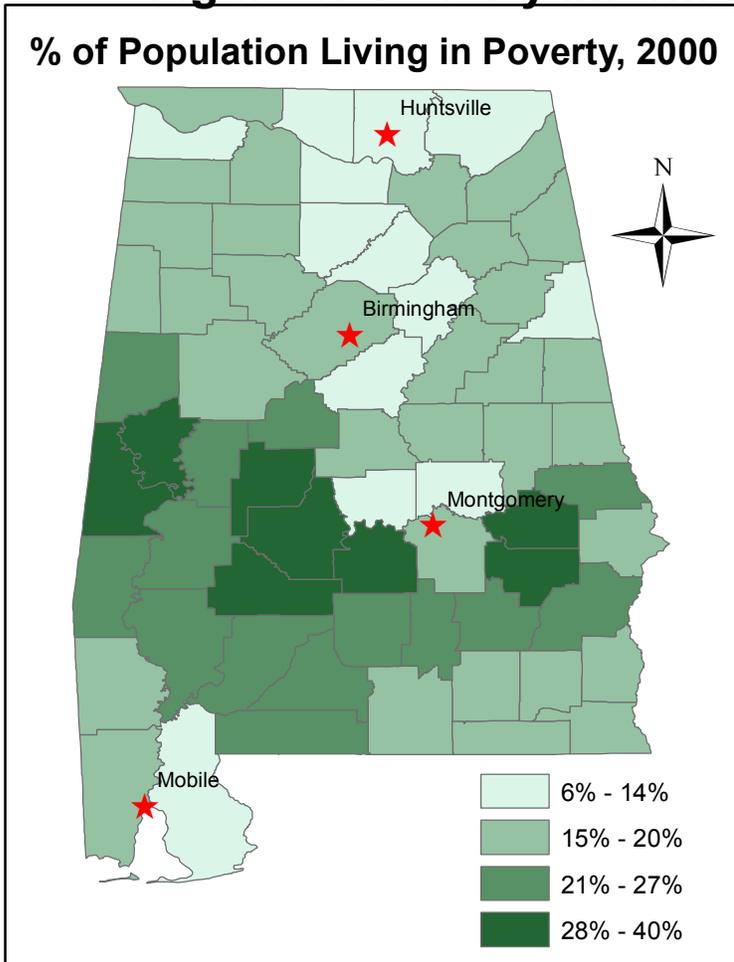
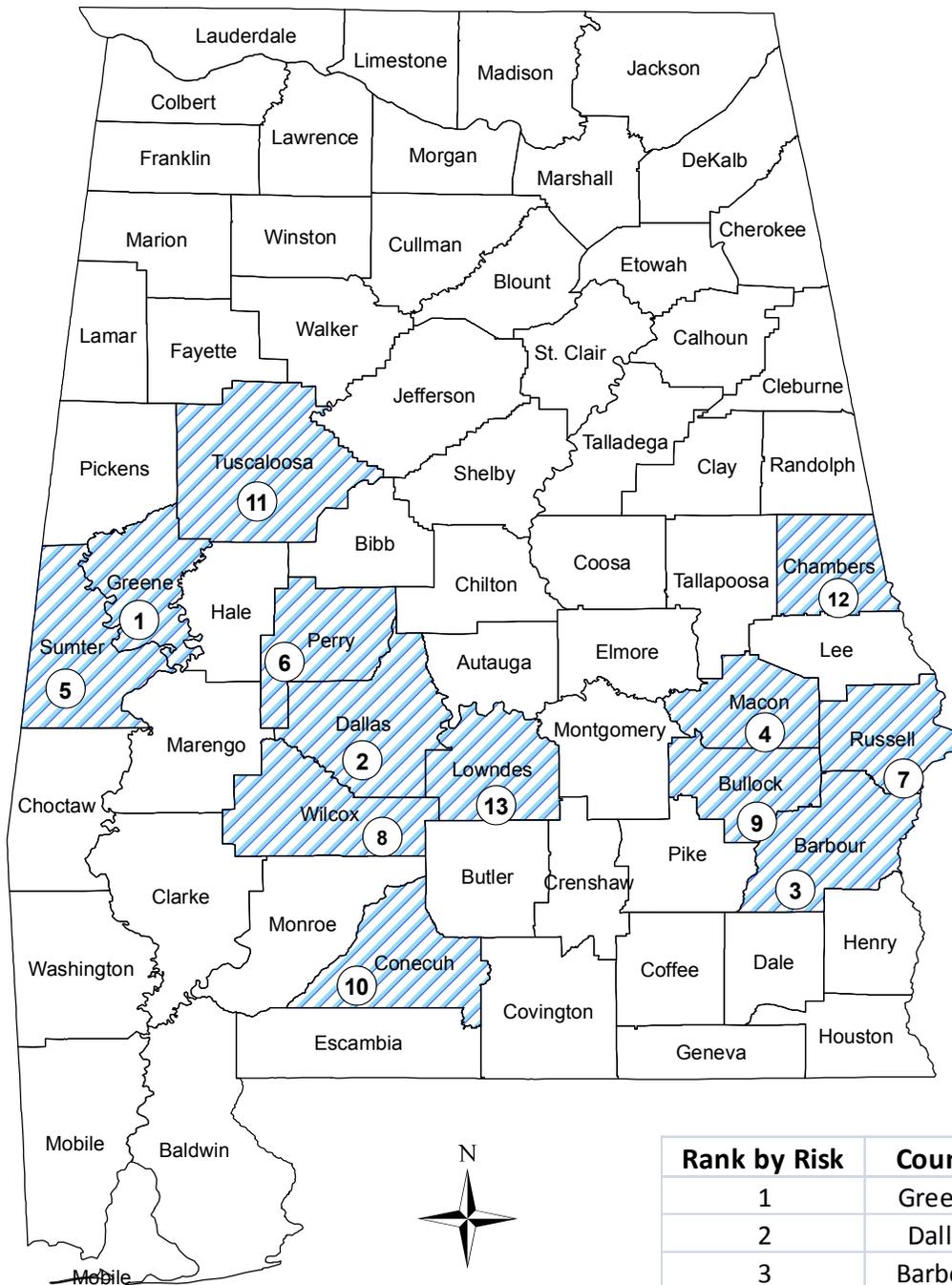


Figure 2. Communities Identified as At-Risk



Legend

 Communities At Risk

Rank by Risk	County	Composite Score
1	Greene	49.37
2	Dallas	48.42
3	Barbour	44.04
4	Macon	43.8
5	Sumter	43.41
6	Perry	40.33
7	Russell	39.62
8	Wilcox	39.32
9	Bullock	39.21
10	Conecuh	38.86
11	Tuscaloosa	35.77
12	Chambers	34.33
13	Lowndes	33.66

Figure 3. Existing Home Visiting Programs in Counties At-Risk, 2010

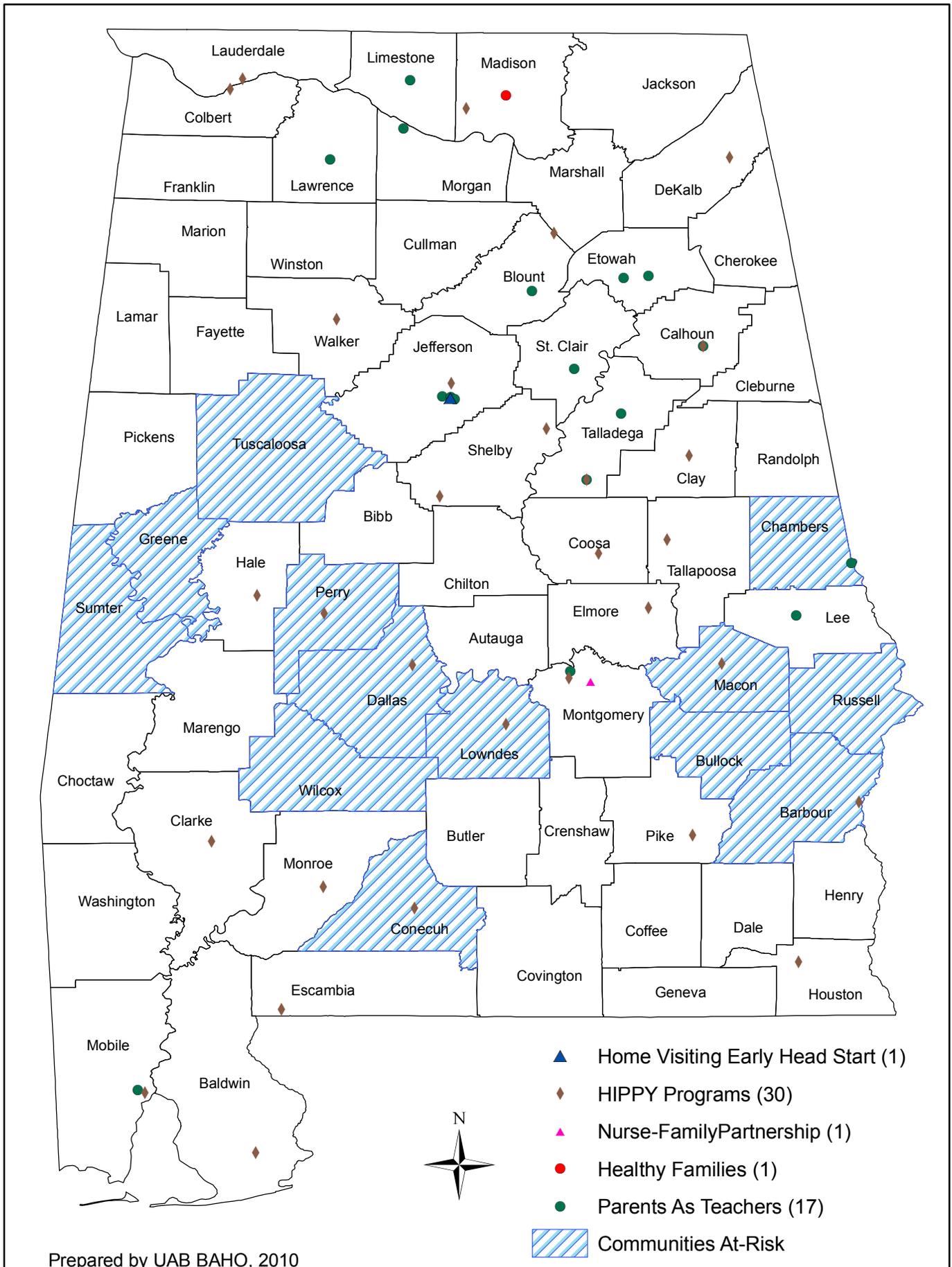
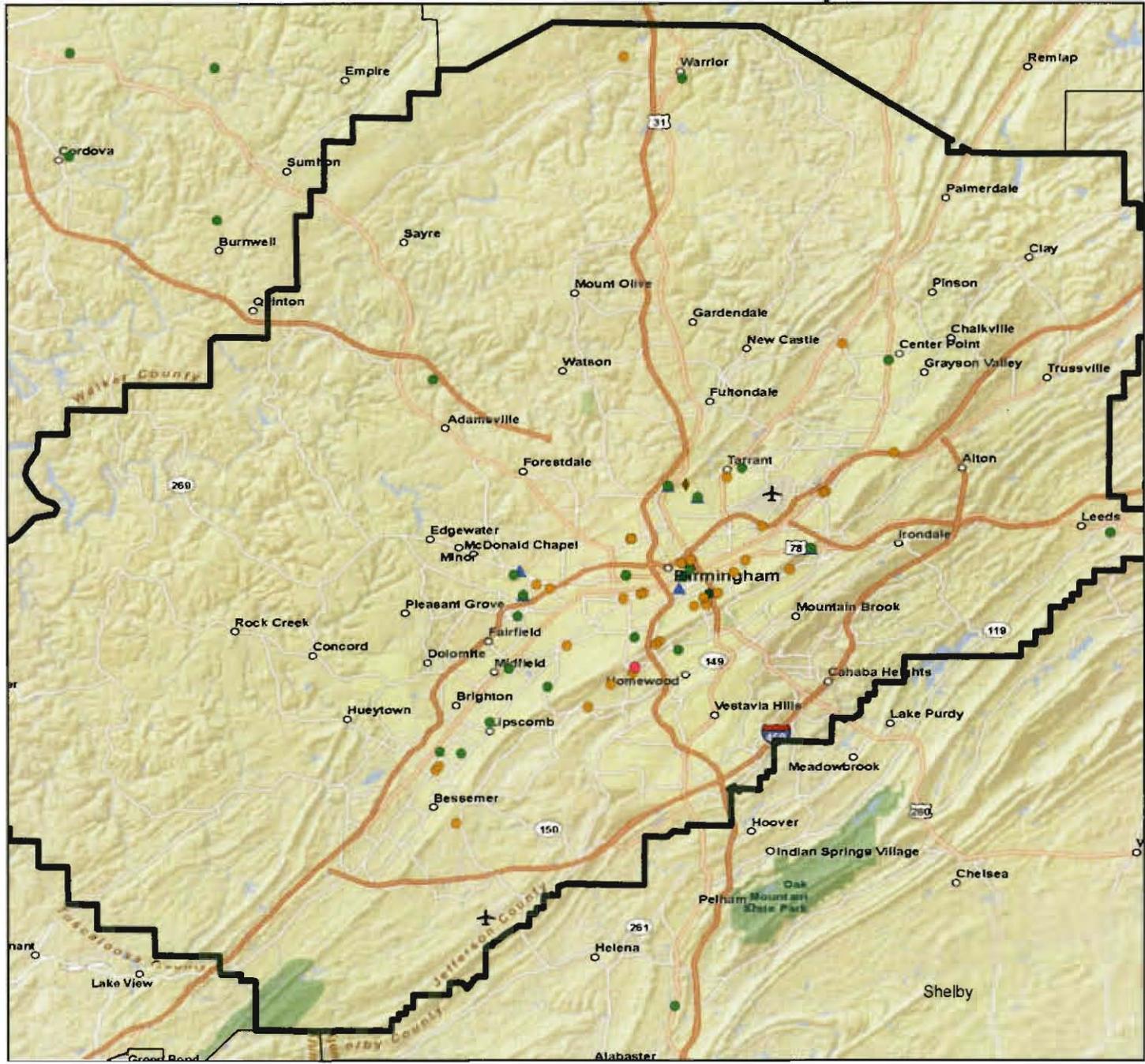


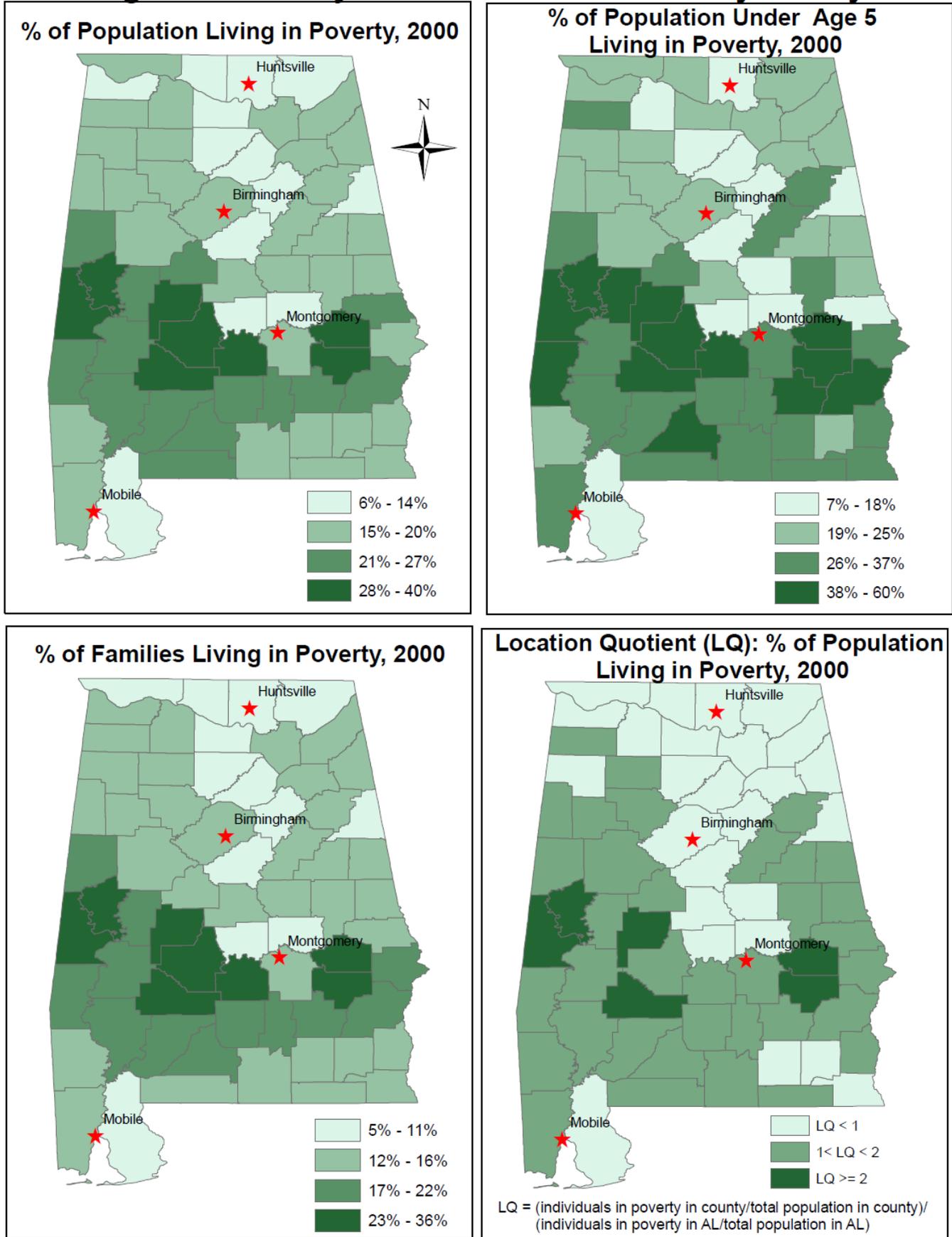
Figure 5. Resources Available in Jefferson County, Alabama, 2010



- ### Legend
- ◆ HIPPY Program (1)
 - Alabama Family Center (1)
 - Mental Health Centers (31)
 - Head Start Programs (20)
 - Nurse-Family Partnership (0)
 - Healthy Families (0)
 - Parents As Teachers (3)
 - ▲ Early Head Start Center (7)
 - Jefferson County



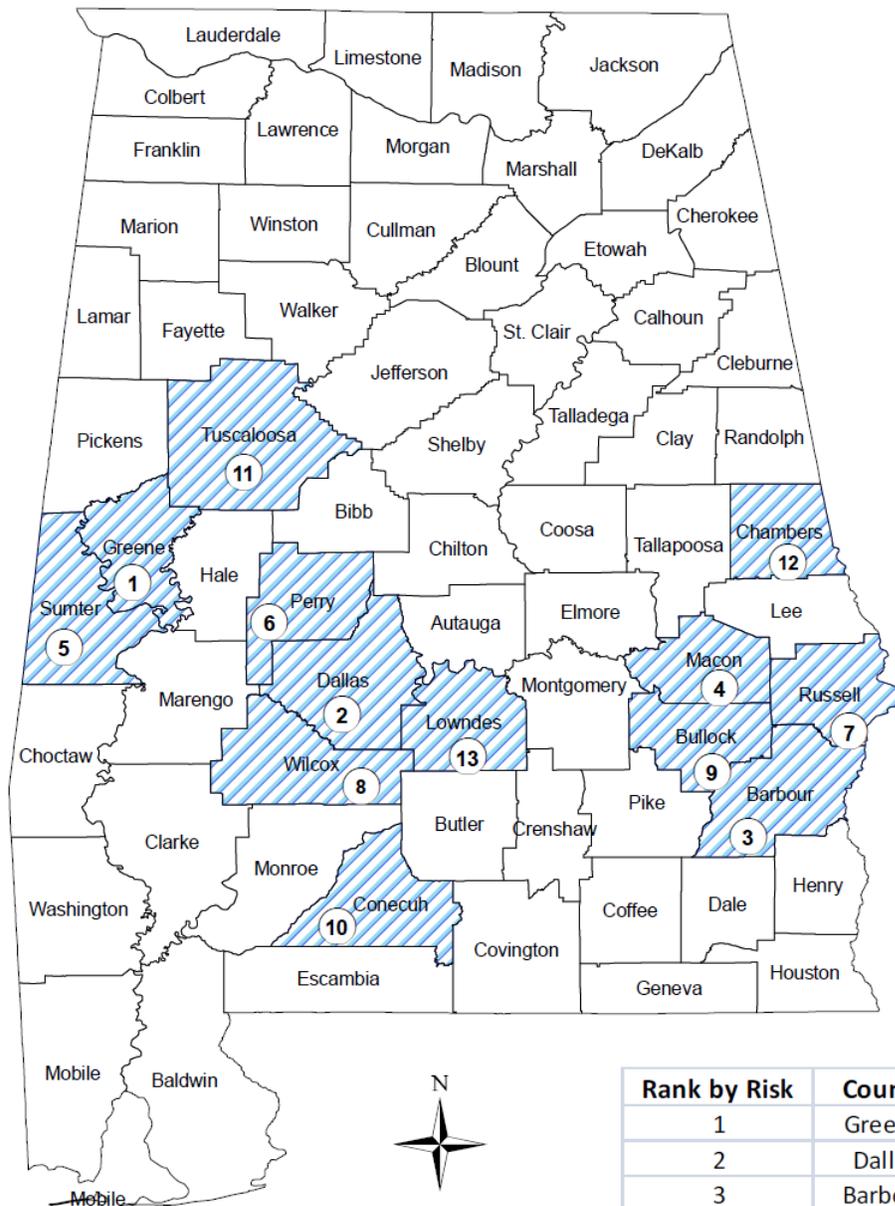
Figure 1. Poverty Information for Alabama by County



Data Source: US Census 2000

Prepared by UAB BAHO, 2010

Figure 2. Communities Identified as At-Risk



Legend

 Communities At Risk

Rank by Risk	County	Composite Score
1	Greene	49.37
2	Dallas	48.42
3	Barbour	44.04
4	Macon	43.8
5	Sumter	43.41
6	Perry	40.33
7	Russell	39.62
8	Wilcox	39.32
9	Bullock	39.21
10	Conecuh	38.86
11	Tuscaloosa	35.77
12	Chambers	34.33
13	Lowndes	33.66

Figure 3. Existing Home Visiting Programs in Counties At-Risk, 2010

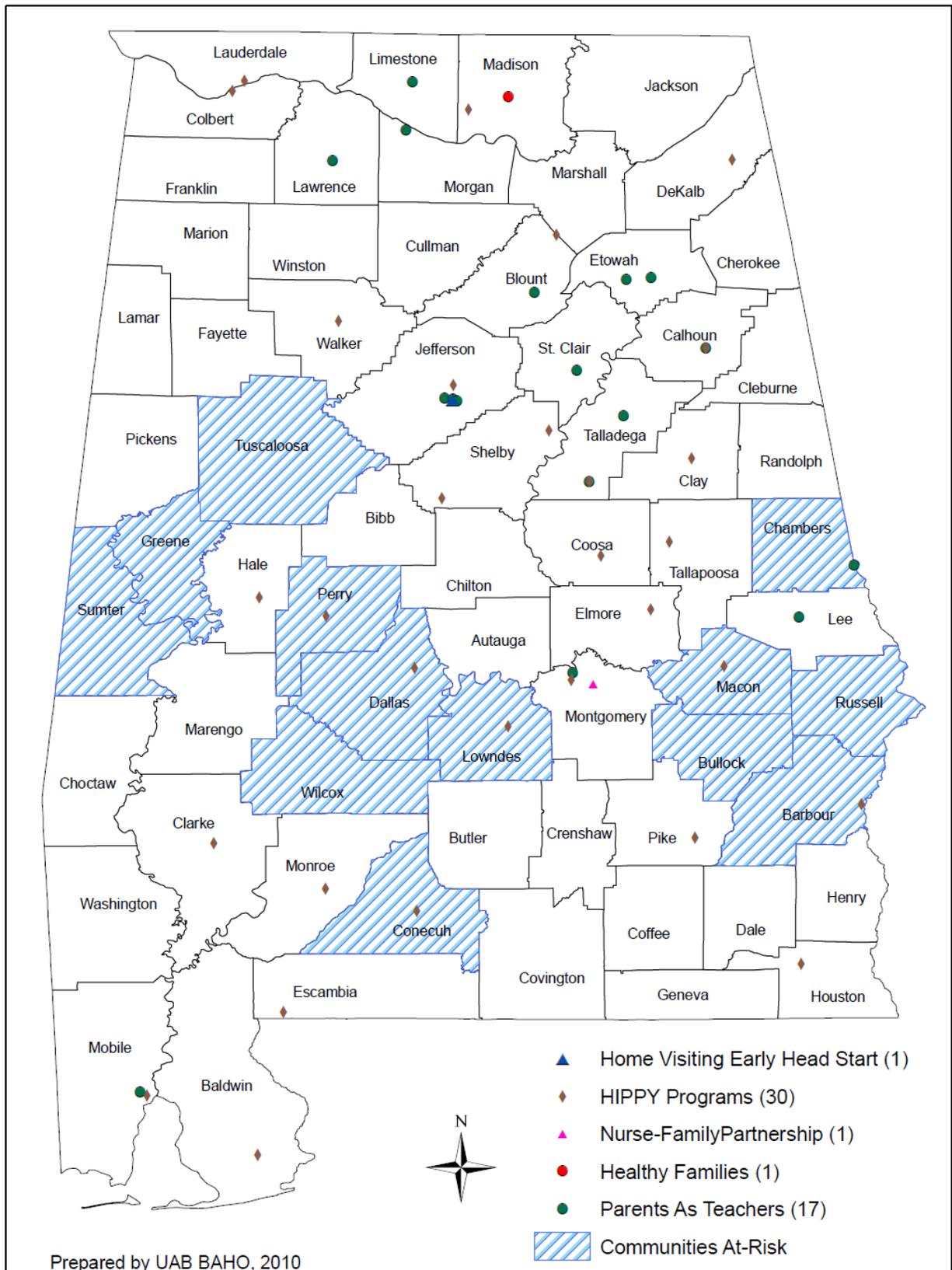


Figure 4. Resources Available in Counties At-Risk, 2010

