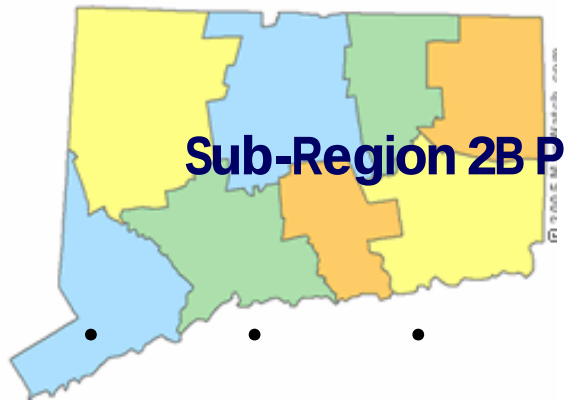
State of Connecticut
Department of Mental Health & Addiction Services
Prevention and Health Promotion Unit



Sub-Region 2B Prevention Priority Report

Prepared by
South Central Connecticut Regional Action Council
October 2008

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Commissioner

dmhas

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Executive Summary

Demographic Profile

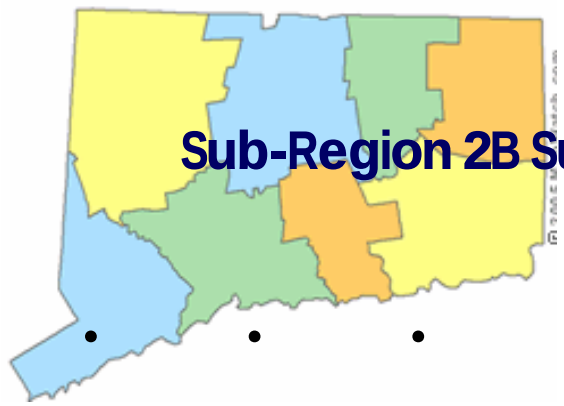
The South Central Connecticut Regional Action Council is one of the 14 sub- regions in Connecticut. SCCRAC serves 13 towns in the south central part of the state. The population varies within the region with the highest population 123,626 (New Haven) and the lowest population being 5,040 (Bethany) based on the 2000 Census Data. Notable increases in population have been consistent throughout the sub-region since the 2000 Census data. Specifically, the largest populated City of New Haven has increased to 130, 625 and Bethany's population (lowest town population) also has risen modestly to 5,344. The most recent population statistics are based on the Economic Development Data and Information Report of 2007.

There is a great disparity with incomes through the state. The median income varies from a high ($100,283) to a low ($32,574). Based on the 2007 EDDI, the median income for the South Central Connecticut sub-region was $72, 523. This is a significant higher average than that of the State of $53, 935. However, New Haven, the largest city within the sub-region, forecasts a troublesome trend. New Haven's median income of $29,604(2000 Census data) and $35, 841 (2007 EDDI) is the largest populated city and lowest median income in the sub-region. New Haven's median income is significantly lower than the state median income average of $53, 935. This spike in population (approximately 7000 residents from 2000-2007) identifies a migration trend of low income residents to New Haven. Social indicator data based on renter occupied units in New Haven are approximately 65% versus owner occupied units being approximately 25%. This is by far the highest renter/owner occupied housing ration throughout the sub-region.

In addition, Connecticut's white and nonwhite populations are not uniform; mainly due to the exodus of the middle class settling in the suburban areas of the state and leaving only the urban poor in the impoverished Connecticut cities. According to the data, in the urban areas such as New Haven, you can see that there is a large shortage of Whites. In many of the wealthy, suburban, and rural Connecticut cities there is a shortage of Hispanics and Blacks. Hispanics and Blacks had the most balanced incidence in the urban areas. New Haven actually has a surplus of Hispanics and Blacks. The other racial category, which is mostly Asian, had a higher percentage of people living in the Woodbridge area. All data comes from the 2000 U.S. Census Bureau. See Table 1 for more demographic information on population size and race.

Table 1. SCCRAC Community Needs Assessment Workgroup (CNAW)

Member Name	Community Sector Represented	Contribution to Sub-Regional Prevention Priority Report
Darryl Hugley	Youth Programming	CNAW
Michael Jefferson	Civic	CNAW
Michael Conaway	School	CNAW
Erma Harris	Religious	CNAW
Sharon Meyers	Healthcare	CNAW
Glenn Xavier	School	CNAW
Quiana Patterson	Local Agency	CNAW
Rhonda Lucineo	Parent	CNAW



Sub-Region 2B Substance Abuse Profiles

Prepared by
South Central Connecticut Regional Action Council
October 2008

Alcohol

Consumption

Data from the GPIY Report of 2000 and the Connecticut Core Survey of 2006 revealed Regional, State, and Local past month alcohol use. New Haven had the highest percentage of past 30 day alcohol use for 7th-8th graders (25.9%-33.2%). East Haven, Guilford, and Orange all had the highest percentage of past 30 day use for 9th-10th graders (48.2%-52.6%).

Connecticut's Core Survey of college student's past month use for underage consumption was at 75.7%. This was a 4% increase from the Connecticut Core Survey of 2004 which saw 71.9% of youth drinking in the past 30 days. The percentage of underage students drinking in 2006 was 71.4% which was over an 8% increase of 63.4% in 2004. 53.6% of students reported binge drinking in the last 2 weeks compared to 45.8% in 2004. Binge drinking and last 30 day use have seen tremendous rise in consumption from 2004 – 2006.

Consequences

In South Central Connecticut, alcohol was attributed to 30% of homicides and 20% of suicide deaths. Connecticut had 29 alcohol related homicides and 51 alcohol related suicides. These numbers come from the Connecticut Department of Public Health. No information could be obtained on the sub-regional level for homicide and suicide deaths related to alcohol.

There were more alcohol involved motor vehicle accidents than alcohol involved motor vehicle fatalities. Per the Department of Transportation (2000), New Haven had the highest number of accidents and fatalities involving alcohol than any other town in South Central Connecticut. Contributing factors for the higher numbers include a larger resident population and the urban community settings. Other towns have smaller resident populations and are considered to be suburban communities.

According to the Connecticut Department of Public Safety Crime Analysis Unit, crimes in New Haven and Hamden had the highest number of property crimes and violent crimes of the sub-region; partly because New Haven has a larger population and Hamden has a larger community of college students. New Haven, East Haven, and Hamden all have a moderate number of DUI offenses, whereas Hamden and Guilford have the highest numbers of underage liquor violations.

Based on Connecticut's Info line 211 statistics of 2007, Statewide Alcohol Inpatient Detoxification and Alcohol Dependency support groups received 2,289 and 3,216 calls respectively. Calls for sober living homes were 1,731. Only residential substance abuse treatment and inpatient drug detoxification received more calls for assistance. Substance abuse treatment calls for New Haven were at its highest of 3,333 a rate of approximately 267 per 10,000 residents. This was the second highest rate in Connecticut in 2007 of any town or city. East Haven and West Haven each had rates of 81 and 83 respectively per 10,000 persons and the 2nd and 3rd highest in the region in 2007. The towns of Branford and Milford had rates of 72 per 10,000 persons each. Localized data indicators of substance abuse request are not exclusive to alcohol and may represent other illicit drugs.

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in the South Central Connecticut sub-region identified alcohol as the most significant substance used among youths ages 12-17 and young adults ages 18-25. Key informants identified drinking alcohol among community members ages 26-65 and older were not perceived as the most significant substance; however, it is perceived by the informants to still be a significant problem across the lifespan in their community.Throughout the sub-region, key informants in New Haven were not convinced that their City was concerned with prevention alcohol and other drug abuse. Neighboring towns in South Central Connecticut identified that their town was concerned about preventing alcohol and other drugs. Informants identified that all youth regardless of socioeconomic status are at risk for substance abuse. Consistent throughout the sub-region was the community perception that alcohol and other drug prevention programs are good investments for the community. The community attitudes of being okay toward adults getting drunk occasionally was divided between being in somewhat agreement and somewhat disagreement. The split in adult

behavior versus behavioral attitudes toward alcohol consumption for youth could be a barrier for effective prevention efforts throughout the sub-region.

Key informants views on effectiveness among existing coalitions that address substance abuse varied in New Haven yet were somewhat effective for neighboring towns in South Central Connecticut. Key strategies identified that were perceived very effective positive youth development programs such as after school programs, peer leadership programs, and faith based youth groups. The most significant strategy and/or activity identified by key informants were adolescent substance abuse treatment services and youth life skill training such as problem solving, drug refusal, and healthy relationships.

Sub-Region 2B Substance Abuse Profile

Tobacco

Consumption

In 2006, the South Central Connecticut Regional Action Council anonymously surveyed youth in the Greater New Haven community to gain understanding of age of onset and past 30 day use with tobacco. The survey was completed and submitted anonymously via the internet by visiting the SCCRAC's online survey page of the South Central Connecticut Regional Action Council's website. A total of 241 surveys were collected. African American respondents consisted of 40% of the respondents while 33% were Hispanics, and 27% identified themselves as White. Respondents represented 11 towns within the sub-region.

In regards to tobacco use, past 30 day use identifies 48 out of 241 respondents or approximately 20% reported having smoked cigarettes at least once in the past 30 days in comparison to 50% who say that they have not smoked in the last 30 days. 8% of respondents from past 30 usage were 7th-8th graders. 12% of the students were in grade 9th-10th. These statistics represent a decline in use among 8th graders from the Statewide GPIY Report of 2000. In 2000, 12.1% of 8th graders in Connecticut and the U.S. reported cigarette use in the last 30 days. It was noted that with the use of cigarettes, a strong correlation of usage with non-cigarette tobacco and marijuana. Initiation of all is at nearly the same age thus suggests that tobacco serves as a "gateway" substance to other risky ATOD behavior.

When ethnic groups were examined, usage among Whites, African Americans, and Hispanics were equally represented with initial use. White students had the lowest initial use of 10.7% while Hispanics was the highest at 16.7%. African Americans initial usage was 12.8%. By the 10th grade, increases in White students were the highest with a 14% increase (24.9%), African American students rose 5% to 17.3% overall and Hispanic students had the lowest increase of 3% (19.5).

Primary sources of cigarettes among youth from 7th-10th grade were from friends. Students in 7th and 8th grade accessed friends 85.8% of the time and students in grades 9th and 10th 92.4% of the time. The second highest access to cigarettes was illegal purchases from stores. 7th and 8th graders purchased from stores at a rate of 29.5% and 54.7% for 9th and 10th graders.

By 10th grade, 23.5% of youth in Connecticut had reported smoking within the last 30 days. One universal trend nationally and throughout Connecticut is the significant increase in cigarette usage from middle school to the end of high school. Data depicting primary sources of cigarettes as well as ethnic groups represented in the consumption of cigarettes is the GPIY Report of 2000.

Consequences

Consequences for cigarette based tobacco use have life threatening affects over the life span. For youth, immediate consequences appear to be low risk due to the long term affects however, cigarettes are the leading cause of death in the United States with approximately over 400,000 deaths per year caused by smoking. In Connecticut, 4,900 adults die each year due to smoking while 76,000 youth will die prematurely from smoking. There are currently 186,000 youth being affected by second hand smoke in the home and 250-700 non-smoking adults who die form second hand smoke exposure.

The Department of Revenue Services in partnership with the Department of Mental Health and Addiction Services are responsible for enforcing the Synar Amendment which enforces Connecticut's tobacco laws are a key environmental strategy that is implemented throughout the United States. Per Federal regulations, no State may have more than a 20% non-compliance rate. Connecticut's non-compliance rate for 2007 was 14%. Region 5 had the highest rate of non-compliance at 18.1% while South Central Connecticut had the lowest of 6.5%. Region 4, 3 and 1 had 17.3%, 13.5% and 13.9% respectively.

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in South Central Connecticut sub-region identified tobacco as the most significant substance used among adults ages 26-65.

Tobacco was not the primary concern for the oldest age group of 66 and older however; it was selected by 30% of key informants as being

most significant for this age group. Tobacco also was significant for youth ages 12-17 but was not overall the most significant. Tobacco like alcohol was the only two substances that were considered a significant problem across the lifespan for each observed age group.

Key informants from the 2008 Readiness Survey identified that insufficient awareness among current efforts among community members were a large barrier to prevention activities. This coupled with lack of knowledge of effective strategies to address substance abuse problems were universally recognized and supported with the perception of readiness on developing a strategic plan to address substance abuse in the community seen with low to medium readiness.

Sub-Region 2B Substance Abuse Profile

Marijuana

Consumption

The National Survey of Drug Use and Health showed that the prevalence of current marijuana use has increased in Connecticut from 5.2% in 1999 to 6.25% in 2002. The Milford GPIY 2000 Report revealed that marijuana usage for youth 7th and 8th grade was 14.1%. By 10th grade, lifetime use had increased to 41.1%. In the past month, 4.9% of youth reported using marijuana three or more days for 7th and 8th graders while 19% reported using marijuana more than three days for 9th and 10th graders within the last 30 days.

Although more recent survey data was unattainable, marijuana continues to be a growing concern for New Haven and surrounding towns based on focus groups and CNAW participants. Marijuana is also mixed with other illicit drugs to form more addictive substances like hash and etc.

Based on the Connecticut Core Survey of 2004 and 2006, college students reported using marijuana 34.7% in the past year in 2004 and 37.6% in 2006. Past 30 day use revealed that 20.5% of collegiate students in 2004 consumed marijuana while 23.2% used marijuana in the past 30 days in 2006. Students who felt that there was great risk with smoking marijuana once or twice was 6.8% in 2006 in comparison of 44.9% of students that felt that smoking marijuana regularly was indeed a great risk. In 2004, the Connecticut Core Survey results revealed that the perception of trying marijuana once or twice was 9% and 44.9% for students who smoked regularly perceived that marijuana was a great risk. This data suggests the perception of marijuana is a great risk overall, reduced from 2004 – 2006 which supports last year and last 30 day use increase over the same period.

Consequences

Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than non-smokers. In the short term, marijuana use may cause adverse physical, mental, emotional, and behavioral changes such as problems with memory and learning, distorted perception, difficulty in thinking and problem solving, loss of coordination, and increased heart rate.

Longer term marijuana use results in changes in the brain similar to those seen after long term use of other major drugs of abuse. Depression, anxiety, and personality disturbances have been associated with marijuana. Marijuana is also mixed with other illicit drugs when consumed which makes marijuana have a "gateway" effect for other drug experimentation. Initiation of marijuana related treatment admissions to publicly funded facilities in Connecticut has increased annually since 1994.

Smoking marijuana impairs short term memory and learning; the ability to focus attention and coordination. It also increases heart rates, can harm lungs and cause psychosis in those already at-risk. Initiation of marijuana related treatment admissions to publicly funded facilities in Connecticut has increased annually since 1994. Connecticut is ranked 19th in the Nation for the rate of marijuana related treated admissions (134 per 100,000).

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in the South Central Connecticut sub-region did not identify marijuana as the most significant substance used for any of the three age brackets. Marijuana was however rated as #1 for the 18-25 age categories by a small portion of key informants. Marijuana was identified as a perceived significant problem in each age bracket from 12-65 year olds. Marijuana was considered a minor problem for residents 66 years of age and older. Marijuana was highlighted in the narrative section of the survey as being a major concern with the different forms of marijuana that is being experimented with that has harsher consequences than traditional marijuana. Another mention regarding marijuana was that perception of enforcement was low while other illicit drugs were concentrated on that have harsher social

Throughout the sub-region, key informants in New Haven were not convinced that their City was concerned with preventing alcohol and other substance abuse. Neighboring towns in South Central Connecticut identified that their

town was concerned about preventing alcohol and other drugs. Informants identified that all youth regardless of socioeconomic status are at risk of substance abuse. Consistent throughout the sub-region was the community perception that alcohol and other drug prevention programs are good investments for the community. The community attitudes of being okay toward adults getting drunk occasionally, was divided between being in somewhat agreement and somewhat disagreement. This split in adult behavior versus behavioral attitudes toward alcohol consumption for youth could be a barrier for effective prevention efforts throughout the sub-region.

Although some towns identified high level of readiness, overall, the majority of communities expressed a moderate level of readiness to develop strategic plans for communities at large.

Sub-Region 2B Substance Abuse Profile

Cocaine

Consumption

According to the National Office of Drug Control Policy, cocaine, both powered and crack is the second highest illicit drug threat after heroin. Based on data from the 1999 – 2001 NSDUH, it was estimated that 1.8% of Connecticut residents used cocaine during the past year. Past year cocaine use was highest among the State's 18-25 year olds (4.8%) and 12-17 year olds (1.5%) although both rates were below those found nationally. However, the rate of cocaine use among adults 26 and older in Connecticut was 25% higher than the nationwide rate. Among 9th and 10th graders, the rate of current cocaine use increased slightly from 1.4% in 1997 to 1.7% in 2000.

The Connecticut Household Survey found that lifetime rates for cocaine use increased from 8.6% in 1995 to 14.6% in 2003 with males and Caucasians with the highest rates of lifetime cocaine use. In contrast, data from the 2001 and 2003 Connecticut Core Survey of college students found that the prevalence of current cocaine use decreased form 2.7% to 2.3% in 2003 (CT SEW Substance Use Profiles).

In the NSDUH, 2002 – 20004 last year use among youth 12 and older nationally was at 2.46%. Last year use for the State of Connecticut for the same age group was 2.14% with a South Central region (New Haven County) use of 2.21%. As evidence by the data, last year survey data use was consistent with National, State and Regional consumption.

Based on the GPIY 2000 Report for the State of Connecticut and Milford (the only town represented individually in the region), lifetime use of cocaine for 7th and 8th graders were slightly higher than State average of use (1.3%) versus 2% in Milford. By 10th grade, lifetime cocaine use almost doubled the State average of 3.6% to 6.9%. The same can be said for crack cocaine as well. By 10th grade, State averages were 2.6% and lifetime use versus 5.7% for Milford youth. Past month cocaine use for Milford youth in grades 7th and 8th was 1.5% while by 10th grade the number grew significantly to 4.3%. Of this 4.3%, 2.6% had used cocaine in the last month 1-2 days while 1.7% used cocaine 3 or more days.

Based on the Connecticut Core Survey of 2006, 3% of students reported past 30 day cocaine use. The last 30 day cocaine use has been steady since 2001 with 2.7% and 2.3% in 2004.

Consequences

There are significant physical and mental and social problems associated with cocaine use, abuse and addiction. In 2001, the social cost of cocaine consumption nationally was estimated to be $62.6 billion, the third largest cost for any drug after both tobacco and alcohol.

In 2001, data from the Connecticut Office of the Chief Medical Examiner indicated that cocaine was a factor 16.6% of all deaths statewide involving drugs. In 2003, 12.6% of all treatment admissions in Connecticut were for cocaine abuse. Cocaine treatment had the second highest treatment admission in the state of Connecticut other than heroin among illicit drugs.Cocaine use is associated with damaged family and social relationships, child abuse or neglect, lost jobs, accidents, prostitution, spread of infections, criminal behaviors, violence and homicide.

Based on the Connecticut Department of Public Health, there were 11,811 hospitalization of "drug induced" principal diagnosis for the period of 2000 – 2002. Almost four times as many hospitalizations (44,756) had drug induced as any (principal or secondary) diagnosis. Males accounted for 54.5% of hospitalizations with any drug induced diagnosis. About 80% of all cases with any drug induced diagnosis were age 15-49 with the highest rates occurring among persons aged 35-44.

Based on the Connecticut Drug Threat Assessment, powered cocaine and crack cocaine pose the greatest drug threat to Connecticut. Cocaine is readily available and its distribution and abuse are associated with more violent crime than any other drug.

The number of deaths involving cocaine abuse has increased gradually in Connecticut since 1997. According to data from the Connecticut Office of the Chief Medical Examiner, cocaine was a factor in the deaths of 11 individuals in 1997, 12 in 1998, 18 in 1999, and 19 in 2000. Nine of the 19 deaths which cocaine was a factor in

2000 also involved heroin and 12 involved methadone, morphine, codeine, and alcohol.

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in the South Central Connecticut sub-region did not identify cocaine as the most significant substance among any age group however; it was identified as a significant problem among the 18-25 and 26-65 age groups.

Cocaine was considered a minor problem for youth ages 12-17 and a non-problem for residents ages 66 and older.

Sub-Region 2B Substance Abuse Profile

Heroin

Consumption

Data from Connecticut's Adult Household Survey show that the lifetime prevalence of reported heroin use among adults 18 and older rose from 1.7% in 1995 to 2.2% (more than 56,000 persons in 2003). Connecticut's rate of heroin use among adults exceeds the National rate. The Connecticut Core Survey administered to University students in 2003 found rates of lifetime usage ranging from 3.1% to 6.1% compared to 2.4% of their college students nationally. The 2000 GPIY Student Survey found that 0.9% of 7th and 8th graders and 1.8% of 9th and 10th graders reported ever using heroin. Milford, a town in South Central Connecticut had a 3% lifetime heroin use for 7th and 8th graders. This is three times the State average for this grade group. 9th and 10th graders reported a lifetime use of 2.2%. The past month use for students in grades 7th -10th is all below 1% which suggest that experimentation was not habit forming. 79% of 7th and 8th graders and 50% of 9th and 10th graders felt it was very hard to obtain the drug while 6% for grades 7th-10th reported it was easy to acquire drugs.

Consequences

Heroin is a highly addictive drug and its abuse has repercussions that extend far beyond the individual user. The medical and social consequence of drug abuse; HIV/AIDS, tuberculosis, fetal effects, crime, violence, and disruption in the family, workplace and educational environment have a devastating impact on society and cost billions of dollars each year. In the United States, the cost of heroin addiction including the cost to treat, economic and social costs like loss of productivity has been estimated to be $26.4 billion.

In Connecticut the rate of primary heroin admissions per 100,000 populations age 12 and older increased 156% between 1992 and 2003. In 2003, 6% of all heroin admissions nationwide occurred in Connecticut.

In 2002, half (49%) of law enforcement officials in Connecticut responding to the National Drug Threat Survey reported heroin use was a high threat in their jurisdiction.

Long term effects of heroin use also can include arthritis and other rheumatologic problems and infection of blood borne pathogens. It is estimated that injection drug use has been a factor in one third of all HIV and more than half of all hepatitis C cases in the United States.

Based on the Connecticut of Health Report from 2000 – 2002, the total deaths from heroin were 144 (2000), 118 (2001), and 122 (2002). In 2000 – 2002, males comprised 83.5% and females 16.5% of all unintentional opiate overdose deaths. About 73% of decedents were White and 8.5% were African American. Almost 18% of decedents were Hispanic (of any race). The largest numbers of deaths and highest death rate occurred in the 40-44 year old age group. During this period, 41% of unintentional opiate and related narcotics poisoning deaths took place in the decedent's home.

Symptoms of heroin use include withdrawal from social situations, isolation, excessive sleeping, lack of appetite, paranoia, stealing, and dangerous withdrawal symptoms when heroin cannot be obtained such as nausea, vomiting, hyperventilation, chills, body aches and extreme restlessness.

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in the South Central Connecticut sub-region did not identify heroin as the most significant substance among any age group, however; it was identified as a significant problem among 18-25 and 26-65 year old residents. Heroin was considered a minor problem for youth 12-17 and a non-problem for 66 and older residents.

Key informants views of effectiveness among existing coalitions that address substance abuse varied in New Haven yet were somewhat effective for neighboring towns in South Central Connecticut. Key strategies identified that were perceived very effective were positive youth development programs such as after school programs, peer leadership and faith based youth groups. Strategies identified that the community needed most were adolescent substance abuse treatment services, counseling, and youth life skills

training such as problem solving, drug refusal and healthy relationships.

Key informants from the 2008 Readiness and capacity survey identified that insufficient awareness among current efforts among community members were a large barrier to prevention activities. This coupled with lack of knowledge of effective strategies to address substance abuse problems were universally recognized and supported with the perception of readiness on developing a strategic plan to address substance abuse in the community seen with low to medium readiness.

Sub-Region 2B Substance Abuse Profile

Misused Prescription Drugs

Consumption

Lifetime use of prescription drugs has risen dramatically from 1992 to 2003 by 94%. This is twice the increase in the number of people abusing marijuana, five times the increase in the number abusing cocaine and 60 times the increase in the number abusing heroin. From 1990 to 1998, the number of new users of pain relievers increased by 181%.

Misuse of prescription drugs may be the most common form of drug abuse among the elderly who use prescription medications approximately three times as frequently as the general population and have been found to have the poorest rates of compliance with directions for taking a medication. Young adults are also the fastest growing segment of the population abusing prescription and over the counter drugs.

In South Central Connecticut, prescription drug us has had tremendous impact on youth. Based on the Milford GPIY Report of 2000, 8.4% of youth have expressed lifetime use of downers (barbiturates, sleeping pills, and Quaaludes). This is consistent with State averages of 8.1%. Lifetime use in pain medicines for the State was 14.2% while only 10.2% for the same age bracket in Milford. There was less than 1% of use for tranquilizers (valium, Librium) and slightly higher for uppers (stimulants and amphetamines) at 3%. This was also consistent with State averages. By 9th and 10th grade, Milford's lifetime use more than doubled all forms of prescription drugs that can be identified as downers, tranquilizers, stimulants, amphetamines, pain medicines, and steroids. Connecticut's average of lifetime use for downers was 12.6% while the town of Milford's lifetime use was 25.4%. These averages were dramatically higher than State averages. Pain medicine's lifetime usage is 14.2% for the State while in Milford, by 10th grade, lifetime pain medicine usage was 27.5%. Stimulants and amphetamines double the State averages of 7.3% for 9th and 10th graders with a lifetime usage of 15.5% for the town of Milford. Tranquilizers use among 9th and 10th graders also more than doubled with 3% versus 7.3%.

Consequences

Prescription medications are increasingly being abused or used for non-medical purposes. This practice is not only addictive but in some cases also lethal. Commonly abused classes of prescription drugs include painkillers, sedatives, and stimulants. Among the most disturbing aspects of this emerging trend is its prevalence among teenagers and young adults and the common misconception that because these medications are prescribed by physicians they are safe even when used illicitly. Prescription drugs can be constituted as pain relievers, sedatives, tranquilizers, stimulants and controlled prescription drugs like OxyContin, Ritalin, and Valium (National Institute on Drug Abuse).

Negative health consequences include the potential for developing tolerance to the drug, physical dependence, sever respiratory depression, cardiovascular failure, seizures or death can follow a large single dose of a prescription drug.

There has been a tremendous rise in the mentions of prescription drug misuse. Between 1994 and 2003, there was a 79% increase in incidents involving prescription drugs with prescription opiates demonstrating the sharpest increase of 168% during this period.

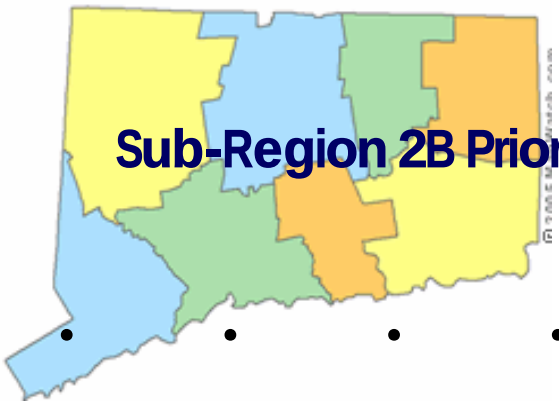
In Connecticut during the period of 1992 – 2003, there has been a 285% increase in the percentage of other opiate (non-heroin) drug primary substance abuse treatment admissions. Nationally, the estimated cost of opiate analgesic abuse in the United States was $9.2 billion.

Readiness and Capacity

The key informants from the 2008 Readiness and Capacity Assessment in the South Central Connecticut sub-region identified prescription drugs as a significant problem among residents 66 and older. Prescription drugs received recognition by some key informants as being most significant among 18-25 year old residents as well. For youth ages 12-17, prescription drugs were not considered the most significant problem but was recognized by a small group that prescription drugs were the most significant among youth ages 12-17.

Throughout the sub-region, key informants in New Haven were not convinced that their City was concerned with preventing alcohol and other substance abuse. Neighboring towns in South Central Connecticut identified that their town was concerned about preventing alcohol and other drugs. Informants identified that all youth regardless of socioeconomic status are at risk of substance abuse.

Consistent throughout the sub-region was the community perception that alcohol and other drug prevention programs are good investments for the community. The community attitudes of being okay toward adults getting drunk occasionally was divided between being in somewhat agreement and somewhat disagreement. This split in adult behavior versus behavioral attitudes toward alcohol consumption for youth could be a barrier for effective prevention efforts throughout the sub-region.



Sub-Region 2B Priority Ranking Matrix

Sub-Region 2B Priority Ranking Matrix

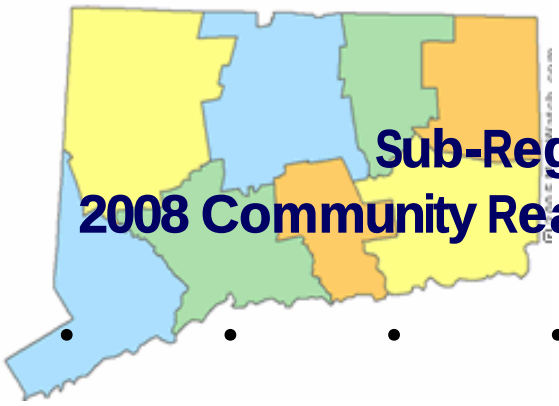
Priority Ranking Matrix

Based upon the community data on the prevalence, short- and long-term consequences, and the CNAW member knowledge of how likely the use, misuse or abuse of a substance is amenable to change (through prevention strategies including changes in societal norms) and on readiness/capacity survey findings, each CNAW member rated each category with the following scale:

Priority Rating Scale: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

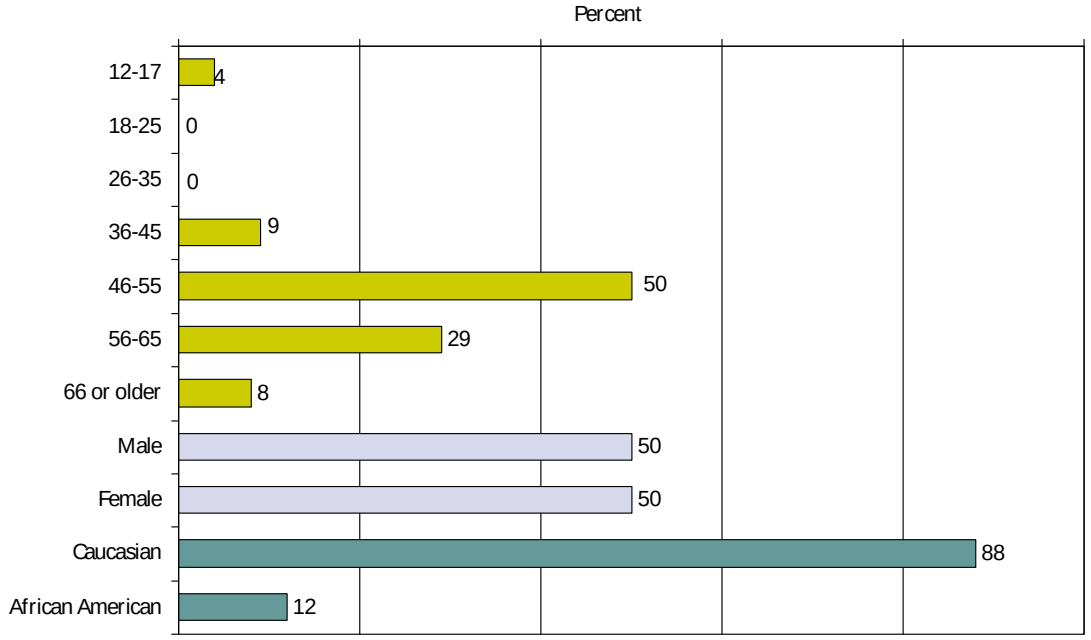
The indicators below are averaged according to the greatest score of all individual responses.

Substance	Magnitude	Impact	Changeability	Readiness/ Capacity	
Alcohol	5	5	3	4	17
Tobacco	5	5	4	4	18
Marijuana	4	3	2	2	11
Cocaine	3	3	3	3	12
Heroin	3	4	3	3	13
Prescription drugs	4	3	4	2	13

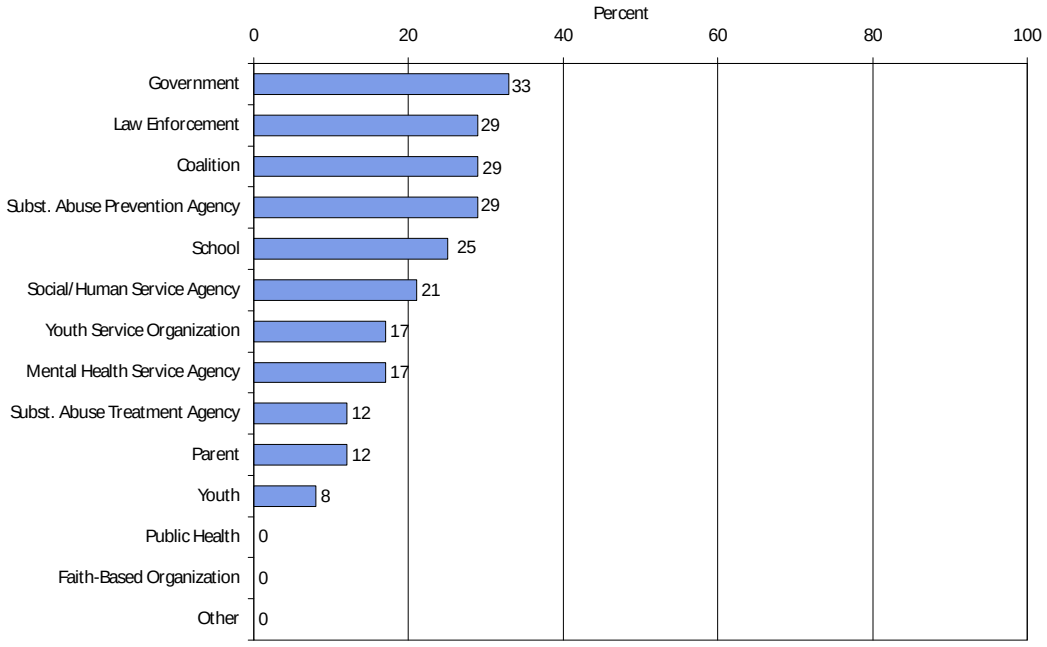


Sub-Region 2B
2008 Community Readiness Assessment

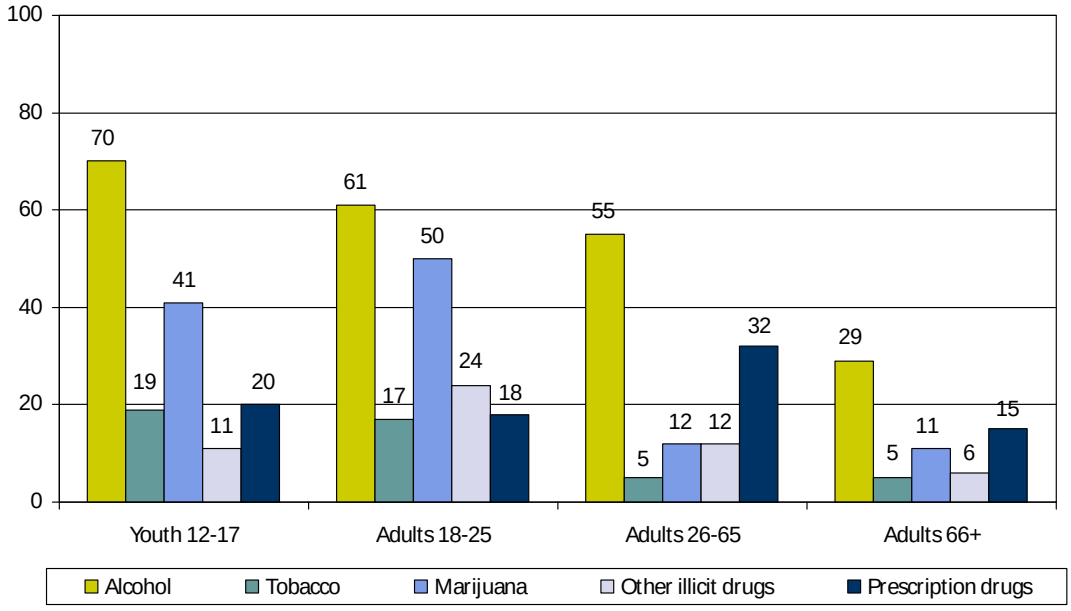
Key Informant Demographics



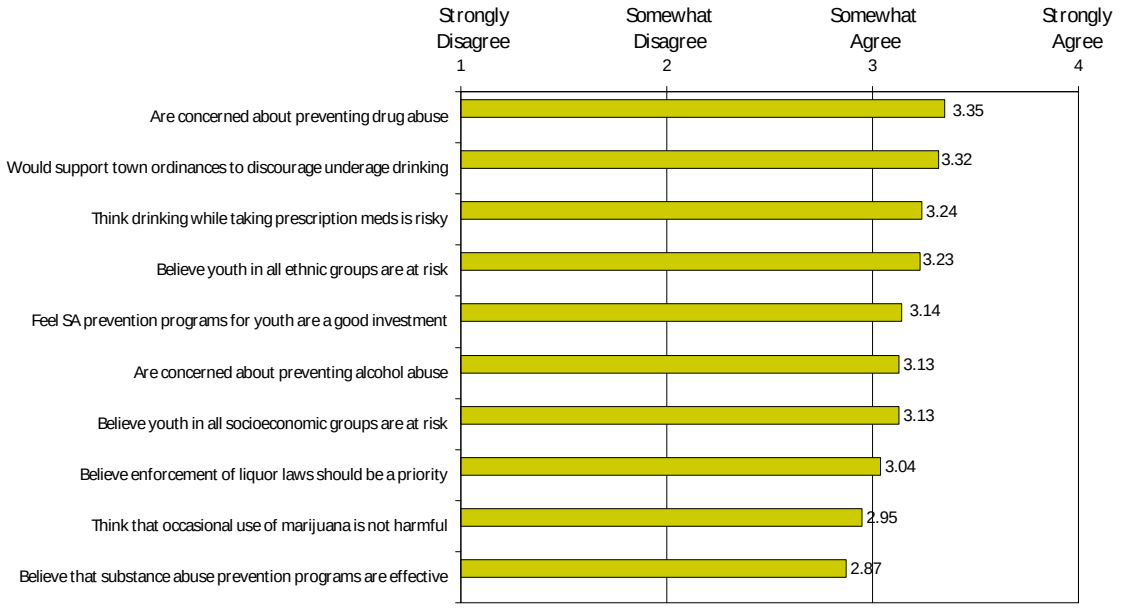
Key Informant Stakeholder Affiliation



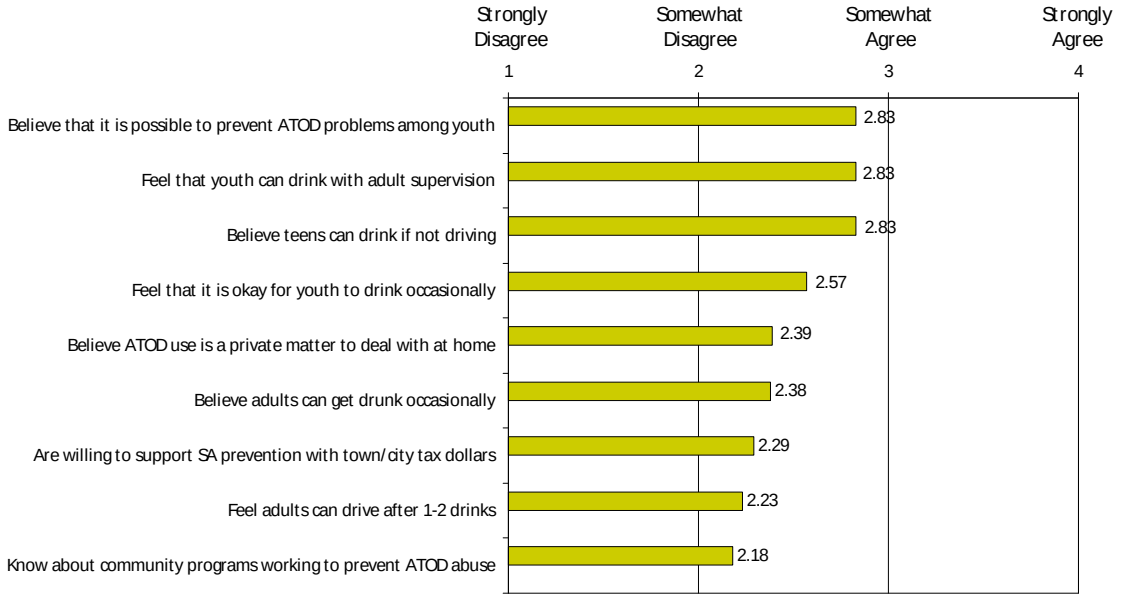
Perceived Community Attitude that a Substance is a "Significant Problem" in Different Age Groups



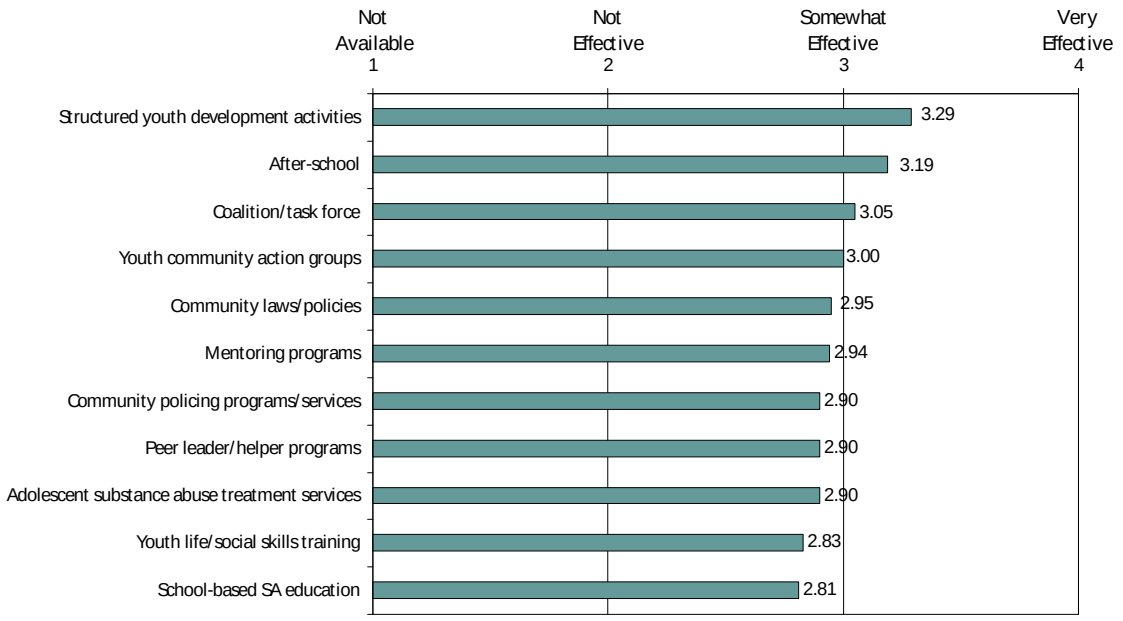
Key Informant Agreement that "Most" Community Residents:



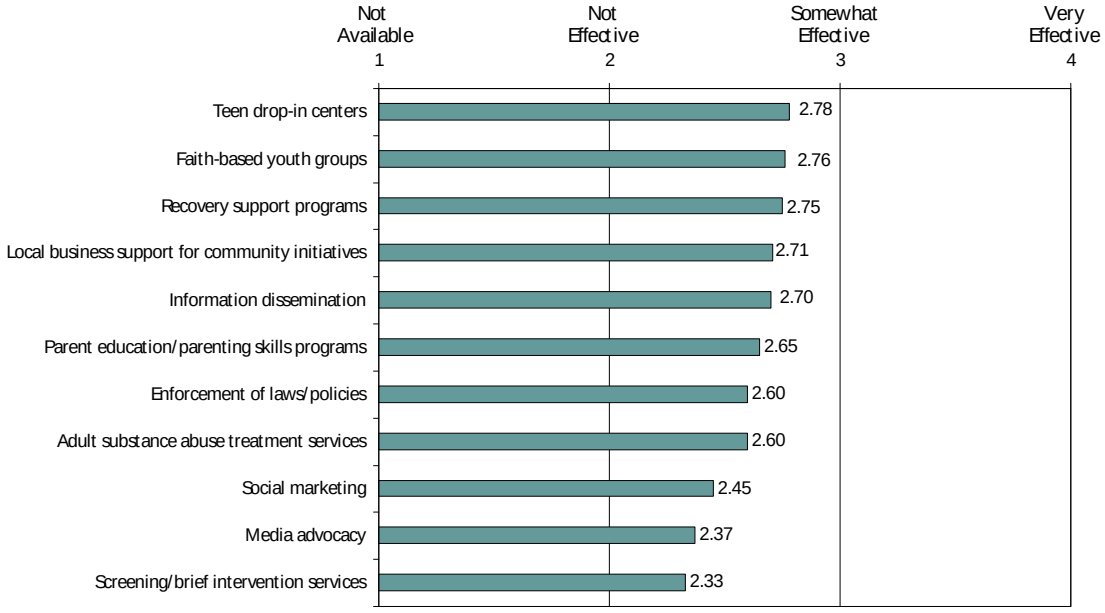
Key Informant Agreement that "Most" Community Residents:



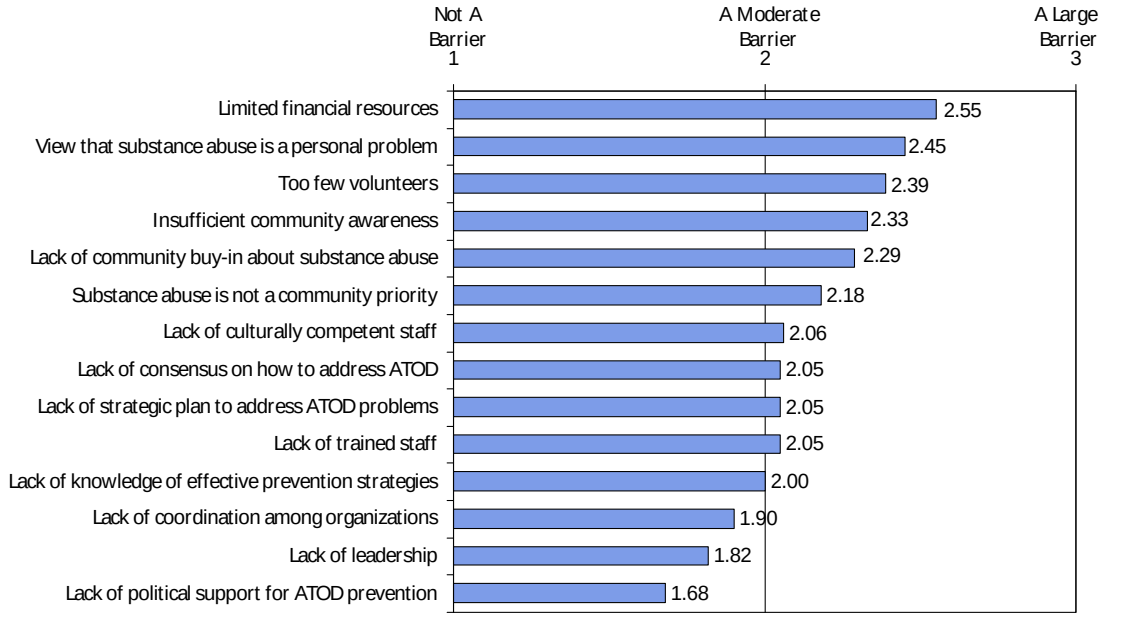
Key Informant Ratings of Substance Abuse Prevention Strategies in the Community



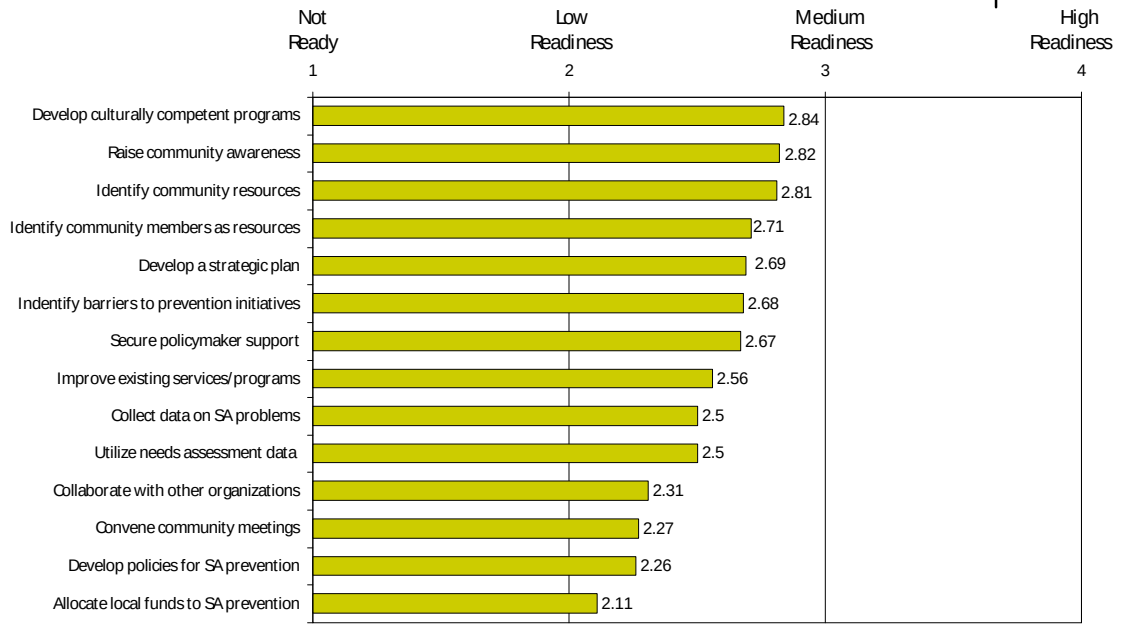
Key Informant Ratings of Substance Abuse Prevention Strategies in the Community



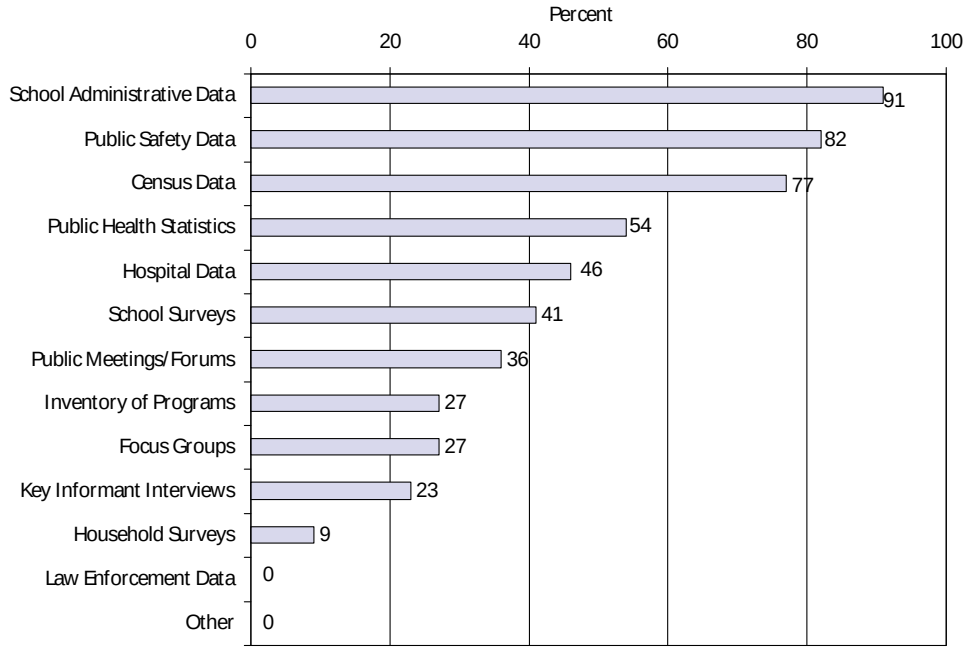
Perceived Barriers to Substance Abuse Prevention Activities in the Community



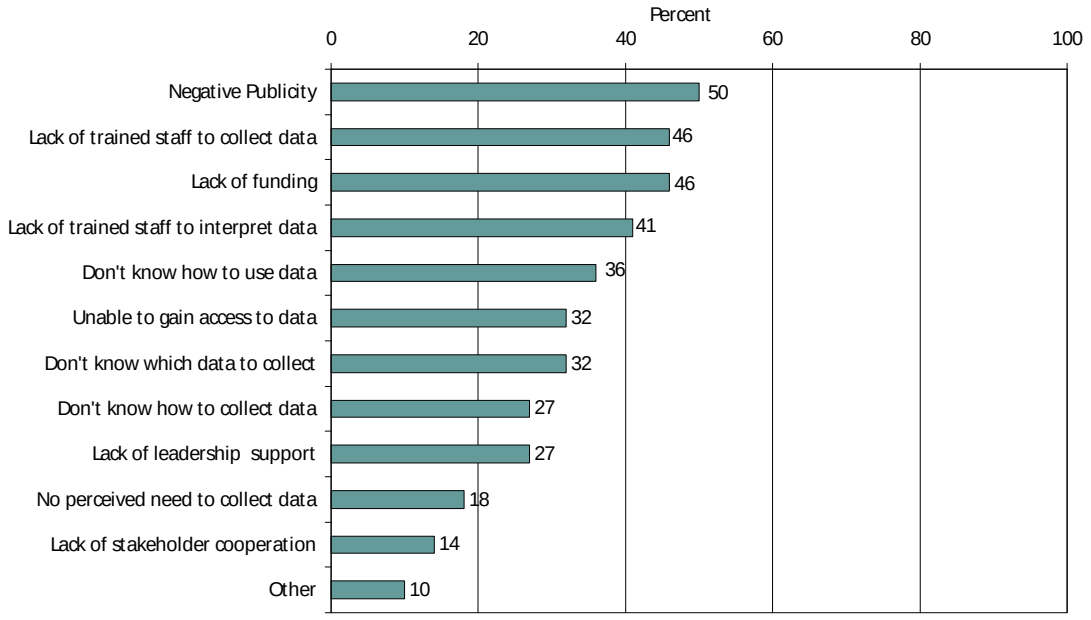
Key Informant Ratings of Community Readiness for Substance Abuse Prevention Planning Activities



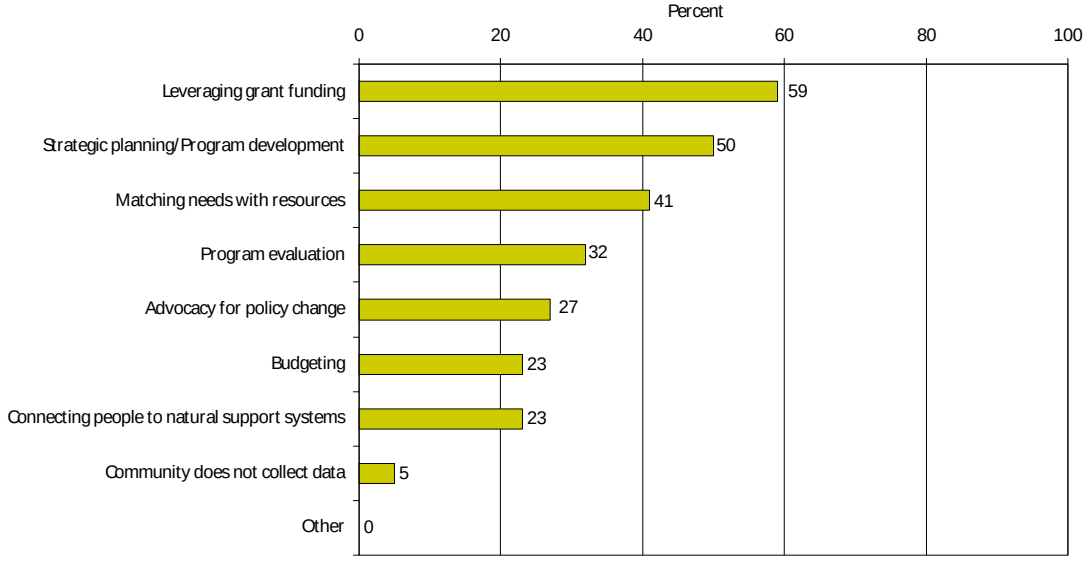
Availability of Substance Abuse Prevention Data



Barriers to Collecting Data



Community Use of Data for Substance Abuse Prevention



Key Informant Ratings of the Community Stage of Readiness for Substance Abuse Prevention

Community Stage of Readiness for Substance Abuse Prevention	STATE Score
1. Tolerates or encourages substance abuse	1%
2. Has little or no recognition of substance abuse problems	12%
3. Believes a substance abuse problem exists, but awareness is only linked to one or two incidents involving substance abuse	17%
4. Recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors	24%
5. Is planning for substance abuse prevention is focused on practical details, including seeking funds for prevention	17%
6. Has enough information to justify a substance abuse prevention program and has great enthusiasm for the initiative	5%
7. Has created policies and/or more than one substance abuse prevention program is running with financial support and trained staff	13%
8. Views standard substance abuse programs as valuable, new programs are being developed for at-risk populations, and there is ongoing evaluation	7%
9. Has detailed and sophisticated knowledge of prevalence, risk factors and program effectiveness, and programming is tailored by trained staff to address community risk factors	4%
Mean State Stage of Readiness (n=414)	**4.73**
Mean Sub-Region 2B Stage of Readiness (n=22)	**4.64**