Lower Fairfield County Regional Action Council

Epidemiologic Profile of Substance Use, Suicide & Problem Gambling

January 2013

Contributors

Ingrid Gillespie, Director, Lower Fairfield County Regional Action Council

Archie C. Swindell, Quantitative Services, who created many of the graphs and provided some of the narrative.

Members of the Lower Fairfield County Regional Action Council, who reviewed existing data, developed a priority matrix, identified risk factors and made recommendations for prevention strategies. Members represented the following sectors:

- Parents
- Mental Health Providers
- Youth service Providers
- Local Prevention Council Chairs
- School Resource Officers
- Substance abuse treatment providers
- Parent educators
- Health care
- Older Adult providers
- School-based Social Workers

Abbreviations

AAS, American Association of Suicidology

ADHD, attention deficit hyperactivity disorder

CDC, Center for Disease Control

CESAR, Center for Substance Abuse Research

CNAW, Community Needs assessment Workgroup

DMHAS, Department of Mental Health and Addiction Services

ED, emergency department

LFCRAC, Lower Fairfield County Regional Action Council

MFSAC, Mid-Fairfield Substance Abuse Coalition

NRT, nicotine replacement therapy

NSDUH, National Survey on Drug Use and Health

PSA, public service announcement

RYASAP, Regional Youth Adult Social Action Partnership

SBIRT, screening, brief intervention and referral to treatment

SCSI, Smoking Cessation Supports Initiative

SW CT, Southwestern Connecticut

SWRMB, Southwest Regional Mental Health Board

TATU, Teens Against Tobacco Use

WISQARS, Web-based Injury Statistics Query and Reporting System

Executive Summary

Alcohol continues to be the most widely abused substance in the LFCRAC Region which includes the communities of Greenwich, Stamford, Darien and New Canaan. Although overall trends may suggest reductions overtime in past 30 day underage drinking use, data from our region shows some differences with national and state data. For example, a decreasing trend over time for perception of risk for alcohol use amongst young adults (18-25 year olds) contrasts with an increasing trend at the national and state levels. The rate of tobacco use is low compared to other substances such as marijuana and alcohol. Rates of tobacco use amongst youth and young adults are decreasing over time, reflecting similar trends at the national and state levels. However, amongst persons living with mental health and/or substance use disorders, smoking rates remain 2- 4 times higher than the general population. Although national data for nonmedical use of prescription drugs has shown decreases overtime, limited data available for the LFCRAC region suggests increases in use. Marijuana is the most commonly used illicit drug both nationally and in the LFCRAC region. Trends for increased use mirror the decrease in the perception of risk. National rates of heroin use also show increases that appear to be reflected by the available data in the LFCRAC region. Comparatively, rates of cocaine use tend to be low in the LFCRAC region. Rates of problem gambling are low compared to other counties in the state. Limited available data for the LFCRAC region suggests there may be a more recent spike in prevalence.

As a region, we are ethnically and economically diverse. Risk factors for substance abuse transcend economic and cultural differences as suggested by low perception of risk and access to illicit drugs such as marijuana. Increasingly there is recognition that efforts to address substance abuse at the local level can be strengthened through collaboration at the local, regional and state level.

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Introduction

Purpose of the profile

Epidemiologic profiles have many users. The primary users are planning groups (such as the Community Needs Assessment Workgroup), coalitions, and applicants for funding. The epidemiologic profile may be used to:

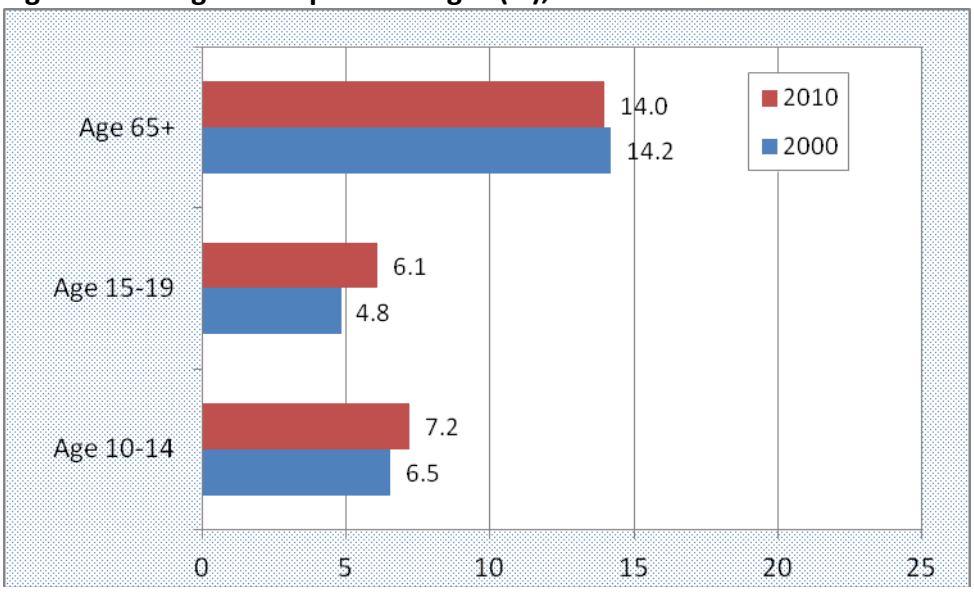
- develop a comprehensive prevention or health promotion plan
- set priorities among populations who need prevention or health promotion services
- provide a basis for determining emerging needs or projecting future needs
- increase general community awareness of substance use and other behavioral health problems
- apply for, and receive, funding
- respond to public data needs (e.g., providers, educators, funding agencies, media, policymakers)
- modify the composition of planning or advisory group membership to reflect the demographics of in the subregion.

Description of the RAC region

Socio Demographic Profile of LFCRAC Region

- The four towns in the LFCRAC area are Darien, Greenwich, New Canaan, and Stamford. Population-weighted average percentages of residents in the four towns are presented, using figures from the United States Census, 2000[1] and 2010.[2]
- The percentages of youth of ages 10-14 and 15-19 have increased by about 1.0 points, while the percentage of residents of retirement age has decreased slightly (**Figure 1**). The largest increases (about 3%) occurred in Darien.

Figure 1: Changes in Population Ages (%), 2000 to 2010

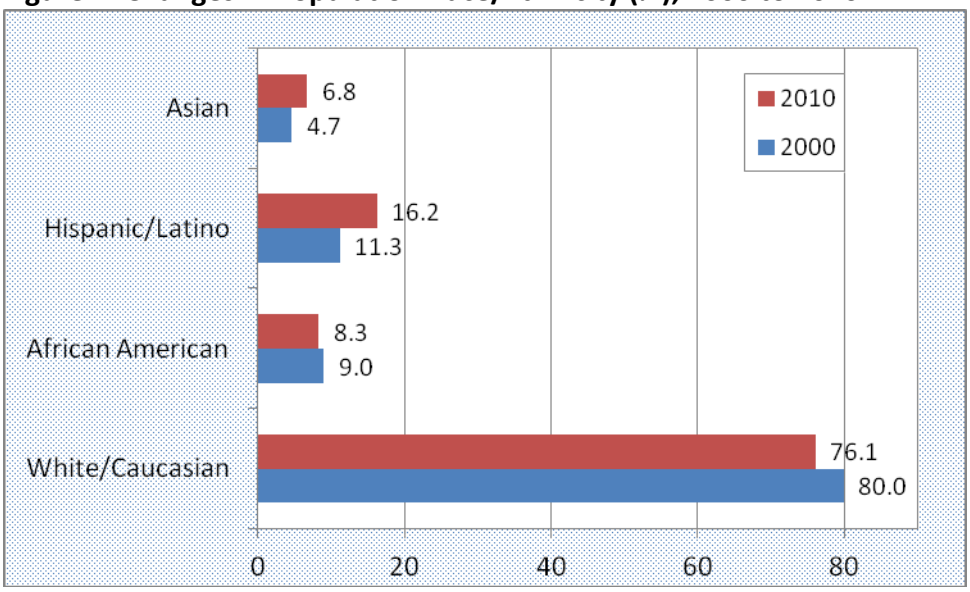


Source: US Census data

- The number of households in the region with children under 18 increased 1.4%, from 32.8% to 34.2%.

- The number of single mothers (female households, no husband present, with own children under 18) increased slightly, from 4.7% to 5.4%, with the largest increase (1.3%) in Darien.
- The racial/ethnic composition of the LFCRAC area changed somewhat, 2000 to 2010, with increases in Hispanic (+5%) and Asian (+2%) residents, a concomitant decrease of 4% in the White residents, and less than a 1% change in African-Americans (**Figure 2**).
- The racial/ethnic composition of Darien and New Canaan changed little; the largest changes occurred in Stamford.
- Percentages of households in Stamford with incomes below $25,000 per year (not adjusted for inflation) decreased from 20% in 2000 to 16.2% in 2010, and were low and essentially unchanged in the other three LFCRAC towns.
- Average median household income in LFCRAC communities ranges from Stamford ($77,827), Greenwich ($120,632), New Canaan ($167,489), Darien($177,448) Median Household income in Connecticut is $67,740.00 (source: CERC Town Profiles 2011).

Figure 2: Changes in Population Race/Ethnicity (%), 2000 to 2010



Source: US Census data

Sources of data

Sources of data included the NSDUH, CDC, US Census data, and various surveys and studies. Specific sources of data are provided throughout.

Strengths and limitations of the profile

Strengths of the profile include the amount of data for most endpoints. Where relevant data existed, they were usually consistent between samples and populations, suggesting robustness. The limitations included the lack of regional data for some of the endpoints, the fact that much of the data were from surveys, and some data had small sample sizes.

Methods

Process to develop the profile

Action	July	Aug	Sept	Oct	Nov	Dec	Jan 2013
Review Community Readiness Data							
Collect data for CNAW group							
CNAW reviews data & develops priority matrix				October LFCRAC meeting			
Review new data sent from DMHAS							
Review new data with CNAW, review priority matrix results Identify risk factors for top 4 priority areas						Dec LFCRAC meeting	
Write profile and submit to DMHAS							

Note: We used quarterly LFCRAC meetings in October and December as the LFCRAC members met the criteria for a Community Needs Assessment Work group. The profile will be presented at the March 2013 quarterly LFCRAC Council meeting.

Summary

Priority Ranking

CNAW members reviewed existing data on alcohol, tobacco, marijuana, prescription drugs, cocaine, heroin, problem gambling and suicide in terms of magnitude, impact and changeability. After review and discussion, which also included whether or not the data matched what they were seeing, the following priorities in order were identified

- Alcohol
- Marijuana
- Tobacco
- Prescription Drugs
- Heroin
- Cocaine
- Suicide
- Problem Gambling

CNAW Priority Ranking Matrix - Aggregate Scores

LFCRAC Sub-Regional Substance Abuse Prevention Priorities
October – December 2012

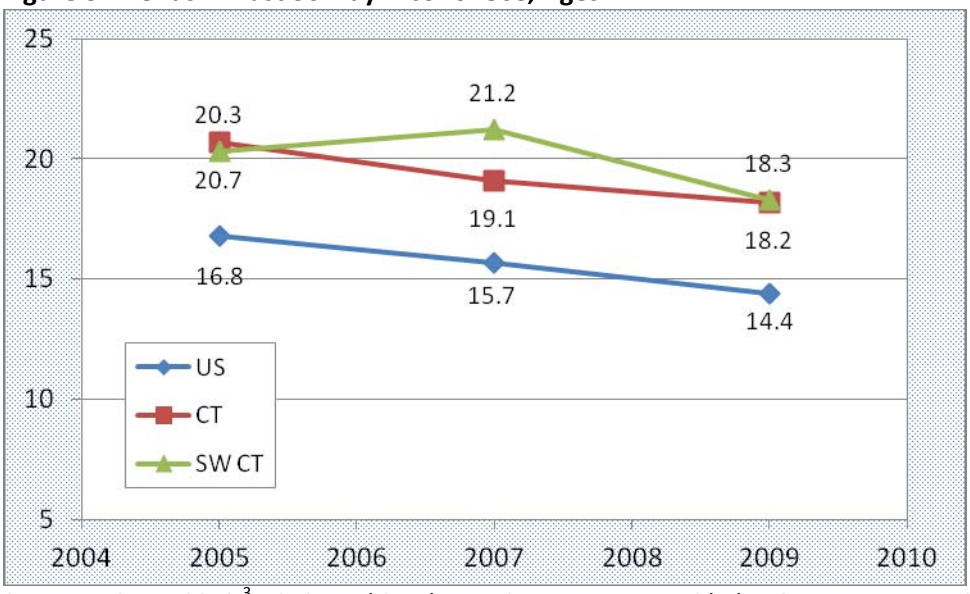
Problem	Magnitude	Impact	Changeability	TOTALS
	Range across towns/region Burden – how many people affected?	Years of potential life lost Health, disability, economic, criminal justice or other costs	Indicator is amenable to change - Evidence-based strategies are available to affect change	
	Priority Rating Scale: 1=Lowest 2=Low 3=Medium 4=High 5=Highest			
Alcohol	5.0	4.5	3.5	13
Tobacco	3.5	3.5	3.3	10.3
Marijuana	3.8	4.0	3.3	11.1
Prescription Drugs	3.5	3.3	2.3	9.1
Heroin	2.5	3.3	2.5	8.3
Cocaine	2.5	3.0	2.5	8.0
Problem Gambling	1.5	1.8	1	4.3
Suicide	2.3	2.8	2	7.1

Alcohol

Magnitude

- Alcohol continues to be the most commonly used substance by youth in Connecticut and in the nation. Its use has generally been decreasing over the past several years, in the nation, state and region (**Figure 3**). Southwest Connecticut (SW CT, **Figure 1** *et seq*.) includes Fairfield County and the western part of New Haven County.

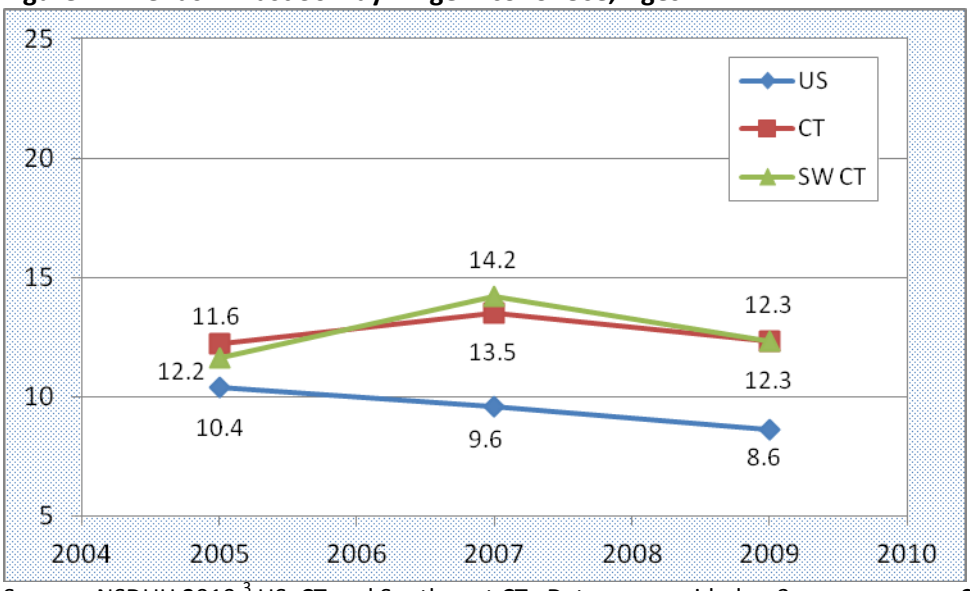
Figure 3. Trends in Past 30-Day Alcohol Use, Ages 12-17



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

- The 30-day use of alcohol by youth aged 12-17 is higher in Connecticut than in the nation – both casual use (**Figure 3**) and "binge" drinking (**Figure 4**, five or more drinks on a single occasion at least once). Of particular note, binge-drinking rates within the 4 LFCRAC communities ranged from 20–24% (Stamford/Lower Fairfield County Community Health Survey; data not shown).

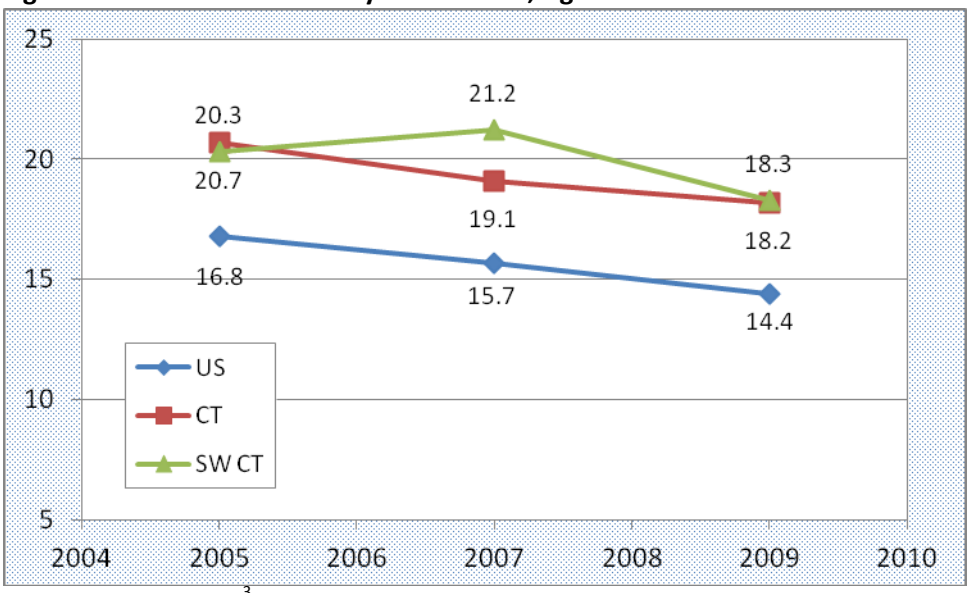
Figure 4. Trends in Past 30-Day Binge Alcohol Use, Ages 12-17



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

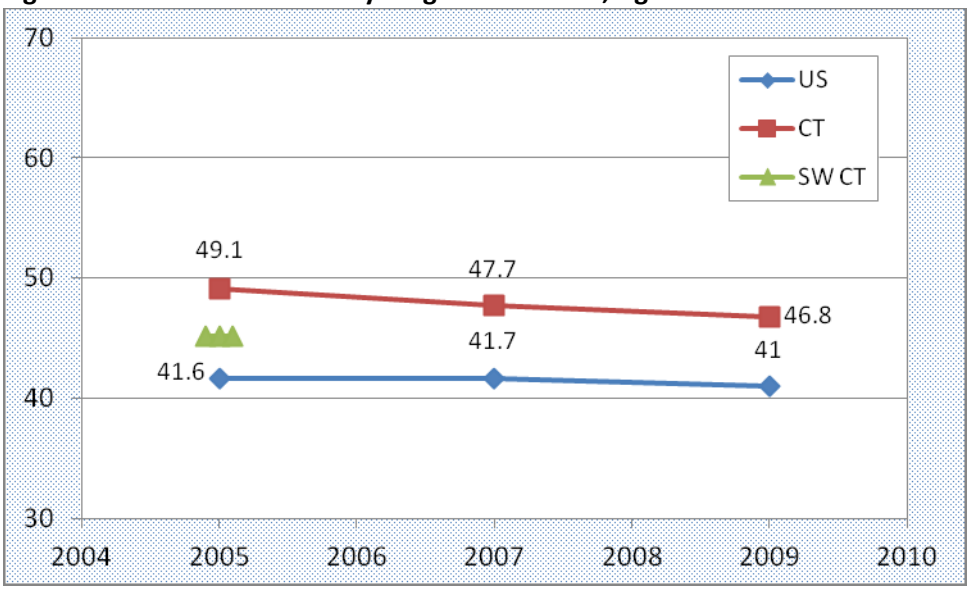
- Alcohol use among youth aged 18-25 was more prevalent than with younger youth, but patterns were similar – declining use for both 30-day (**Figure 5**) and binge drinking (**Figure 6**), with alcohol use in Connecticut higher than in the nation. Data for the 18-25 age group are sometimes difficult to obtain, as these youth are not included in surveys of public school students.

Figure 5. Trends in Past 30-Day Alcohol Use, Ages 18-25



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

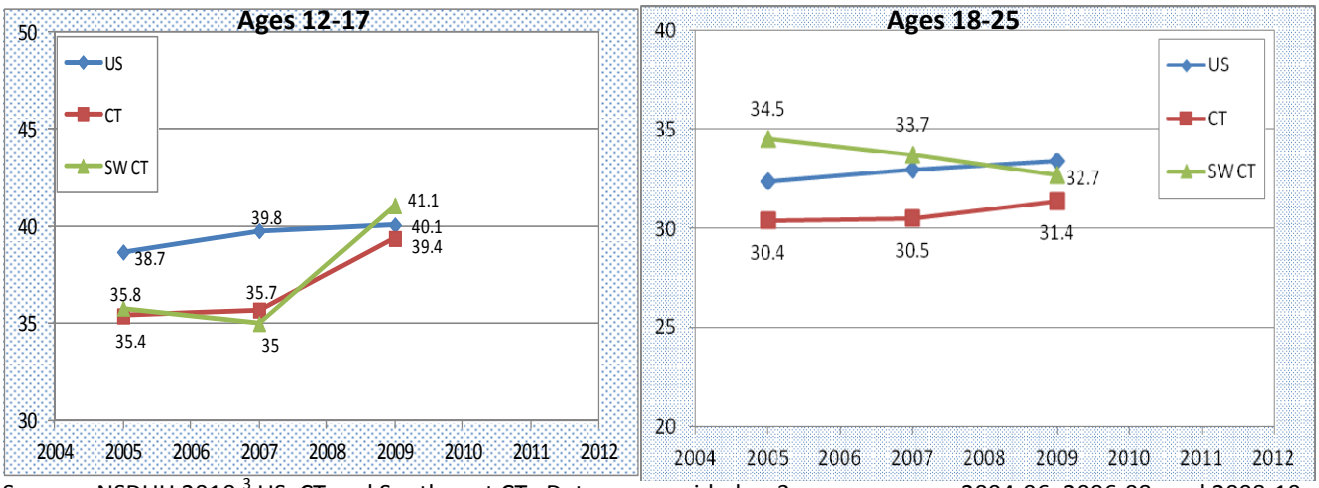
Figure 6. Trends in Past 30-Day Binge Alcohol Use, Ages 18-25



Source: same as in Figure 2. Insufficient data for Southwest CT from years 2006-08 or 2008-10 to report statistics. Prevalence in 2004-06 was 45.2%.

- Declines in patterns of alcohol use are associated with a pttern of increased perception of great risk in age groups 12-17 and 18-25, both nationally and regionally (**Figure 7**).

Figure 7. Perception of Great Risk from Alcohol, Ages 12-17 and 18-25



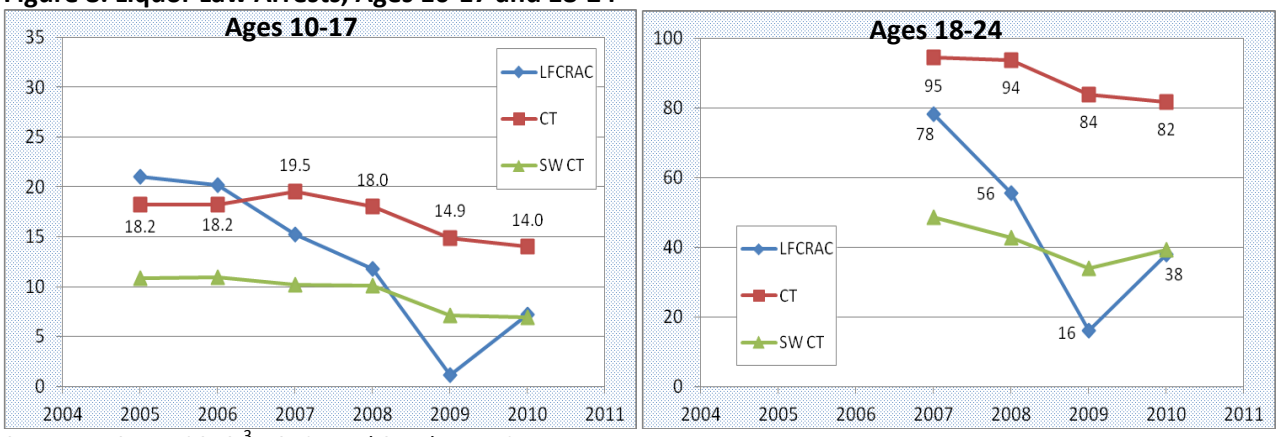
Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

- 2008 data from one community in lower Fairfield County Regional Action Council (LFCRAC) reported higher recent use of alcohol (defined as drinking a significant amount of an alcoholic beverage on at least one occasion within the past 30 days) for youth Grades 7-12 was higher (24.5%) than rates for use in CT (18.3%).
- *Older Adults:* The proportion of older adult alcohol admissions who reported alcohol as their only substance of abuse decreased from 87.6% in 1992 to 58.0% in 2009, while the proportion who reported alcohol in combination with drugs increased from 12.4% to 42.0% (source: TEDS Report 2011).

Impact

- In the U.S. in 2005, alcohol abuse killed 75,000 people each year, and shortened their lives by 30 years. According to government studies, excessive alcohol use was the third leading preventable cause of death, after tobacco use, and poor diet and exercise habits.[4]
- Over half of the alcohol consumed by adults and 90 percent of the alcohol consumed by youth occurs while binge drinking.
- The relative low cost and easily availability of alcohol and the fact that binge drinking is frequently not addressed in clinical settings contribute to the acceptability of excessive alcohol use.
- Every day, almost 30 people in the United States die in motor vehicle crashes that involve an alcohol impaired driver – one death every 48 minutes (source: SAMHSA National Prevention Strategy: Preventing Drug Abuse and Excessive Alcohol Use).
- World-wide, alcohol abuse is directly responsible for 2.5 million deaths every year. Over 6% of male deaths are related to alcohol, more than 5 times the rate of alcohol-related deaths of females. A spokesman for WHO stated that, "no drinking is entirely safe".[5]
- Rates for liquor law arrests showed an unexpected drop during 2009 for age groups 10-17 and 18-24 (**Figure 8**). Given that this is not consistent with data for the state or SW CT, it is unclear whether this might represent a problem with data collection rather than a reflection of the problem in our region.

Figure 8. Liquor Law Arrests, Ages 10-17 and 18-24

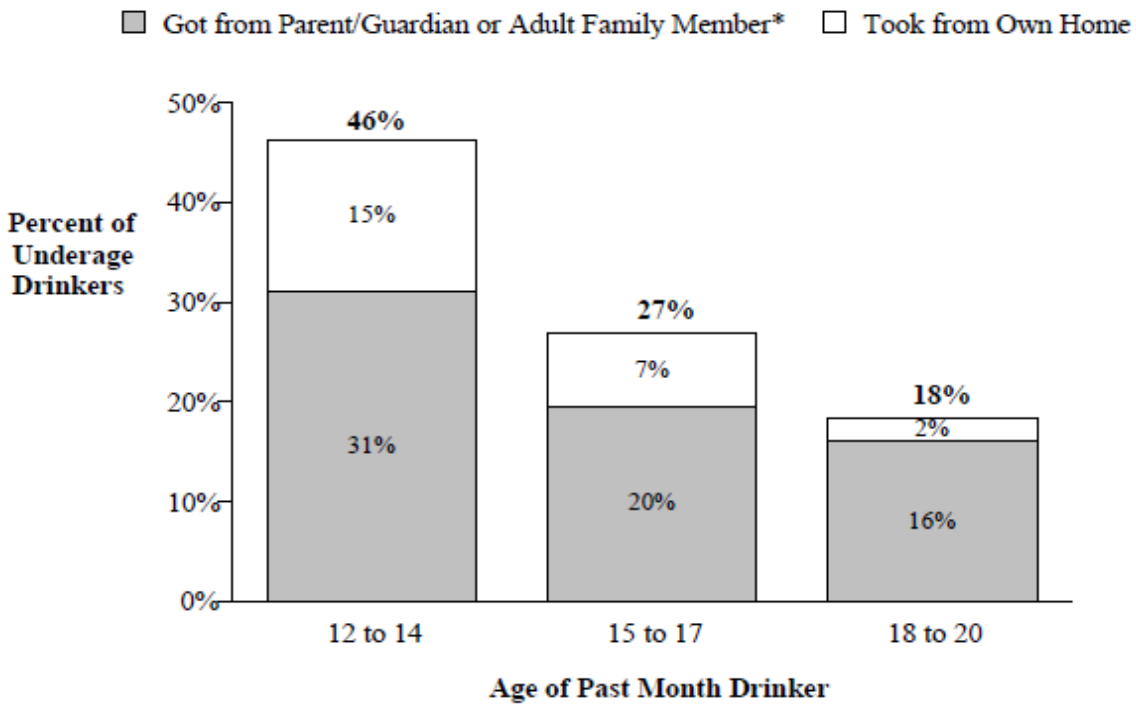


Source: NSDUH 2010,[3] US, CT and Southwest CT.

Capacity

- Alcohol is the top priority issue in the LFCRAC region. Although we are challenged to get quantitative data representative of the region, CNAW members representing law enforcement, parents, health care, and youth service providers.
- Related risk factors identified by this group were parental norms and tolerance, low perception of risk, easy access and financial ability to purchase. A March 7, 2011 report from the Center for Substance Abuse Research (CESAR) indicates that "…almost half of young drinkers ages 12-14 years obtain alcohol from family or home followed by nearly thirty percent of 15 to 17 year olds who use this same source (**Figure 9**).

Figure 9. Percent of Current Underage Drinkers Who Reported Getting Alcohol from Their Family/Home the Last Time They Drank, by Age, 2009



*Includes obtaining alcohol for free from parent/guardian or adult family member and paying a parent/guardian or adult family member to purchase it

To reduce demand for alcohol by those under 21 years, CNAW recommended the following strategies:

- Develop a campaign that highlights facts that resonate with both youth and parents (e.g., data related to age of onset and later problems with alcohol, effect on developing brain, and impact of parental discussions about the risks of alcohol)
- Ensure parents and teens clearly understand the implications of the Social Host Law
- Increase the visibility of youth who chose not to drink
- Implement developmental asset-based strategies and programs to strengthen resiliency skills and increase self esteem in youth
- Train pediatricians and family physicians in SBIRT (Screening, Brief Intervention and Referral to Treatment).

For those over 21 years of age:

- Provide information on recommended drinking guidelines and
- Provide awareness of simple online screening tools (e.g., www.alcoholscreening.org).

For older adults:

- Educate older adults and Senior Service providers about the dangers of mixing alcohol and medications
- Broadly disseminate a simple guideline titled "What to ask your pharmacist or doctor about your medications"
- Train physicians in SBIRT tools and approaches for older adults.

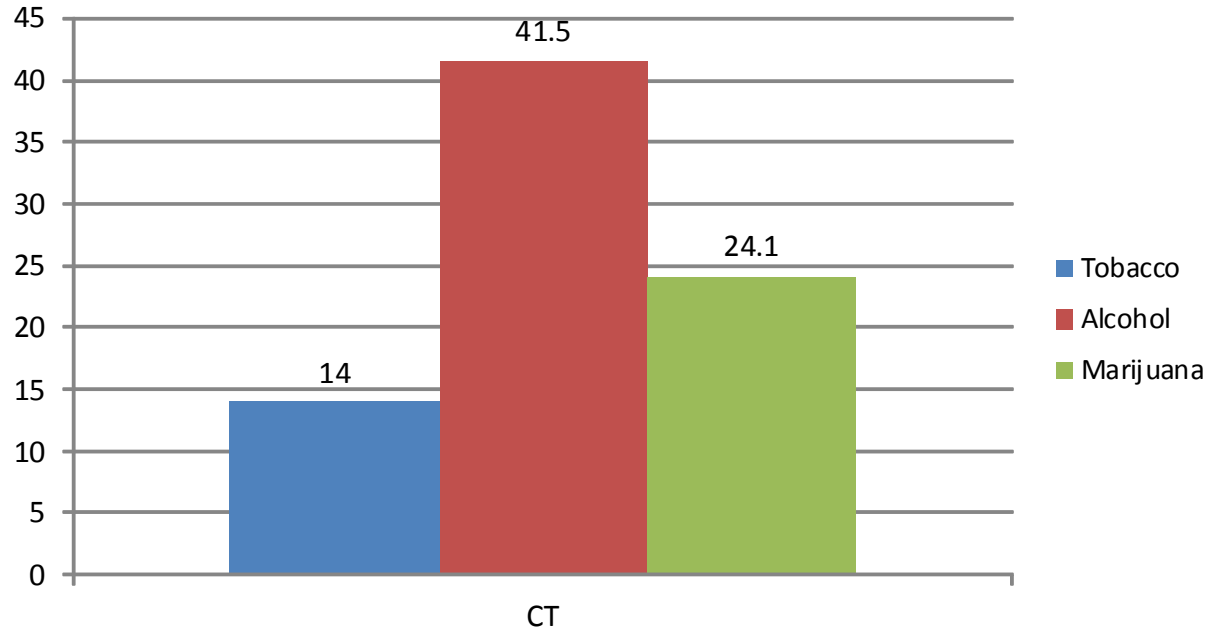
It is felt that these strategies, which are being implemented to varying degrees will be much more effective with a coordinated approach at the local and regional level. More funding is needed to hire staff that can coordinate these efforts. There are dedicated volunteers but the coordination requires longer hours than volunteers can typically provide on a consistent basis.

Tobacco

Magnitude

- The percentage of high school kids who currently smoke is low (14%) in comparison with other current user rates for other substances such as marijuana (24.1%) and alcohol (41.5%)(**Figure 10**).

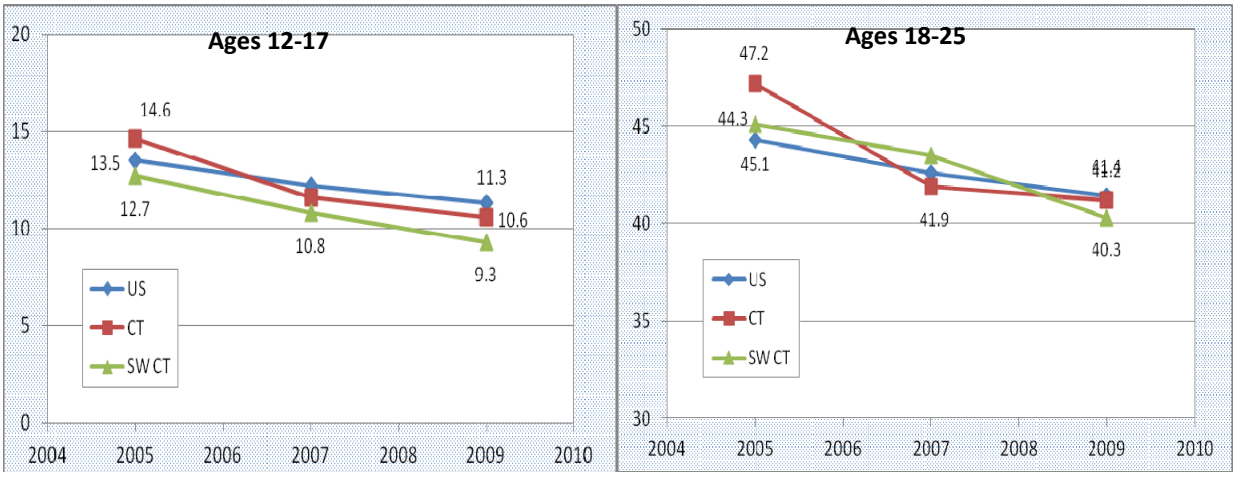
Figure 10. Comparison of Current Users for Tobacco, Alcohol, Marijuana in CT (%) Grades 9-12



Source: CT School Health Survey 2011 Results

- As with alcohol, the use of tobacco by young people has continued to decline for several years – in the nation, state, and region (**Figure 11**). The prevalence of tobacco use is 3-4 times higher among youth aged 18-24 than among those aged 12-17, but the slopes of the trend lines (i.e., the rates of decreased use) are similar for both groups (**Figure 11**).

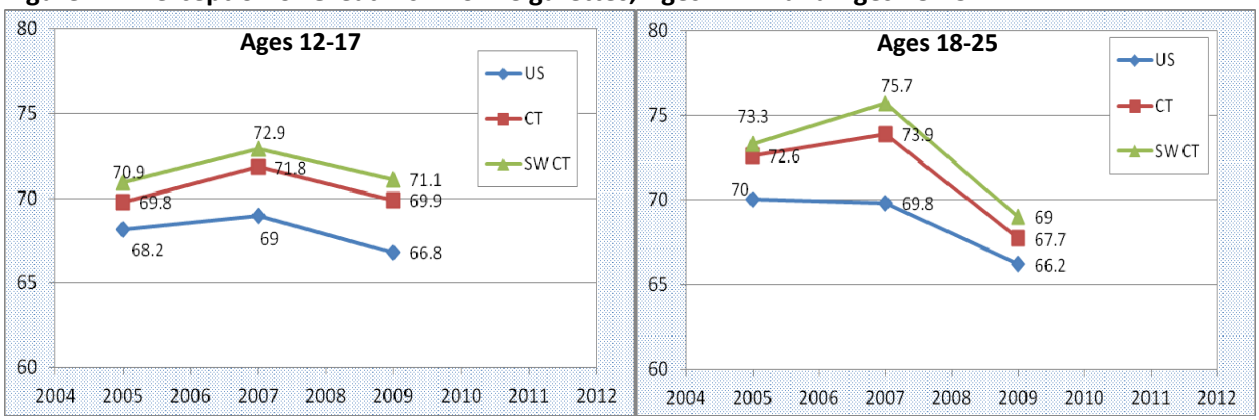
Figure 11. Trends in Past 30-Day Tobacco Use, Ages 12-17 and 18-25



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

- One of the four core measures in federal guidelines is the perception of risk from substances or behaviors (*please see Appendix3 for the list of core measures*). A perception that a substance does not cause very much harm is associated with a greater likelihood of its use – both logically, and as a fact observed repeatedly in youth surveys. **Figure 12** below shows that perception of risk for youth 12-17 years increased until 2007 and then started to decline.
- Perception of risk from tobacco has also decreased among youth aged 18-25 (**Figure 12**) – although perception of great risk remains above 65% – while tobacco use in this age group has continued to decrease.

Figure 12. Perception of Great Risk from Cigarettes, Ages 12-17 and Ages 18-25

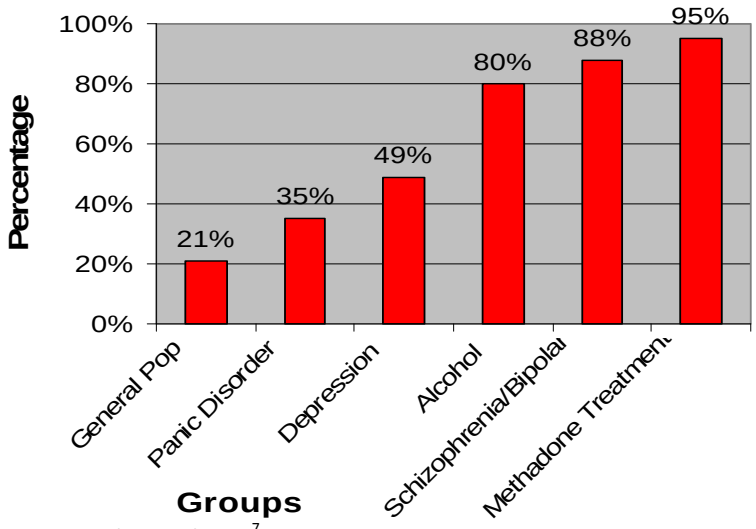


Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

Smoking rates for those living with mental illness or those with substance use disorders are 2- 4 times higher than the general population (**Figure 13**).

People living with a mental illness consume 45% of cigarettes smoked in US.[6] While representing approximately 13% of the general adult population, individuals with mental and/or substance use disorders in Connecticut represent approximately 62% of all adult smokers in the state (source: 2008 CT Tobacco & Health Trust Fund Report).

Figure 13. Comparison of smoking rates in the US



Source: Hughes et al 1986[7]

Impact

- Smoking-related diseases cause an estimated 440,000 American deaths each year (source: CDC).
- The use of tobacco continues to be the leading preventable cause of death in the United States. The number of deaths annually from tobacco use stands at 443,000 – about 20% of all deaths – including 49,400 deaths from second-hand smoke exposure.[4]
- Diseases associated with cigarettes smoking include cancers of the lung, trachea, oral cavity, esophagus, kidney and urinary bladder, as well as cardiovascular and cerebrovascular diseases.
- The resting heart rates of young adult smokers are 2-3 beats/minute faster than non-smokers and studies have shown that early signs of heart disease and stroke can be found in adolescents who smoke (source: Campaign for Tobacco-Free Kids, *Smoking's Immediate Effects on the Body*).
- People with mental illness and/or substance use disorders die, on average, 20-30 years sooner than others. Most of this is attributed to smoking-related diseases.[6]
- Annual health care costs in CT directly caused by smoking is $1.63 million
- Smoking-caused productivity losses in CT is $1.03 billion Tobacco campaign
- More deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined (source: CDC Tobacco Facts).

Capacity

Community members from all sectors support promotion of tobacco prevention for the general population; in particular youth and young adults. There is still a strong public sentiment against smoking. Children understand this message but perception of risk shows a decrease with age and there is an increase in smoking rates amongst high school students and young adults.

However, amongst those living with mental illness and those with substance abuse disorders, there are well established norms that do not support smoking cessation (e.g., perception that one cannot quit smoking while addressing other addictions). Nevertheless, some behavioral health providers are now incorporating smoking cessation as part of an overall health and wellness focus. This is a challenge because not all providers have the funding to have designated personnel to facilitate agency-wide smoking cessation initiatives. Without that designated position, it has been difficult to get smoking cessation initiatives up and running in a number of behavioral health organizations.

Available Resources

<u>1. Tobacco Prevention Programs</u>

- Reducing demand through educating about health risks and increasing perception of risk:
  - Schools and youth service provider agencies incorporate tobacco prevention in their curricula or after-school programs. They either use in-house staff or access a local expert to provide a one-time presentation or a series of tobacco education classes.
    Gap: If a school or group wants a more extensive tobacco curriculum, this can be a challenge due to lack of available trained staff (i.e., providers typically do not have the financial capacity for their staff to be absent from their funded responsibilities for more than 1- 2 days).
  - American Lung Association offers a program called TATU (Teens Against Tobacco Use) where high school teens are trained to do one- class presentations to middle school or elementary age kids. The time for training is a challenge for students in this region who often have extremely busy schedules. This is a free resource and there are presently 2 trainers in the

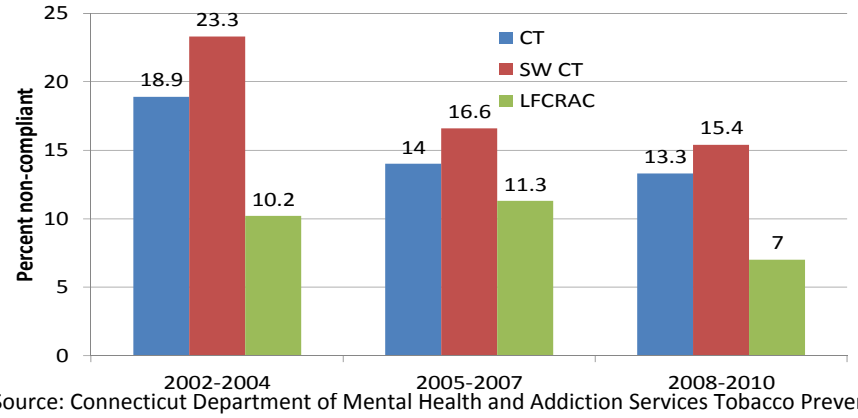
LFCRAC region, one who is designated for a specific school and the other who is available for all communities in this area.

- LFCRAC was funded to implement a curriculum called STEP for ages 5-10 years. This was a 2 year initiative ending in June 2013. Target audience has been kids enrolled in summer or after school camps.

- Reducing access by decreasing underage tobacco sales:

  - Resources needed: To reduce underage tobacco sales and tobacco signage, a designated bilingual staff person to work with the small retail stores is needed. LFCRAC had previous funding for this position which resulted in the capacity to develop relationships with the store owners and provide time effective responses to tobacco training requests for new staff. Through this outreach work, we noted that many of the retailers were receptive to ensuring that staff were trained about tobacco laws and the importance of consistently checking identification. We also noted that, during the time that we were doing this outreach, noncompliance rates were reduced (**Figure 14**). The funding for this position has ended and has left a significant gap in our ability to maintain consistent relationships with the small retailers.

Figure 14. Comparison of Trends in Tobacco Non-Compliant Rates



Source: Connecticut Department of Mental Health and Addiction Services Tobacco Prevention and Enforcement Program

  - Gap: If a school or group wants a more extensive tobacco curriculum, this can be a challenge due to lack of available trained staff.

<u>2. Smoking Cessation Supports</u>

- As of January 2012, Medicaid now covers smoking cessation supports including counseling and NRTs. However, the billing requirements are challenging. This is something that is being addressed by a number of groups.

- CT Quitline offers free smoking cessation supports including counseling and NRTs.

- Smoking Cessation Supports Initiative (SCSI) is a group of tobacco cessation advocates working to increase smoking cessation support for those living with mental illness and those with substance use disorders. The group is not funded but members are knowledgeable on best practices and are a good resource to providers interested in implementing smoking cessation programs and policies.

- A free smoking cessation curriculum called Learning About Healthy Living is available for clinicians working with those living with mental illness and/or with substance use disorders. But lack of funding

to provide designated staff and/or beliefs about smoking cessation (as noted above) are barriers to implementing this curriculum and incorporating smoking cessation as part of the overall substance abuse recovery program.

- Gap: Funding to hire a staff person/agency dedicated to building, implementing and monitoring smoking cessation initiatives.

Other gaps: Capacity to implement smoking cessation programs for youth is limited due to lack of proven effective programs. Teens cannot use NRTs therefore smoking cessation is limited to behavioral change strategies and the programs are often short in duration.

Prescription Drugs

Magnitude

- Nationally, NSDUH 2011 data has indicated:
  - nonmedical use of prescription drugs among youths 12-17 and young adults 18-25 years was the second most prevalent illicit drug use category (with marijuana being first).
  - declines in nonmedical prescription drug use amongst youth and young adults between 2002 (3.2% and 4.1%, respectively) and 2011 (2.3% and 3.6%, respectively)(**Table 1**).
  - past month prevalence amongst young adults (5%) was lower in other years since 2003 which varied between 5.9 and 6.5 %.
- The most prevalent category of misused prescription drugs is pain relievers. However, use has declined for both youth and young adults.

Table 1. Comparison of Nonmedical Pain Reliever Use Rates, 2002 and 2011

	2002	2011	% Change
Youth (12-17)	3.2 %	2.3%	.9%↓
Young Adults (18-25)	4.1%	3.6%	.5%↓

- Since 2007, the number of prescriptions for A.D.H.D. medications dispensed to people ages 10 to 19 has risen by 26%, to almost 21 million yearly, or about two million individuals, the New York Times reports (June 9, 2012).
- The Monitoring the Future 2012 survey found that adderall was the most common prescription drug used for nonmedical purposes (**Figure 15**) amongst 12th graders. It is referred to as the Good Grade pill as students take the drug to study longer and stay focused. In a Sept 1 2011 CNN report, Alan DeSantis, a professor and researcher at the University of Kentucky, found that 30% of students at the university have illegally used a stimulant, like the ADHD drugs Adderall or Ritalin.
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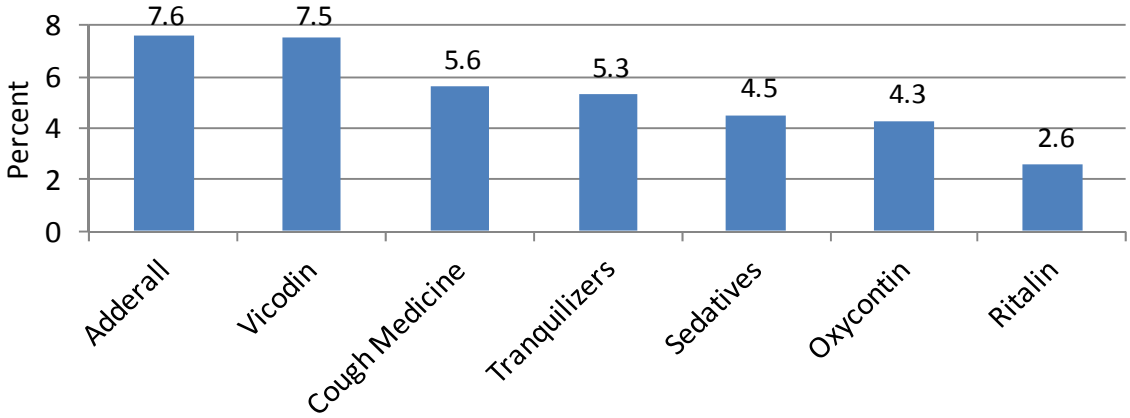
Figure 15. Nonmedical Past Year Use of Pharmaceuticals among 12th Graders (Percentages)



Source: University of Michigan, 2012 Monitoring the Future Study

- *Older Adults:* Since 2007, top-selling opioids dispensed to people 60 years and older have increased 32% according to a Journal Sentinel/MedPage. This is double the growth for prescriptions dispensed in the 40-59 year old age group.

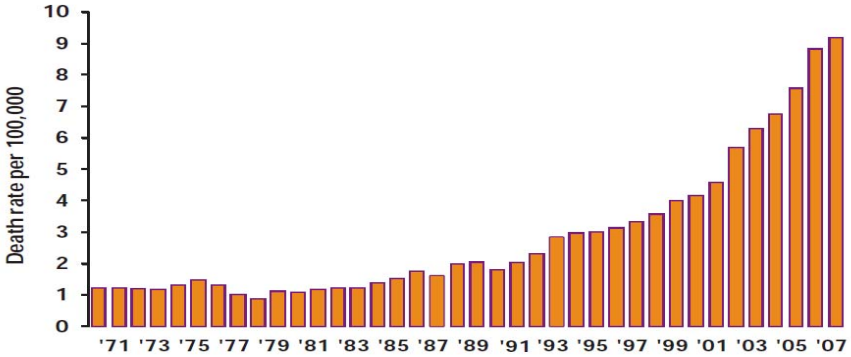
In LFCRAC Region

- Stamford Community Needs Assessment 2012 showed a range of 6-11% of respondents in LFCRAC communities has used a prescription drug on their own (i.e., not prescribed by a physician).
- Treatment providers indicate younger population addicted to heroin, a number of whom started on prescription drugs.
- Two LFCRAC communities reported an increase in adderall use amongst teens.
- Survey comparison data in one community showed an increase in nonmedical use of prescription drug use by 12th graders from 2.7% (2008) to 6.4% (2011). Although these are much lower rates of use than alcohol or marijuana, it does indicate a significant increase.

Impact

- Nationally, emergency department visits involving the misuse or abuse of pharmaceutical drugs have doubled over the past five years (source: SAMHSA National Prevention Strategy: Preventing Drug Abuse and Excessive Alcohol Abuse).
- Rate of unintentional drug overdose death attributed to increase in prescription drug abuse (**Figure 16**).

Figure 16. Rate of Unintentional Drug Overdose Death in the US, 1970-2007



Source: Center for Disease Control, National Vital Statistics System

- In 2009, more than one half million drug-related emergency department (ED) visits made by adults aged 50 or older resulted in hospitalization. The majority of these visits (71%) involved adverse reactions to pharmaceuticals (source: Drug Abuse Warning Network [DAWN] Report May 22, 2012).
- In 2009, there were 15,597 fatal overdoses involving drugs such as hydrocodone and oxycodone (source: CDC).
- Law enforcement officials are seeing an increase in crime related to prescription drugs. One community reported that 13% of narcotic arrests in 2011 were prescription drug related. Of those prescription drug-related arrests, 75% of the offenders were addicted to the prescription drugs.
- Treatment providers indicate incidents of people becoming addicted to prescription drugs due to an injury and resulting pain

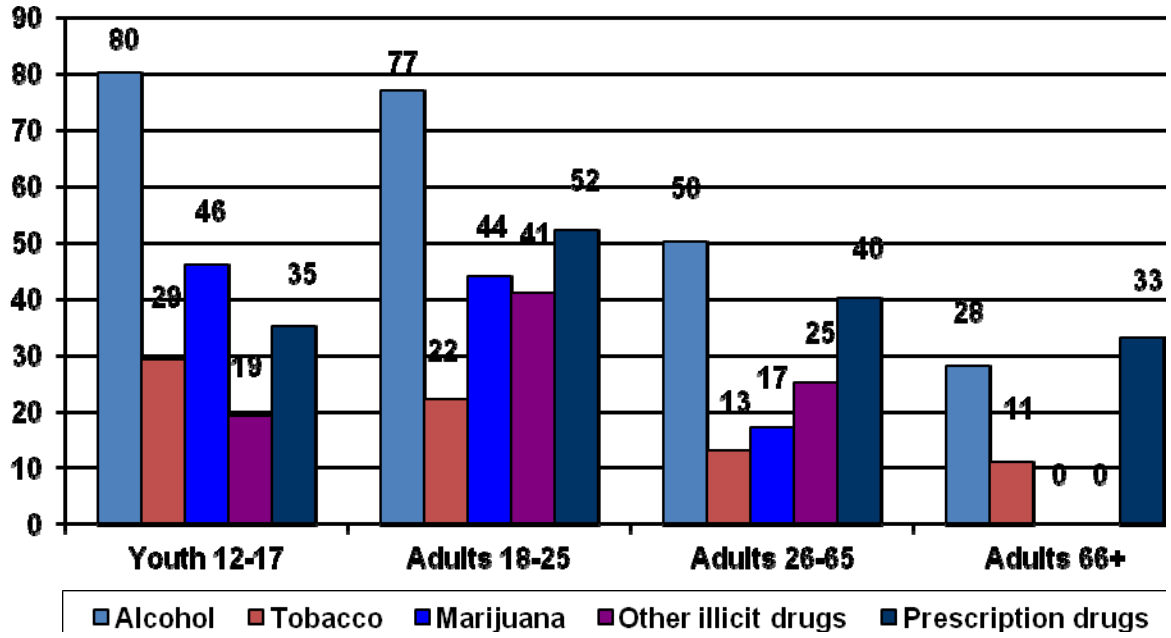
- In 2010, the CDC reported that 2 million people admitted to using a prescription pain killer non-medically for the first time during the previous year, ***with 70% of these medications obtained from friends or relatives either directly for free, through purchase or by theft.***

Capacity

Prevention

Community Readiness Survey results indicated that adults aged 18-25 and 26-65 perceived nonmedical use of prescription drugs as the second most significant problem after alcohol as noted in **Figure 17.** Adults, 66 years and older perceived prescription drugs as the most significant problem where as youth aged 12-17 ranked it third after alcohol and marijuana respectively.

Figure 17. Perceived Community Attitude that a Substance is a "Significant Problem" in Different Age Groups in the Community: LFCRAC, 2012 (Percentages)



Source: Community Readiness Survey Questions 11-14

Most respondents to the Community Readiness survey indicated that communities perceive nonmedical use of prescription drugs is more of a problem for young adults (18-25 years) than other age groups (**Figure 17** above). This may be associated with the low perception of risk for this age group. For example, students at the University of Kentucky, where 30% take adderall see it as "slightly more dangerous than the soft drink Mountain Dew and nowhere near as dangerous as drinking beer and smoking." Adderall is an amphetamine prescribed for individuals diagnosed with ADHD. Students take this drug to stay focused and study longer. Anecdotally, local community leaders know that nonmedical use of Ritalin, a central nervous stimulant prescribed to treat ADD and ADHD, is being used by some high school students to improve their concentration and study longer. Local data on Ritalin use is not available.

Prevention Resources

Reducing demand through educating about health risks and increasing perception of risk

- To address the myths surrounding nonmedical use of prescription drugs, key points about prescription drug abuse are consistently disseminated in a variety of venues (e.g., presentations, media, newsletters, publications and more). The primary target audience is youth and young adults and parents
- Prevalence and sources of access are also emphasized in the aforementioned venues. The primary target audience is the general population with a particular focus on parents. Because medicine cabinets are the primary source for those abusing medications, it is also important to educate many different sectors of the community
- There are two Training of Trainers programs focused on prescription drug abuse. One is the Teen Influencer and the other is the PACT 360 program. These are programs that include Powerpoint presentations and a number of other tools for presenters.
  Need: More trained presenters/facilitators are needed to increase the outreach efforts
- *Other needs*: Development of a cost effective public campaign. In previous years, cost effective Lock Your Meds campaign was implemented in this region, which was effective at the time.

Reducing access:

- Two communities have Medication Drop Boxes located inside their Police Department lobbies. These have been extremely successful, collecting an average of 30 pounds per month of unwanted and unused medications.
- Two communities participate in the biannual DEA Rx Drug Drop Off events. At these events, basic information on the risks of nonmedical use is provided.
- A number of physicians in LFCRAC region are using the Connecticut Prescription Monitoring Program but we need to have all prescribing physicians using this system. According to the Department of Consumer Protection (DCP), 20% of the 25,000 physicians in Connecticut use this system

Treatment Resources

- State and privately funded treatment providers in this region are qualified to treat prescription drug abuse

Recommendations and needed resources

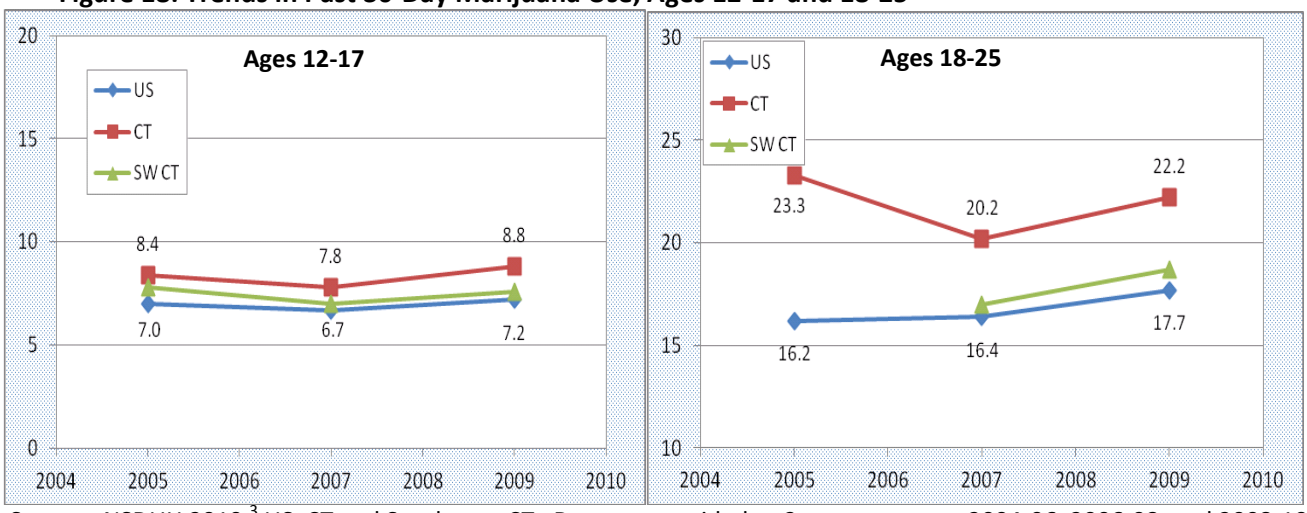
- Increase the number of people who can do small group presentations/discussions on prescription drug abuse. More people will be reached in a variety of venues. As noted above, there are two tools that can be used and the LFCRAC Director can provide the training.
- Increase outreach capacity through dissemination of prescription drug information to schools, physicians, pharmacies, realtors.
- Strengthen perception of risk amongst youth and adults through broad and continual dissemination of the facts.
- Increase the number of doctors screening for prescription drug abuse. The LFCRAC SBIRT committee has been working with physicians on this and hopes to recruit additional training resources.
- Develop and implement a cost-effective campaign that includes PSAs and other modes of advertising.
- Coordination of these regional efforts is important to ensure effective use of resources and to measure the impact of the strategies. Funding for a prevention coordinator position would help with outreach and coordination of efforts to increase awareness and early intervention of prescription drug abuse and other priority areas.

Marijuana

Magnitude

- Marijuana is the most commonly used illicit drug in the United States.[8] In the nation and in Connecticut, the use of marijuana has been increasing for the past five years, unlike use of alcohol or tobacco.[9]
- For age groupss 12-17 and ages 18-25, the 30-day use of marijuana had decreased around 2007 but has been increasing again since then (**Figure 18**).
- Use by youth aged 18-25 is about 2.5 times higher than those aged 12-17 (**Figure 18**). In some Connecticut towns, prevalence of 30-day use of marijuana is almost the same as for alcohol.

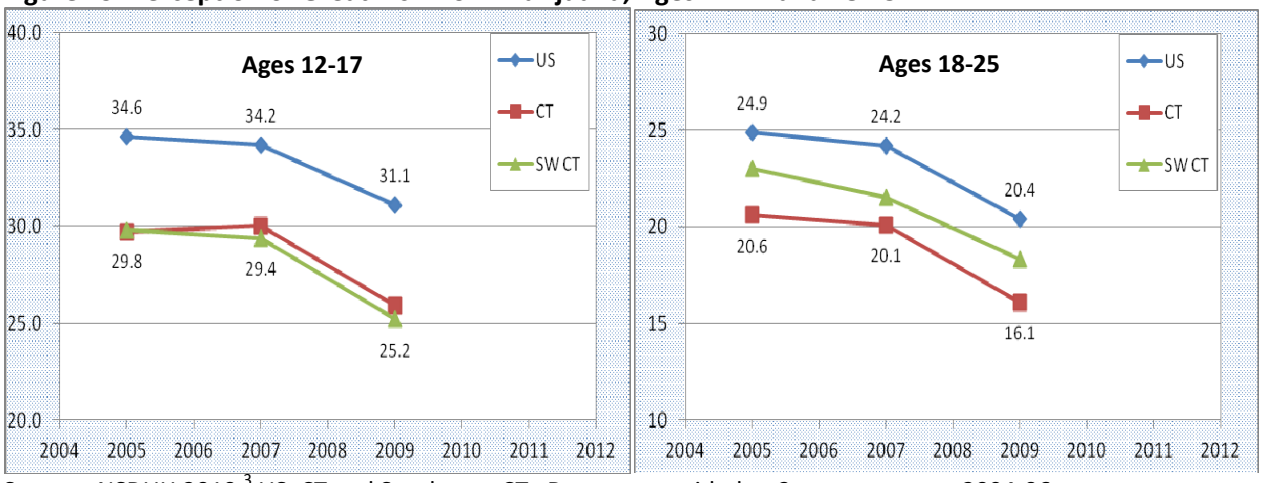
Figure 18: Trends in Past 30-Day Marijuana Use, Ages 12-17 and 18-25



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

- Perception of risk from marijuana has decreased sharply starting in 2007; coincident with the increase in its use (**Figure 19**).

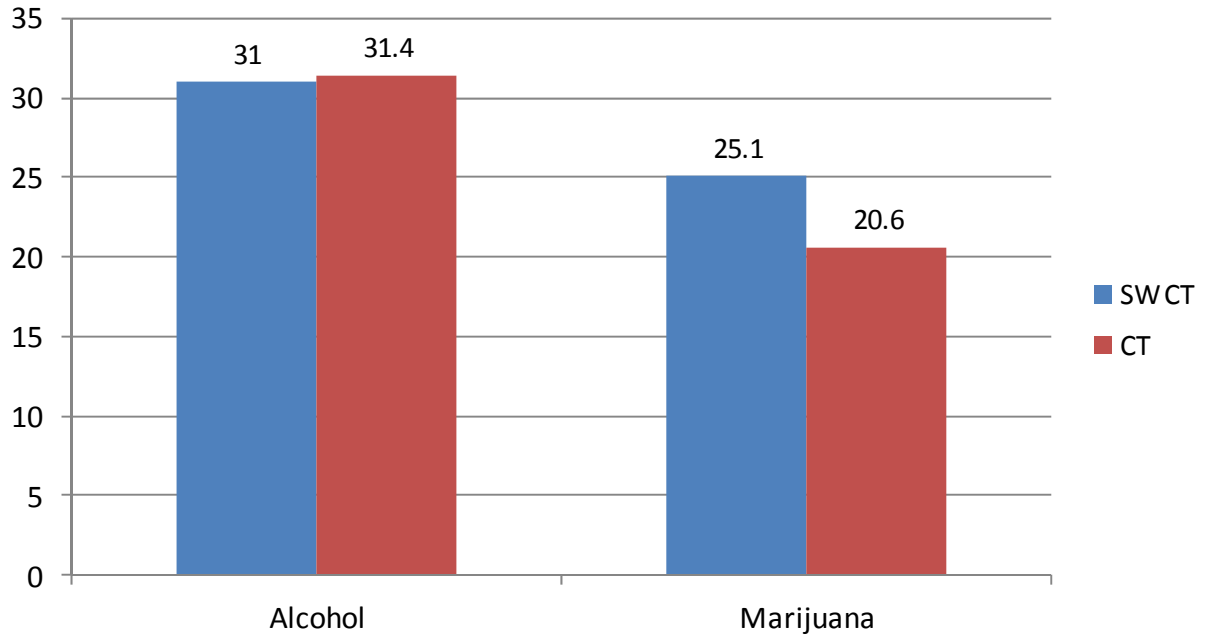
Figure 19. Perception of Great Risk from Marijuana, Ages 12-17 and 18-25



Source: NSDUH 2010,[3] US, CT and Southwest CT. Data are provided as 3-year averages, 2004-06, 2006-08, and 2008-10.

- In 2011, marijuana and alcohol were the top two drugs identified at by 18-25 year olds based on self reporting at time of admission (**Figure 20**). The rate for marijuana use was higher in SW CT than the overall rate for CT.

Figure 20. Treatment Admissions based on self reporting at time of admission for 18-25 year olds, 2011 (%)



Source: DMHAS 2011

Impact

- Marijuana can cause distorted perceptions, impaired coordination, difficulty with thinking and problem solving, and disrupted memory and learning. There are associations between marijuana use and mental health problems, including depression, anxiety, suicidal ideation, and personality disturbances. There are associations between marijuana use and mental health problems, including depression, anxiety, suicidal ideation, and personality disturbances.
- The main psychoactive substance of marijuana, tetrahydrocannabinol, can be retained by fatty tissues and re-released slowly over a period of days or weeks.
- Marijuana also contains hundreds of other chemical compounds in amounts which vary from plant to plant, and which have different and largely unknown effects.
- Marijuana smoke is a lung irritant, and frequent marijuana smokers have many of the same respiratory problems observed in tobacco smokers.
- Marijuana was once thought not to be addictive, but more recent research now points to its addictive potential. It is estimated that about 9% of users become addicted, and that this percentage increases among those who start young (17%) or who use marijuana daily (25-50%). Long-term users who try to quit report withdrawal symptoms such as irritability, sleeplessness, anxiety, and craving – analogous to withdrawal from nicotine by cigarette ex-smokers.
- Recently, marijuana has been legalized for medicinal purposes in Connecticut and other states. It is not yet clear whether regulatory oversight will be sufficient to prevent more widespread abuse.

Capacity

CNAW members ranked marijuana as the second highest priority area to address. Members indicated that the legislation decriminalizing marijuana and approving the drug for medical purposes correlates to the perception of low risk for this illicit drug

To address this perception of low risk use of marijuana, CNAW members felt that the following prevention strategies are needed:

Reducing demand

- Through ongoing and widespread dissemination of information on myths and facts about marijuana with a primary focus on the health related risks
- Clarification of difference between legalization and decriminalization as there continues to be confusion. Decriminalization does not mean legalization
- Implementation of a regional public awareness campaign
- Ensuring physicians are kept updated on trends and research for marijuana.

Reducing access

- Ensure community members understand legislation and regulations for medical marijuana use
- Educate parents about signs and symptoms of marijuana use
- Support school policies related to marijuana and other illicit drug.

Treatment Programs

- There are treatment providers, state and privately funded for both youth and adults in this region
- *Gap:* Affordable intensive treatment for teens
- *Gap:* Affordable substance abuse treatment services for teens under 14 years of age

Heroin

Magnitude

National data from the 2011 NSDUH report indicates:

- The estimated number of new users of heroin increased for young and older adults from the time period 2002–2005 to 2009–2011 (**Table 2**). The increase was observed amongst young adults (40.4%) and older adults (48.2%), whereas youth heroin use decreased during this time period (3.5%).

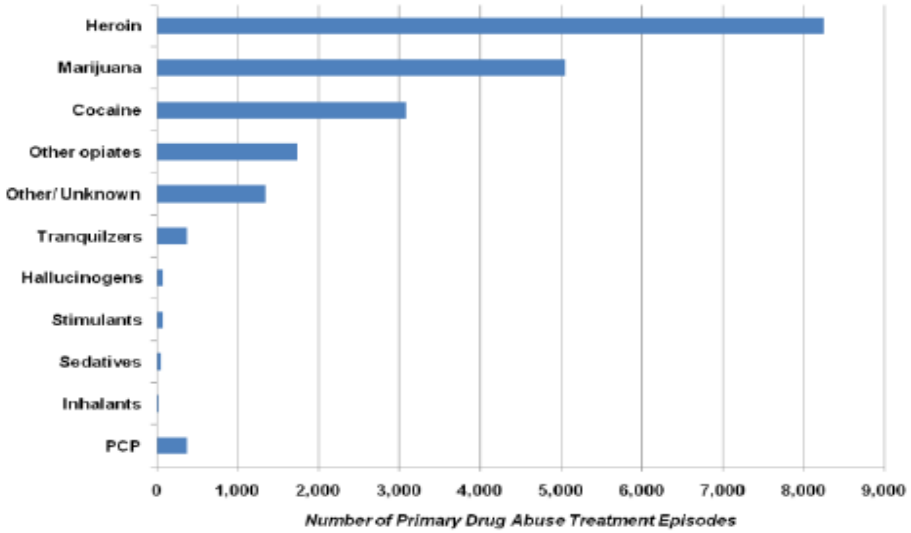
Table 2. Change in number of heroin users in the US by age group for 2002-2005, 2009-2011

	2002-2005	2009-2011	% change
Young Adults (18-25)	53.000	89,000	40.4 ↑
Older Adults (50+)	28,000	54,000	48.2 ↑
Youth (12-17)	28,000	27,000	3.5 ↓

- The **average age at first use** among recent heroin initiates aged 12 to 49 was **22.1 years**, which was similar to the 2010 estimate (21.4 years).

In Connecticut:
Figure 21 below depicts substance abuse primary treatment admission in Connecticut in 2010. The data show heroin is the most commonly cited drug among primary drug treatment admissions in Connecticut.

Figure 21. Connecticut Primary Drug Abuse Treatment Episodes in 2010 by Type of Drug



Source: Substance Abuse Treatment Admissions by Primary Substance of Abuse 2009, www.dasis.samhsa.gov/webt/quicklink/TN09.htm

In LFCRAC Region:

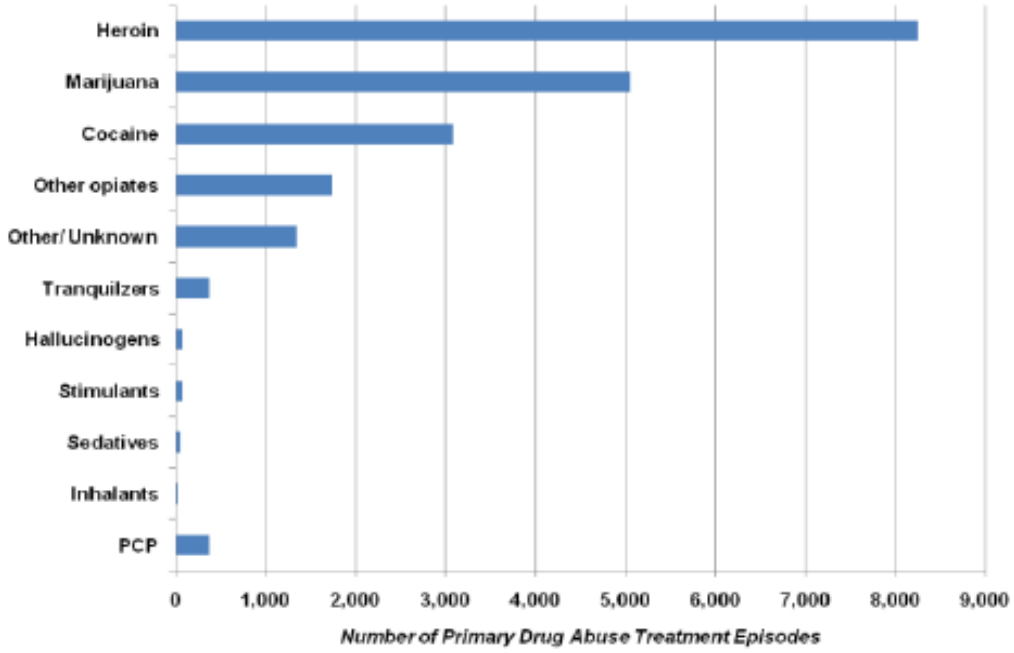
- Law enforcement officials in some LFCRAC communities have indicated there has been an increase in heroin use. Although use is primarily amongst adults, law enforcement officials have seen an increase in heroin use amongst youth. They indicated the increase in heroin in this region is because:
  - Heroin can now be snorted versus injected, therefore more appealing
  - Individuals addicted to Rx opiates switch to heroin which is a cheaper opiate.

- Stamford hospital survey data from 2011 found that a range of .1-.7% of respondents from LFCRAC communities had used heroin within last 12 months.

Primary :

Figure 22 below depicts substance abuse primary treatment admission in Connecticut in 2010. The data show heroin is the most commonly cited drug among primary drug treatment admissions in Connecticut.

Figure 22. CT Primary Drug Abuse Treatment Episodes in 2010 by Type of Drug



Source: Substance Abuse Treatment Admissions by Primary Substance of Abuse 2009, www.dasis.samhsa.gov/webt/quicklink/TN09.htm

Crime, Drug Arrests, 2009, Rate per 10,000

Crime arrest data for illicit drugs was an aggregate for all drugs and it is not clear what percentage is for heroin arrests. Therefore figures on arrest data for heroin are not included this report.

Impact

- Heroin suppresses the Central Nervous System which can slow down breathing to the point of respiratory arrest
- Risk of addiction is high.
- Extreme withdrawal symptoms (e.g., extreme craving for the drug, restlessness, muscle and bone pain, vomiting
- Risk of accidental overdose. Heroin can be mixed with a number of other ingredients before it reaches the user. Therefore, one is not sure of the potency of the heroin.
- If injected, risk of contracting hepatitis virus, HIV or other blood- borne diseases
- Heroin is an illicit drug, therefore associated legal risks
- In one LFCRAC community, law enforcement is noticing a correlation between heroin use and motor vehicle theft and house burglaries

Capacity

Prevention

Awareness about the harmful effects and high potential for addiction continues to be important information for parents and youth. Although NSDUH 2011 study indicated that "the percentages of youths who perceived great risk in using other drugs once or twice a week were 79.7 percent for heroin". This is high in comparison to perception of other illicit drugs such as marijuana (44.8%).

Information on harmful effects is available through presentations and numerous websites. One of the local law enforcement also provides visual samples which parents appreciate.

Treatment

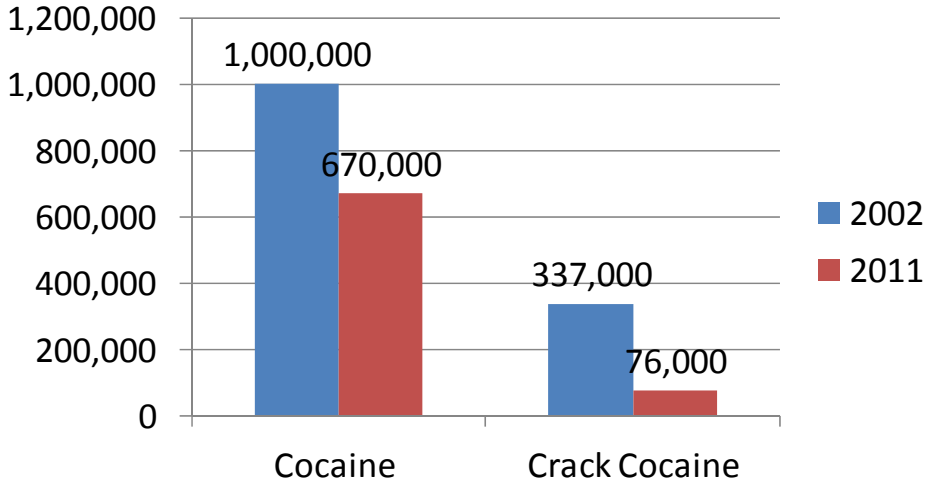
All treatment providers have the capacity to treat heroin addiction through a number of behavioral and medication treatment modalities. One of the larger DMHAS funded providers in the region does have a methadone clinic.

Cocaine

Magnitude

NSDUH 2011 survey results indicate that the number of people who initiated the use of cocaine averaged 1,800/day. This number has not changed substantially since 2008. The average age at first use among recent initiates has also remained fairly stable at 20.1 years since 2002. However there has been a substantial change in numbers of initiates for both cocaine and crack cocaine between 2002 and 2011 as noted in **Figure 23** below. The change in numbers correlates to 33 percent and 77 percent decrease for cocaine and crack cocaine, respectively.

Figure 23. Change in annual number of initiates for cocaine and crack cocaine between 2002 and 2011.



Source: NSDUH 2011

In the LFCRAC region, primary users are adults. Cocaine is an expensive drug and therefore not as readily available for youth. However, CNAW members are not sure if perception of risk also correlates with very low use amongst youth in the more affluent LFCRAC communities.

Crack cocaine is being used by adults in some LFCRAC communities but law enforcement officials indicate that the rates of use are low compared to other illicit drugs such as marijuana or heroin. DMHAS treatment data for 2011 indicates that the admission rate for cocaine amongst 18-25 year olds is 15.8% for SW CT as compared with the CT rate of 17.9 percent. It is important to note that the limitation of this data is that these percentages represent those individuals who indicate cocaine use at the time of admission.

Impact

Crime arrest data for illicit drugs was an aggregate for all drugs and so it is not clear what percentage is for cocaine arrests (data not available). Therefore figures on arrest data for cocaine or crack cocaine are not included this report

Cocaine:

- Powdered form, ingested nasally
- Very addictive
- Overdose can develop quickly and so users can die before help arrives.
- Prolonged use of snorting cocaine cause ulcerations in the mucous membrane of the nose and holes in the barrier separating the nostrils.

Crack cocaine:

- Derived from powdered cocaine, smoked
- Highly addictive (more so than powdered cocaine)

Related health risks for cocaine and crack cocaine:

- Heart disease, heart attacks, respiratory failure, strokes, seizures, and gastrointestinal problems are not uncommon among long-term users of cocaine and crack (source: http://alcoholism.about.com/od/coke/a/cocaine.htm)

Capacity

Readiness to support prevention and treatment of cocaine

Prevention Resources

The topic of illicit drugs is covered in schools where substance abuse prevention classes are provided. Clinicians from local treatment provider agencies and/or local law enforcement readily discuss this in their presentations to students and parents. However, these presentations are by invitation and not everyone requests these types of drug information presentations.

LFCRAC sends out alerts and research updates which can include the topic of cocaine.

Treatment Resources

At this time, there is an adequate number of treatment providers; state funded and private, to meet the needs of those addicted to cocaine.

Problem Gambling

Magnitude

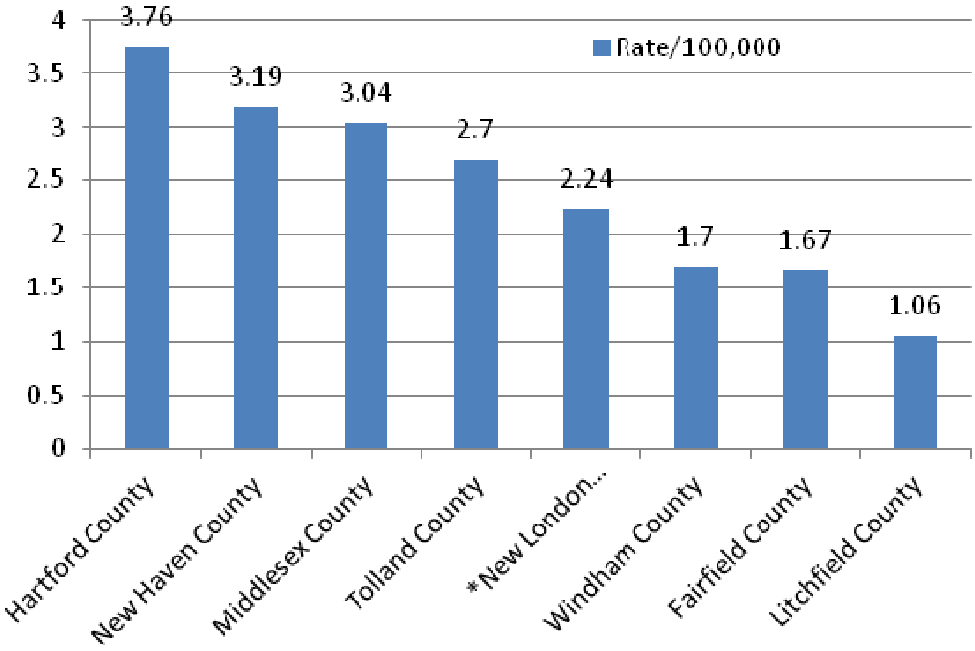
In the LFCRAC region, gambling was rated as the lowest priority issue in terms of magnitude and impact. CNAW members representing many different sectors did not know of any data measuring gambling or that it was a topic that needed to be addressed. In previous regional profiles, gambling was also rated as a low priority. A 2009 state-sponsored report titled *Gambling in Connecticut: Analyzing the Economic and Social Impacts* provided prevalence rates for probable problem and probable pathological gamblers shown in **Table 3** below. Problem gambling was defined by the National Council on Problem Gambling "as behavior that causes disruptions in any major area of life" and "pathological or compulsive gambling, a progressive addiction." These prevalence rates were calculated based on responses to widely accepted screening tools called SOGS used in 2,298 random telephone surveys.

Table 3. Prevalence of probable pathological and problem gamblers 18yrs + in Connecticut

Use	Probable pathological gamblers:	Problem gamblers:
Past year	.7 percent (18,667)	1.5 percent (40,001)
Lifetime	.9 percent (24,001)	2.2 percent (58,669)

Fairfield county prevalence rates are low compared to most other counties, placing 2nd lowest in overall ranking (**Figure 24**).

Figure 24. Connecticut Prevalence Rates by County*



Source: South Oaks Gambling Screen data 2009
*Foxwoods and Mohegan Sun are in New London County

Anecdotally, offshore sports wagering and gambling associated with organized crime have identified as the most significant gambling issues in this region. Both of these issues are being addressed by local law enforcement.

Many people are not aware of the gambling laws or know the signs and symptoms of problem gambling. This information is not requested and when offered, is often politely refused.

More treatment providers are being trained in gambling awareness because a comorbidity is frequently observed with problem and pathological gambling. A national study of lifetime gambling prevalence and comorbidity found that, amongst pathological gamblers, 73.2% had an alcohol-use disorder, 38.1% had a drug use disorder, and 60.4%.[10] In Connecticut, nearly 15 percent of problem gamblers sought help for alcohol or drug use compared to 3 percent of non-problem gamblers, based on results of the results of a survey by the Spectrum Gaming Group.[11]

Impact

CT Problem Gambling Services Help Hotline 2011 report that the top three problems reported to have resulted from gambling for both women and men are:

- anxiety and depression
- family/spousal conflict
- difficulty paying bills (related to mismanagement of funds due to problem gambling).

Physical health issues related to pathological gambling include:

- allergies
- respiratory problems
- nervous system disorders
- sleep disturbances
- back problems
- dental or oral problems
- obesity
- chronic tiredness
- colds and flu
- migraines
- gastric pains.

Pathological gamblers are also more likely to rate themselves as being in poorer overall health.[12,13]

Capacity

Readiness to address gambling was scored as the lowest priority on the matrix (1 out of 5)

Prevention Resources

LFCRAC oversees the training and implementation of a curriculum called "Taking Charge: A Path to Healthy Choices". This is a multi-session group curriculum addressing risk behaviors, problem solving, risk reduction and healthy decision making for middle and high school-aged youth. Education about gambling includes definitions, impact on the developing brain and related laws, and these are incorporated into a curriculum that focuses on building social competency skills. Infusing gambling into the curriculum has been an effective strategy to increase awareness on this topic. Evaluation results show the biggest learning curve for gambling.

Treatment Resources

Two of the largest treatment providers in LFCRAC region participate in a pilot funded by DMHAS Problem Gambling Services where the focus is to create gambling informed treatment which includes but is not limited to screening questions for gambling and providing appropriate treatment.

Recommendations

1. Hold quarterly regional meetings for providers implementing gambling prevention and treatment services. LFCRAC will be participating in these meetings which should begin by spring 2013. The meetings will provide an opportunity to share updates on resources and initiatives which will ensure better coordination and effective use of resources.

2. Continue to use opportunities to infuse gambling awareness into existing programs and other opportunities.

Suicide

Magnitude

Overall regionally, CNAW members indicated that suicide was low in terms of magnitude although one community ranked it high because there had 4 suicide attempts in recent months. There is no data specific to the LFCRAC region but on June 7, 2012 a local paper reported the following statistics:

- Suicides are in Fairfield County are at a 20 year high
- 371 suicide cases were reported in CT in 2011 (most cases reported since 1991)
- 2011: Fairfield County had the third most suicides in CT with 64 out of a population of 918,714 (New Haven County had the most with 99 suicides out of 862,989 people, and Hartford County was second with 87 suicides out of 894,714) (source: Office of the Chief Medical Examiner- CT)
- CT is low in terms of completed suicides but has the second highest *rate* of attempted suicides in the US. One percent of Connecticut residents surveyed said that they had attempted suicide, compared with the national average of 0.5 percent (source: CDC Report 10/20/2011 http://www.cdc.gov/media/releases/2011/p1020_suicidal_thoughts.html).

Additional prevalence data:

- 1999 to 2007 **-** Suicide has been one of the top 5 leading causes of death for 10-54 year olds in CT, and second for young adults 18-24 in college (sources: AAS, WISQARS).

Self-Reported Suicidal Behavior in CT (Youth 9-12th grade, 2009) (source: Connecticut School Health Survey 2001 Results)

- Sad or Hopeless: 25% reported feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped participating in usual activities during the 12 months before the survey.
- Considered Suicide: 14.1% reported seriously considered attempting suicide during the 12 months before the survey.
- Made a Suicide Plan: 11% made a plan about how they would attempt suicide during the 12 months before the survey.
- Attempted Suicide: 7.4% attempted suicide during the 12 months before the survey.

Attempt resulting in medical treatment: 2.7% had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the 12 months before the survey.

Capacity

Community readiness to address this issue scored low as suicide is a difficult topic to discuss. However, all agreed that existing resources should be used to their maximum capacity to help prevent suicides.

DMHAS Region 1 Regional Priority Services Report from August 2012 supported this approach as noted in its recommendation to "increase capacity of community members to understand suicide trends, risk factors and resources available (note: The Regional Priority Services Report identifies mental health service priority needs and recommendations and is a collaborative effort with Regional Mental Health Boards and Regional Action Councils).

Gaps

There is a need for more mental health services for youth in our region. A CNAW member indicated that the number of kids with suicidal ideation and other mental health issues has increased and schools in some of LFCRAC communities have supported this.

Resources available:

Website: www.preventsuicidect.org is a comprehensive site of information and other resources for anyone to use. It includes information on warning signs, resources (including trainings) materials for download and relevant links.

QPR Training: A simple educational program that teaches ordinary citizens how to recognize the warning signs of a suicide crisis and how to question, persuade and refer someone to help. RYASAP and LFCRAC Directors are QPR trainers and can be contacted to do these one hour trainings.

Mental Health First Aid: LFCRAC is working with regional partners (RYASAP, MFSAC and SWRMHB) and local partners to increase the number of community members trained in Mental Health First Aid. We have an excellent trainer for this region and she has completed a number of trainings to different groups. We hope to have more school staff trained in this course so that they are able to recognize the warning signs of a child in distress.
Note: Regional Action Councils and the Regional Mental Health Board will share the costs to send the Mental Health First Aid trainer to get certified in the newly developed Youth Mental Health First Aid.

Resource List of Behavioral Health Services in LFCRAC region: A comprehensive list of behavioral services for both youth and adult was created by the LFCRAC SBIRT committee that is available for clinicians, school support staff, physicians and others who may be seeking assistance for a client or patient. This list of services is in binder, on CD and will soon be on the LFCRAC website.

Keep The Promise (KTP) advocacy organization: This organization is a statewide legislative advocacy group. Increasing school based mental health services is one of their legislative priorities. They will help communities and groups to organize and support this issue.

Recommendations:

Regional Action Councils and Regional Mental Health Boards continue to work together to regionally coordinate mental health capacity building initiatives such as Mental Health First Aid Training.

LFCRAC communities support advocacy efforts to increase mental health services for youth in this region.

Continue to support anti-bullying programs in schools (bullying is a risk factor for suicide).

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Appendix 1: Definitions

Sex: Individuals mark either “male” or “female” to indicate their biological sex.

Race: The racial classifications used by the Census Bureau adhere to standards issued by the federal Office of Management and Budget. OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race and that respondents should be offered the option of selecting one or more races. If an individual did not provide a race response, the race or races of the householder or other household members were imputed using specific rules of precedence of household relationship.

Hispanic or Latino Origin: Hispanics or Latinos who identify with the terms “Hispanic,” “Latino,” or “Spanish” are those who classify themselves in one of the specific Hispanic, Latino, or Spanish categories listed on the questionnaire (“Mexican,” “Puerto Rican,” or “Cuban”) as well as those who indicate that they are “another Hispanic, Latino, or Spanish origin.” People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are “another Hispanic, Latino, or Spanish origin” are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Educational Attainment: Respondents are classified according to the highest degree or the highest level of school completed. Educational attainment data are needed for use in assessing the socioeconomic condition of the U.S. population. Government agencies also require these data for funding allocations and program planning and implementation. These data are needed to determine the extent of illiteracy rates of citizens in language minorities in order to meet statutory requirements under the Voting Rights Act. Based on data about educational attainment, school districts are allocated funds to provide classes in basic skills to adults who have not completed high school.

Median Age: The median age is the age that divides the population into two equal-size groups. Half of the population is older than the median age and half is younger. Median age is based on a standard distribution of the population by single years of age and is shown to the nearest tenth of a year.

Poverty Status: To determine a person's poverty status, one compares the person’s total family income in the last 12 months with the poverty threshold appropriate for that person's family size and composition. If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered “below the poverty level,” together with every member of his or her family. If a person is not living with anyone related by birth, marriage, or adoption, then the person's own income is compared with his or her poverty threshold. The total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold.

Arrests for Liquor Law Violations

Definition

Arrests recorded for possession of alcohol by minor, sale or provision of alcohol to minors, or fake/false identification. This does not include public drunkenness, driving under the influence or administrative actions taken by the Department of Consumer Protection Liquor Control Commission against liquor permittees.

Strengths

Liquor law violations are a direct consequence of alcohol misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations

Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Drug Law Violations

Definition

Arrests related to narcotic drugs, such as unlawful possession, sale, use, growing and manufacturing of narcotic drugs.

Strengths

Narcotic drug law violations are a direct consequence of drug use. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations

Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Alcohol and Other Drug Related School Suspension or Expulsion

Definition

A sanction determined the school administration due to violation of a publicized policy; or serious disruption of the educational process; or endangerment to persons or property.

Strengths

Students who use alcohol, tobacco or other drugs at an early age and use substances frequently are more likely than other students to continue to face suspension or expulsion. These data are based on uniform definitions applied to all schools in the state and, therefore, have comparative values.

Limitations

The definition for counting drug or alcohol disciplinary offense is uniformly defined statewide. However, the specific data collection requirements have changed in recent years. Therefore, these data are not necessarily comparable across years. The data should be used with discretion.

Tobacco Retailer Violation

Definition

Tobacco retailers who sold tobacco to minors working undercover for the CT DMHAS Tobacco Prevention and Enforcement Program.

Strengths

Tobacco use by minors is a consequence of access to tobacco products. The Synar Amendment requires states and U.S. jurisdictions to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons under 18. As a result, over the last 14 years, data reported by states and the District of Columbia has indicated a clear downward trend towards reducing tobacco sales to minors. Data on retailer violations have been systematically collected by DMHAS for many years.

Limitations

This indicator may be unstable for areas or subgroups that have small population sizes, which are not routinely subject to inspections by DMHAS.

Appendix 2: Priority Setting Process

The CT State Epidemiologic Workgroup developed a process systematically collecting rankings of the substance abuse and behavioral problems with the highest prevalence in and impact on the subregion. After preparing the eight Subregional Profiles, the RAC convenes its Community Needs Assessment Workgroup to review the data and information contained Profiles. Using a Priority Rating Matrix (shown below), each CNAW member scores each problem on a scale of one to five (low to high priority) using the following criteria:

Magnitude (Burden and breadth of problem)

- A relatively large number of people are affected
- The number affected is sufficient to assess statistically significant change over time, settings and sub-groups

Impact (Depth of problem across dimensions)

- The social (i.e., health, economic, criminal justice) costs are high

Changeability (Reversibility)

- The indicator is amenable to change
- Resources and evidence-based strategies are available to affect change in the indicator

Appendix 3: Four Core Measures

1. **Past 30-Day Use**
   - The percentage of respondents who report using alcohol, tobacco, or marijuana at least **ONCE** in the past 30 days
2. **Perception of Peer Disapproval**
   - The percentage of respondents who report **their peers feel regular use** of alcohol, tobacco, or marijuana is wrong or very wrong.
3. **Perception of Risk**
   - The percentage of respondents who report that **regular use** of alcohol, tobacco, or marijuana has ***moderate risk*** or ***great risk***
     - **Regular use** is defined for *alcohol as one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day*.
     - **Regular use** is defined for *tobacco as one or more packs of cigarettes a day.*
     - **Regular use** for *marijuana is not defined*.
4. **Perception of Parental Disapproval**
   - The percentage of respondents who report their parents feel **regular use** of *alcohol* is ***wrong*** or ***very wrong***
   - The percentage of respondents who report their parents feel ANY use of *cigarettes* or *marijuana* is *wrong* or *very wrong*