Greater Valley Substance Abuse Action Council, A Program of BHcare

Epidemiologic Profile of Substance Use, Suicide & Problem Gambling

December 2012

Contributors

Pamela Mautte
Lorrie McFarland
Beth Gaillard
Joyce Macauda
VSAAC Prevention Committee
Community Needs Assessment Workgroup

Abbreviations

CDC	Centers for Disease Control
CNAW	Community Needs Assessment Workgroup
COPD	Chronic Obstructive Pulmonary Disease
CT	Connecticut
DAWN	Drug Abuse Warning Network
DESPP	Department of Emergency Services and Public Protection
DHHS	Department of Health & Human Services
DMHAS	Department of Mental Health & Addiction Services
DPH	Department of Public Health
DPS	Department of Public Safety
DUI	Driving Under the Influence
LPC	Local Prevention Council
MTF	Monitoring the Future
MVA	Motor Vehicle Accident
NHTSA	National Highway Transportation Safety Administration
NIDA	National Institute on Drug Abuse
ONDCP	Office of National Drug Control and Policy
OSME	Office of State Medical Examiner
RAC	Regional Action Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SDE	State Department of Education
SEOW	State Epidemiological & Outcomes Workgroup
SPF	Strategic Prevention Framework
STEP	Statewide Tobacco Education Program
TEDS	Treatment Episode Data Set
US	United States
VSAAC	Valley Substance Abuse Action Council
YPLL	Years of Potential Life Loss
YRBSS	Youth Risk Behavior Surveillance System

Executive Summary

The purpose of this profile is to describe 1) the burden of substance abuse, problem gambling, and suicide, 2) prioritize prevention needs, and 3) indicate the capacity of the sub-region's communities to address those needs. It is based on data –driven analysis of issues in the sub-region, with assistance from key community members. The profile and data will be used as a building block for community level processes including capacity and readiness building, strategic planning, implementation of evidence based programs & strategies, and evaluation efforts to reduce substance abuse and promote good mental health.

The overall profile offers the communities of the VSAAC service area, information regarding substance use and misuse, both illegal and legal; plus information on suicide and gambling. The information is gathered from many sources and separated into individual profiles of eight areas of concern: alcohol, tobacco, prescription pills, marijuana, heroin, cocaine, suicide and gambling. The information is gathered from federal and state data and is then compared to local data when available.

Our CNAW group offered their individual insights regarding their communities and their perception of their communities. This information is included in each of the profiles. The individual profiles give a picture of the problem, specific information regarding the drug or activity, how the communities may be impacted and some suggestions for addressing the problems. Charts are incorporated into the profiles for visual understanding of some numerical and/or percentage figures. Each community has a different make-up; therefore the information is more general than specific for some of the problem areas. The profiles, however, will be used by all communities as a basis for each community to develop strategies to address their own issues.

Table of Contents

Introduction 5

Summary 7

Ranking 8

Profiles

- Alcohol 9
- Tobacco 12
- Marijuana 14
- Prescription Drugs 17
- Heroin 19
- Cocaine 22
- Suicide 23
- Gambling 25

Appendices

- Appendix 1 – Data Sources
- Appendix 2 – Priority Setting Process

Introduction

Purpose of the Profile

The Greater Valley Substance Abuse Action Council, a program of BHcare, is one of 13 Regional Action Councils in CT. Our mission is to reduce alcohol, tobacco, other drug use, suicide, risky behaviors, and promote good mental health in our service area among youth and, over time among adults through community mobilization, public awareness, and advocacy. We support the CT Department of Mental Health & Addiction Services (DMHAS) Prevention services which promotes the overall health and wellness of individuals and communities by preventing or delaying substance use. Prevention services are comprised of six key strategies including information dissemination, education, and alternative activities, strengthening communities, promoting positive values, and problem identification and referral to services. VSAAC serves Sub-Region 2B which includes the following 11 communities located in the south central part of the state: Ansonia, Bethany, Derby, Orange, Oxford, Milford, New Haven, Seymour, Shelton, Woodbridge, and West Haven. In 2004, DMHAS adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF) at the State, sub-regional and community levels. The SPF is a five step data driven process known to promote youth development and prevent risky behaviors across the life span. VSAAC has written this epidemiological profile with assistance from community members in support of the SPF process. This report is an analysis of the magnitude, impact and capacity within sub-region 2B of the following 8 areas of concern for CT: Alcohol, tobacco, prescription drug use, marijuana, heroin, cocaine, problem gambling, and suicide.

Description of the RAC Region

The areas covered by VSAAC range from the smallest City in CT – Derby to one of the largest cities, New Haven; and from cities to very rural communities. Three major thoroughfares, Interstates, 8, 95 and 15 cross the area connecting the area with New York City to the East, Waterbury to the North, and Bridgeport to the South. Rt 8 links directly with Interstate 84 with direct access to Boston, MA. Milford, West Haven and New Haven have beaches on Long Island Sound; Milford, Orange, Shelton and Derby border the Housatonic River and Ansonia, Derby and Seymour border the Naugatuck River.

New Haven is the home of internationally recognized Yale University and Yale-New Haven Hospital. Derby is the home of Griffin Hospital and Milford Hospital is located in that city. Ansonia is the location of BHcare, Inc., a major mental health organization. Aside from Yale, New Haven is home to Southern CT State University, Gateway College, the University of New Haven and Albertus Magnus College.

The total population of the service area is 367,544 with 48.2% falling in the age range of 25-59. 48.4% of the population is male and 51.6% is female. The male median age is 40.2 years and the female median age is 42.5 year. 61.5% of the population is white, non-hispanic; 15.8% are hispanic; 16.2% are black/African American; and 4.2% are Asian. 86.91% graduate high school and 86.91% achieve a bachelor degree or higher.
Earnings range from $30,417 to$129,008 with the median at $65,916. A total of 12.7% live below the poverty level with a range from 2.1% in Woodbury to 25.2% in New Haven.

The city of Shelton is part of the wealthy Fairfield County (considered a NY suburb), the wealthiest county in CT. All other communities are part of New Haven County. Each town has at least one library. There are numerous parks and recreation areas. Major shopping malls and national and international businesses, including Sikorsky Aircraft adjoining the city of Shelton, can be found the eleven town area.

Sources of Data

The data used to compile this report have been drawn from a variety of sources including the following:

VSAAC Survey of Student Needs – Since 1992, VSAAC has been working in partnership with local school districts to implement this survey which measures substance use, attitudes and behaviors in youth grade 7, 9, and 11

Survey Sample Size	**2007**	**2009**	**2011**
Grade 7	1028	999	826
Grade 9	1077	1002	852
Grade 11	860	996	726
Total	**2965**	**2997**	**2404**

National and State Surveys – National Survey on Drug Use and Health (NSDUH), Center for Disease Control 's (CDC), Youth Risk Behavior Survey (YPRS) both State and National data,

Secondary Data – This data includes arrests, motor vehicle accidents / fatalities, Office of the Chief Medical Examiner Data, treatment admissions, school suspension / expulsions, and State of CT Epidemiological Outcomes Workgroup (SEOW) from State and Federal sources.

Community Needs Assessment Workgroup (CNAW) – participants reviewed data compiled by VSAAC from the aforementioned data sets as well as participant anecdotal information and feedback. Members than provided a ranking input on the 8 priority areas. Strengths and limitations of the profile
This profile attempts to summarize data collect from National, State and local sources. The data is believed to be reliable, valid and relevant. However, it is **not** practical to include all available data. Some data used may be from reports earlier than 2010 if more currant data is not available.

Methods

Development of this profile was a multi-step process. Available data on the state's eight priority areas was compiled, reviewed, tabulated and summarized. VSAAC then convened the Community Needs Assessment Workgroup (CNAW) to review the profiles for each of the priority areas. At the conclusion of the meeting, workgroup members provided input on the profiles and ranked the priority areas in magnitude, impact, consequences, and changeability of the priority.

Summary

Priority Ranking

VSAAC held a Community Needs Assessment Workgroup (CNAW) which met and examined a multitude of data from national, state, and local resources to determine local priorities. Community readiness data as well as anecdotal data was very helpful in determining rankings for the eight priority areas. Member contributions to this process were both in person, e-mailed and phone responses.

CNAW members prioritized the following in priority order:

1. prescription drug misuse
2. marijuana
3. alcohol
4. heroin
5. suicide
6. tobacco
7. cocaine
8. problem gambling

The first five priorities were also very closely ranked in magnitude and impact. Prescription pill abuse has now been listed as number one a change from the past two profiles in which alcohol was ranked the first priority. Marijuana and alcohol were tied with the same rating but the group chose to rank marijuana second. Marijuana was discussed at length because of the recent decriminalization and legalization of the substance and the impact new legislation is having on the sub-region.

The 2012 Community Readiness for Substance Abuse Prevention Assessment illustrated that VSAAC's mean stage of readiness is 4.43 slightly below the State's average of 5.08. The key leaders interviewed illustrated that the data collected is mostly used for strategic planning /program planning, followed by evaluation, leveraging grants and resources. While this is good news that we are using data for planning and evaluation, it is of great concern that we report problems in funding to collect data and the negative stigma data can bring to a community. While VSAAC has overcome many of these barriers in the Valley towns, we are still working to break the barriers down in other communities, a slow process. In reviewing the readiness data the CNAW members echoed the low rankings of the community's attitude towards substance abuse prevention stating the limited financial resources play a huge role in the low rankings. The communities are not overly concerned about substance abuse because they are grappling with so many other pressing issues. Therefore, our changeability rankings of the eight priority areas are reflective of the 2012 community readiness data. It is important to note that, as with any survey responses and CNAW meetings, the selection of key stakeholders they represent can influence the outcome of this report. The limitation of the CNAW included not having diverse representation from each of the towns in our sub-region.

CNAW Priority Ranking Matrix - Aggregate Scores

SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

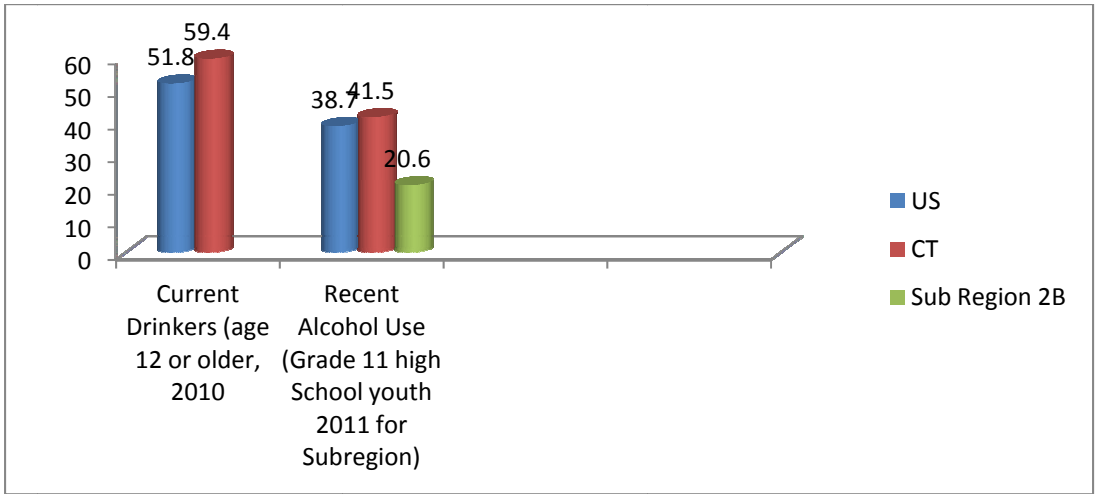
PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	TOTAL	RANKING
Alcohol	4	3.9	2.6	10.5	3
Tobacco	2.6	3.2	3.2	9	6
Marijuana	4.1	3.9	2.5	10.5	2
Prescription Drug Misuse	4.1	4	2.9	11	1
Heroin	3.4	3.7	3.2	10.3	4
Cocaine	2.6	2.8	3	8.4	7
Problem Gambling	2	2.1	2.4	6.5	8
Suicide	3.2	3.5	3	9.7	5

Alcohol

Magnitude

Alcohol is the most widely used and abused substance in the United States. Current national data suggest that alcohol use rates in Connecticut are higher than national averages.

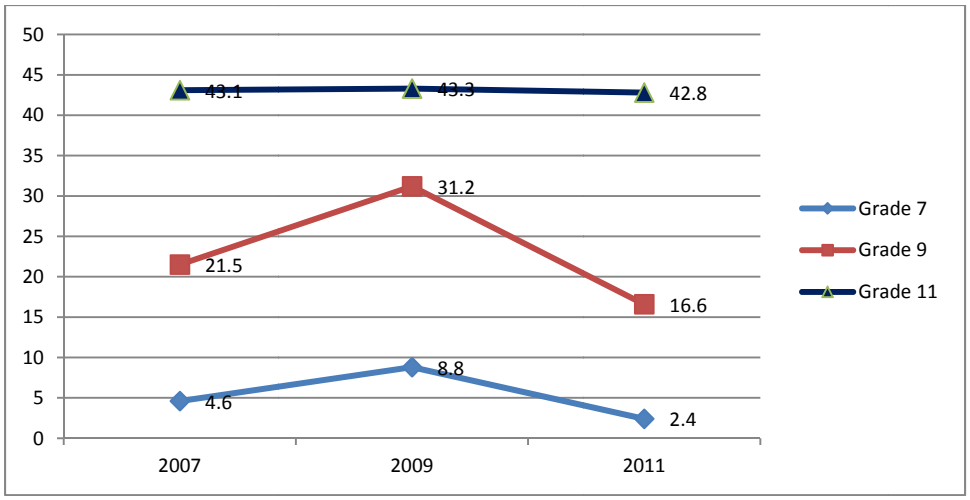
Alcohol Use in the United States, Connecticut and Sub-Region



Source: National Survey of Drug Use and Health (2010), Valley Survey of Student Needs (2011)

According to the National Survey on Drug Use and Health (NSDUH), 51.8% of all Americans and 59.4% of Connecticut residents aged 12 or older reported being current drinkers in 2010. According to the Survey of Student Needs In 2011, the rate of recent use among youth in the Sub-region (20.6%) was below both the State and National averages

Current Use in the Last 30 Days



Valley Survey of Student Needs (2011)

Recent alcohol use among high school youth in the Sub-region increased in 2009 for all grades however a dramatic drop in 2011 for grades 7and 9 with grade 11 slightly decreasing. Also between 2009 and 2011, the percentage of 9th grade high school youth in Sub-Region 2B who report that there is moderate or great harm associated with alcohol use rose from 45.6% to 72.6% and a slight increase in 11 grade from 2009 to 2001 from 65.6 to 69.5.

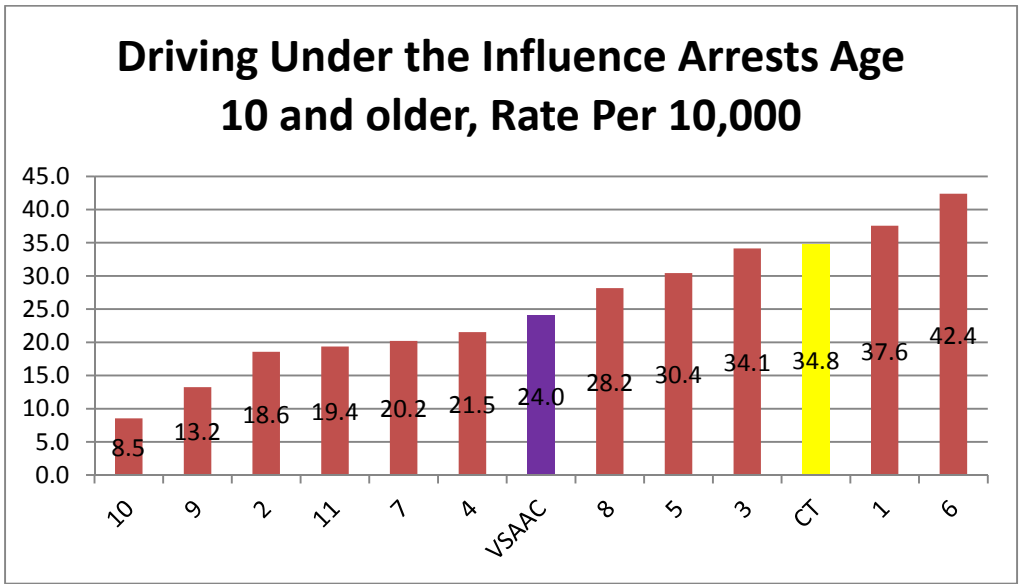
Impact

The consequences and impact of alcohol use, abuse and dependence include increased crime, long and short term negative health effects and unintentional injury and death. According to the US Centers for Disease Control (CDC):

- Excessive alcohol use is the 3rd leading lifestyle-related cause of death in the US.
- Excessive alcohol use is responsible for 2.3 million years of potential life lost (YPLL) annually.

In Sub-Region 2B:

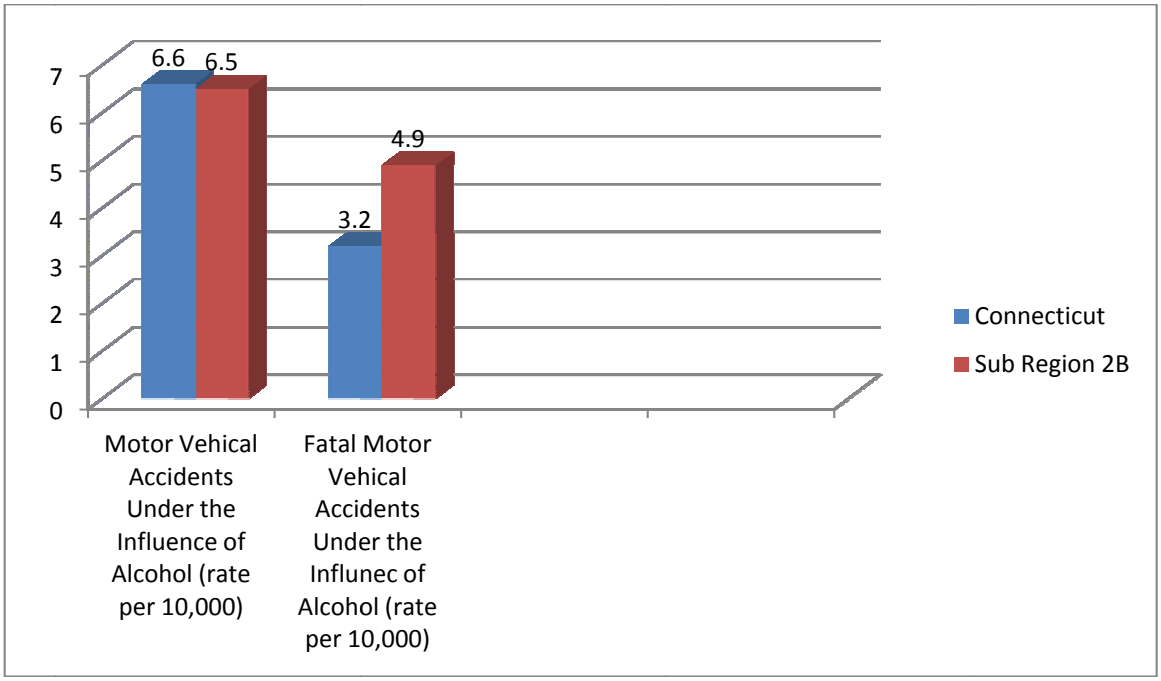
- In 2010, the rate of liquor law arrests age 10 and older (.08 per 10,000) was the second lowest among all Regional Action Councils (RACs) and was below the state average of 3.9 per 10,000 (CT Department of Emergency Services and Public Protection, DESPP).
- From 2007-2009, 5 out of the 11 individual communities had crude alcohol-induced death rates above the state average of 6.1 per 100,000 (range 6.4 - 22.5; CT Department of Public Health, DPH).
- In 2010, the rate of driving under the influence (DUI) arrests for individuals 10 and older (24.0 per 10,000) was the 4th lowest among all RACs and was lower than state average (34.8 per 10,000; CT DESPP).



Source: CT Department of Emergency Services and Public Protection (2010)
RAC Number

- In 2010, the rate of motor vehicle accidents (MVA) under the influence of alcohol (6.5 per 10,000) was fairly equal to the average for Connecticut (6.6 per 10,000; National Highway Transportation Safety Administration, NHTSA).
- In 2010, the rate of *fatal* motor vehicle accidents under the influence of alcohol (4.9 per 100,000) was the fourth highest among all RACs and was above the state average (3.2 per 100,000; NHTSA). The rates in 5 of 11 individual communities were also above the state average.

Motor Vehicle Accidents under the Influence of Alcohol in Connecticut and Sub-Region 2B



Source: National Highway Traffic Safety Administration (2010)

Capacity

According to the2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.

Among the Sub-Region 3B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that teens can drink if they are not driving. Participants believe having structured activities for youth is very effective.

VSAAC'S Community Needs Assessment Work Group for region 2B ranked the magnitude of the alcohol problem in our community a 4 out of a 5 (scale: 1-5, with 5 being the highest). The impact of the problem in the community ranked 3.9 out of 5, however, the community perception in our changeability only scored a 2.6.

Throughout the region, there is long standing awareness and support for the prevention of alcohol abuse, especially among youth. Most communities have school resource officers and drug and alcohol prevention programming in the schools. Many communities have a history of local programs such as mock crashes and alcohol free graduation parties aimed at reducing alcohol-related accidents and consequences around prom and graduation time.

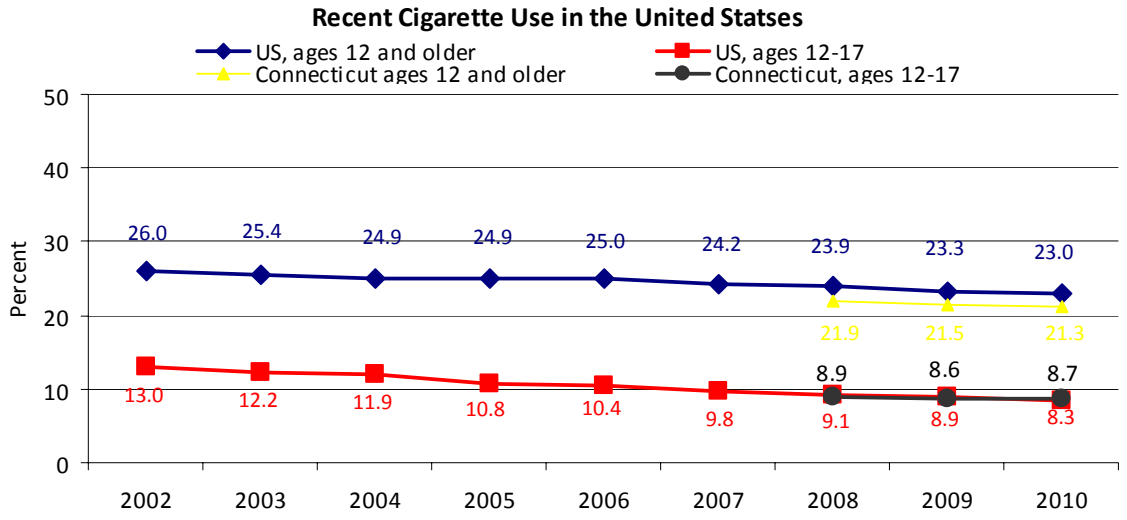
For the last four years VSAAC has had an extensive underage drinking prevention media campaign. Billboards and transportation signs have been a strong visible sight in the lower Naugatuck Valley. VSAAC also continues to provide seller-server training to employees of alcohol retailers throughout the region. Several Local Prevention Councils have written strategic plans that include the reduction of youth alcohol use as a priority. Some specific activities of these local organizations include the development of media campaigns about social and coordination of Sticker Shock campaigns aimed at reducing the likelihood that adults will buy alcohol for minors. Many local communities are focusing on social hosting laws campaign to bring awareness to the adults and youth in the community.

Additional resources are needed to promote continued awareness about the dangers of alcohol use for all ages, not just youth.

Tobacco

Magnitude

After alcohol, tobacco is the second most commonly used substance in the United States. According to the National Survey of Drug Use and Health (NSDUH), the percentage of Americans aged 12 or older reporting recent cigarette use declined from 26.0% in 2002 to 23.0% in 2010. Since 2008, the rates of recent cigarette use in Connecticut tend to be similar to or lower than the national rates.

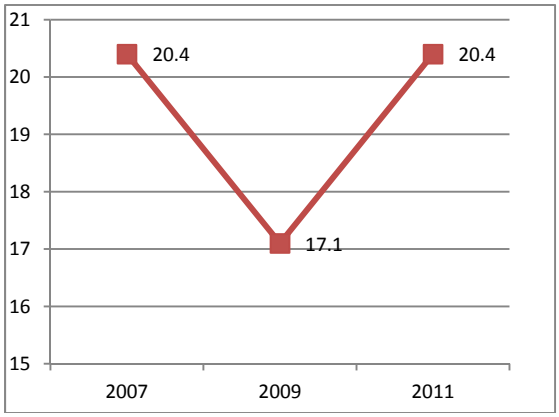


Source: National Survey of Drug Use and Health

In Sub-Region 2B, recent cigarette use among high school youth declined in 2009 however rising up again to 2011 from 2009 to 2011. During the same period, perceived harm for cigarette use rose in 2009 but dropped a good amount from 2007.

RECENT USE

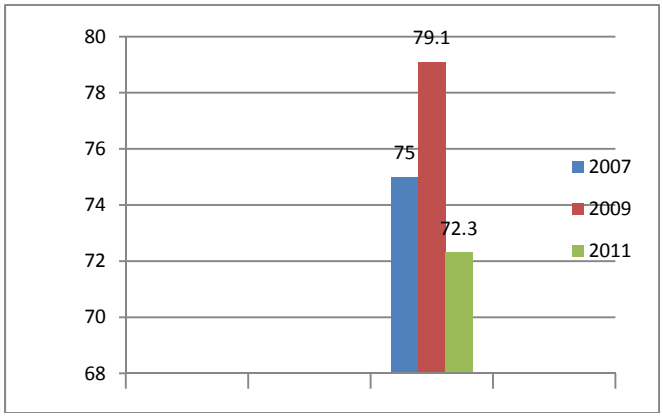
Grade 11



(Source: Valley Survey of Student Needs 2011)

PERCEPTION OF HARM

Grade 11



(Source: Valley Survey of Student Needs 2011)

Impact

According to the US Surgeon General, of every three young smokers, one will quit and one will die of tobacco related causes. Nearly all tobacco use begins in childhood and adolescence. In fact, 80% of adult cigarette smokers who smoke daily, report that they started smoking by the age of 18.

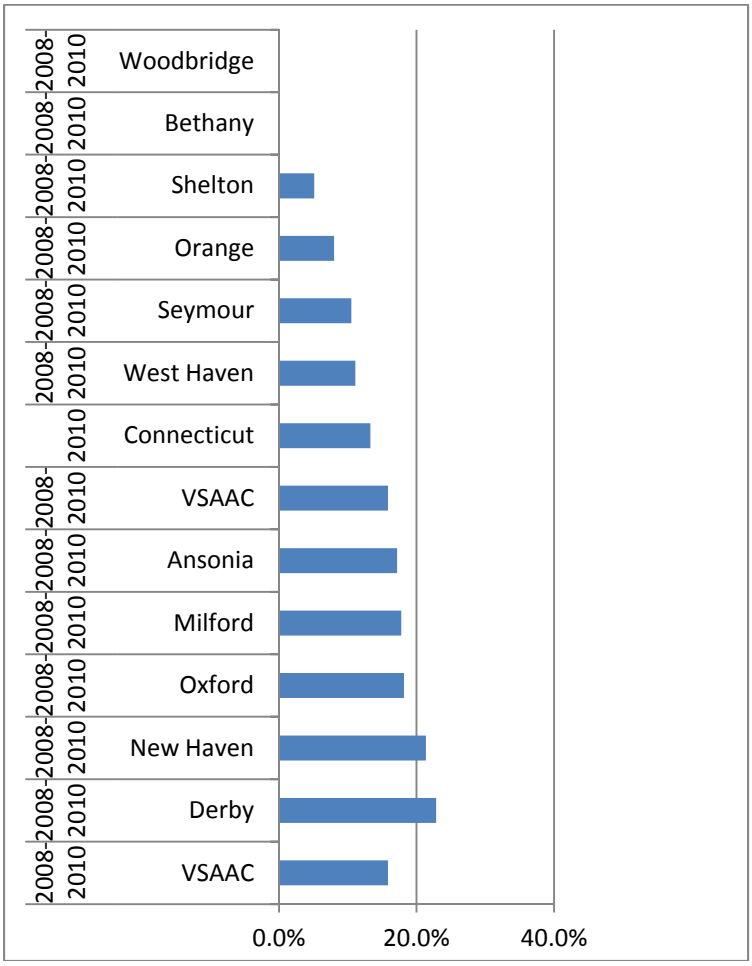
The US Centers for Disease Control report the following:

- Each year in the United States, adverse health effects from cigarette smoking account for an estimated 443,000 deaths.
- More deaths are caused each year by tobacco use than by HIV, illegal drug use, motor vehicle injuries, suicides and murders combined.
- Smoking causes and estimated 90% of all lung cancer deaths among men and 80% of all lung cancer deaths among women.
- Compared to nonsmokers, smokers are at increased risk of coronary heart disease, stroke, lung cancer and COPD.

In Sub-Region 2B:

- In 2008-2010, the percentage of tobacco retailers who were non-compliant (15.8%) was above the state average of 13.3% (CT Department of Mental Health and Addiction Services, DMHAS). Five individual communities in Sub-Region 3B had non-compliance rates above the state average. Those rates ranged from 10.5% to 22.9%.
- Nine of Eleven communities had crude lung cancer death rates above the state average of 49.9 per 100,000 in 2007-2009 (CT Department of Public Health, DPH).

Percent of Tobacco Retailers Non-Compliant
(2008-2010)



(Source: Ct Department of Mental Health and Addiction Service)

Capacity

According to the2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.

VSAAC'S Community Needs Assessment Work Group for region 2B ranked the magnitude of the Tobacco problem in our community a 2.6 out of a 5 (scale: 1-5, with 5 being the highest). The impact of the problem in the community ranked 3.2 out of 5, and the community perception in our changeability scored a 3.2.

There has long been widespread awareness about the risks and dangers of tobacco on a statewide and local level. VSAAC continues to support programs in our community that increases awareness of the risks associated with smoking. VSAAC has been continuing to work with local school districts and local prevention councils to educated students and the community. The statewide STEP program has been a large success in our area during the school year and summer programs. VSAAC has worked with in its own agency to support those who are working towards quitting and making our facility a smoke free campus.

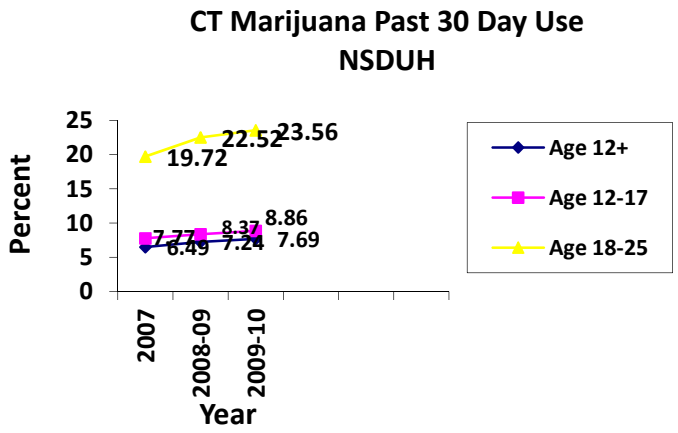
Marijuana

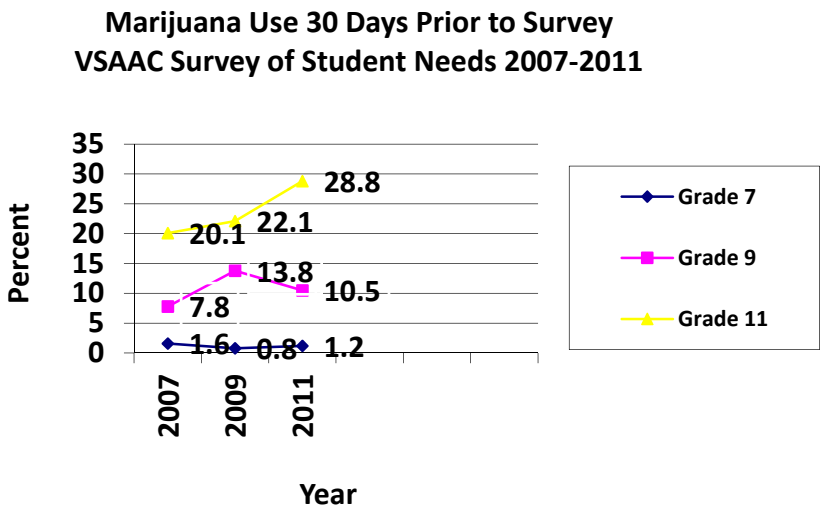
Magnitude

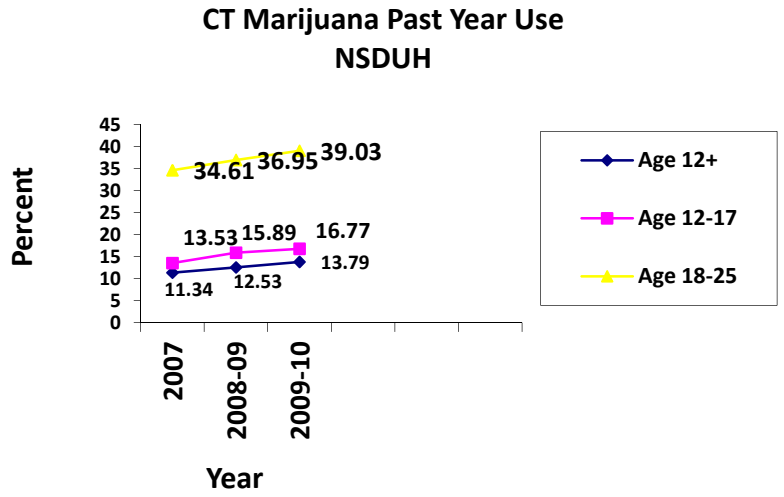
Marijuana remains the most commonly used illicit drug in Connecticut and in the United States. A 2009 study by the National Institute on Drug Abuse (NIDA) on marijuana use revealed that more than 28 million Americans abused marijuana. Abuse of any substance requires regular use. For that study, 4.3 million Americans met the criteria for marijuana addiction.

Approximately 33,000 (10.9 percent) of the 297,000 adolescents in Connecticut used an illicit drug in the past month; 26,000 (8.9 percent) used marijuana, and 13,000 (4.4 percent) used an illicit drug other than marijuana. There are no significant differences on measures of illicit substance use between males and females in Connecticut. The percentage of adolescents and young adults reporting use of marijuana in the past thirty days in Connecticut has progressively been on the rise since 2007, with the biggest increases seen in the 18-25 age groups. In 2010, 23.56% of young adults ages 18 to 25 had used marijuana in the last 30 days.

Comparatively, VSAAC's 2011 *Survey of Students Needs* shows 28.8% of 11th grade students have used marijuana 30 days prior to the survey. This is the highest reported 30 day use among 11th grade since 2007. There was only a slight increase in use of among 7th grade, and a decrease among 9th grade from 13.8% in 2009 to 10.5% in 2011. Both Connecticut and VSAAC's sub-region have higher rates of marijuana use among adolescents than the national rate.







Impact

In response to the decriminalization of marijuana (under .5 oz) in 2011, and the legalization of medical marijuana in Connecticut in 2012, the task force, "CT Marijuana Abuse Prevention Alliance" was created to engage existing coalitions in a state wide educational effort. The task force will research and collect information from other states who enacted similar legislation and its' impact on communities.

VSAAC's Key informant survey found marijuana to be ranked *third,* as a significant problem in the community, following alcohol and tobacco. The percentage of high school seniors who thought there was a great risk of harm from regular marijuana use decreased from 57.9% in 2006 to 44.1% in 2012 – the lowest level since 1979. (MTF 2012)
VSAAC's 2011 *Survey of Student Needs* shows that 19.5% of 11th grade students report no risk in smoking marijuana regularly, while 12.1% of 9th grade students, and 7.2% of 7th grade report no risk associated with regular marijuana use. All three grade levels reported regular alcohol use (1-2 drinks nearly every day) to be of much greater risk at 71%, 68%, and 65% respectively.

Dr. Robert DuPont, the first Director of the National Institute on Drug Abuse suggests that "the recent legalization of marijuana use in Colorado and Washington State, and the legalization of "medical marijuana: in 18 states and District of Columbia will lead to further decreases in youth perception of risk from harm" (IBH, 2012)

According to 2003–2006 TEDS data, **among adolescent admissions in Connecticut, marijuana and alcohol were the most prevalent substances of abuse.** Of the total male admissions, 91.2 percent (1,927) of male admissions reported marijuana use and 60.6 percent (1,281) reported alcohol use. Of the total female admissions, 79.5 percent (575) reported marijuana use and 58.5 percent (423) reported alcohol use.

Consequences

- Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than nonsmokers.
- 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.
- Recurring marijuana use can trigger the onset or relapse of schizophrenia.
- Longer term adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system. Long-term marijuana use causes changes in the brain similar to those seen after long-term use of other major drugs of abuse.
- Marijuana has been shown to compromise the ability to learn and remember information, often leading to deficits in accumulating intellectual, job or social skills.
- Depression, anxiety, and personality disturbances have been associated with marijuana use.
- The National Institute on Drug Abuse reports that marijuana is a worse carcinogen than tobacco to the lungs as it contains 70% more toxins.
- Risk of heart attack more than quadruples in the first hour after smoking marijuana.
- Initiation of marijuana use at younger ages has been linked to higher and more severe patterns of use of marijuana and other substances in adolescence and adulthood.
- The number of marijuana-related treatment admissions to publicly funded facilities in Connecticut has increased annually since 1994. In 2006, Connecticut's marijuana-related treatment admissions rate was 132 per 100,000 population.
- According to the National Institutes of health, marijuana addiction impacts all Americans with a cost of more than $400 billion annually for health care, job loss, traffic accidents, and crimes associated with the drug.

Capacity

According to the 2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but the community is at a low level of readiness to allocate funding for substance abuse prevention, develop policies and identify barriers to substance abuse prevention. Among the Sub-Region 2B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that recover groups as well as adult and adolescent treatment are somewhat effective. The key informants ranked marijuana as a significant problem among 12-25 years old, second to alcohol.

VSAAC's Community Needs Assessment Work Group for sub region 2B ranked the magnitude of the marijuana problem in our community a 4.1 out of 5 (scale: 1-5, with 5 being the highest). The impact of the problem in the community ranked 3.9 out of 5, however, the community's perception in on changeability only scored a 2.5.

Prescription Drugs

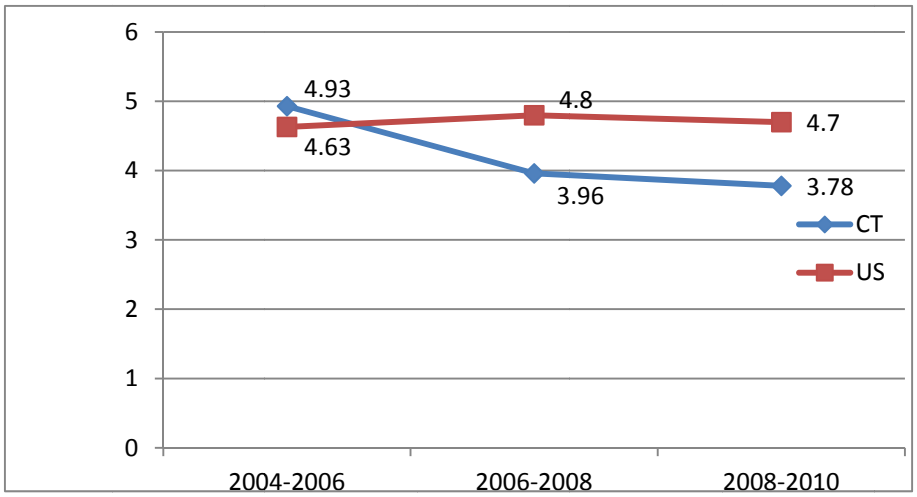
Magnitude

In 2010, approximately 7.0 million persons were current users of psychotherapeutic drugs take non-medically (2.7 percent of the US population), an estimate similar to that in 2009. This class of drugs is broadly described as those targeting the central nervous system, including drugs used to treat psychiatric disorders (NSDUG, 2010). The medications most commonly abused are: Pain relievers – 5.1 million, Tranquilizers-2.2 million, Stimulants – 1.1 million, Sedatives -0.4 million.

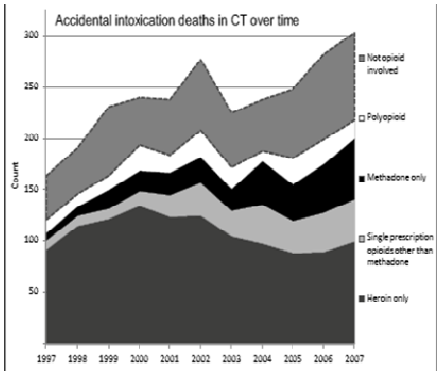
While the aforementioned data describes the types of drugs that are being abused, there is a growing epidemic of prescription painkiller abuse. Approximately, three out of four prescription drug overdose deaths in the US are from opioid pain relievers according to the Centers for Disease Control. Findings reported by the Substance Abuse and Mental Health Services Administration – Drug Abuse Warning Network reported the misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.

Trend data comparing 2004 to 2010 NSDUH survey responses show that nationally persons aged 18+ has shown slight decreases in the rates of past year non medical pain reliever use as you can see in the chart below.

Recent Past Year Non Medical Pain Reliever Ages 18+NSDUH Surveys
CT & US trends



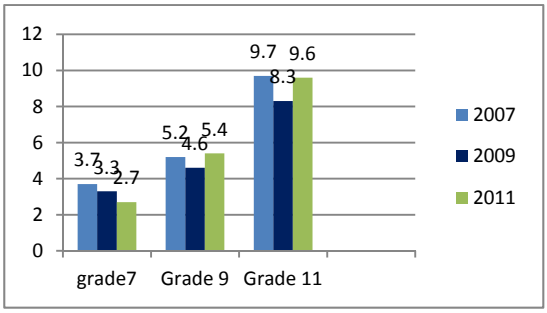
VSAAC participated in a study funded by the Centers for Control (CDC) with principal investigator Traci Green, PhD, MSC, Assistant Professor of Medicine and Epidemiology, The Warren Alpert School of Medicine at Brown University. Based on the premise that drug overdoses in CT are the leading cause of adult injury and death (out numbering the combined deaths resulting from motor vehicle accidents, fire, and firearms), the study sought to identify issues that surround those overdose injuries and death. Three communities in CT were selected to be part of the study- Ansonia, Seymour, and Wallingford. The study aimed to determine and understand why the high rates of prescription opioid abuse and overdose are occurring in these communities.



Leading cause of adult injury death, more than deaths due to MVA, fire, firearms combined

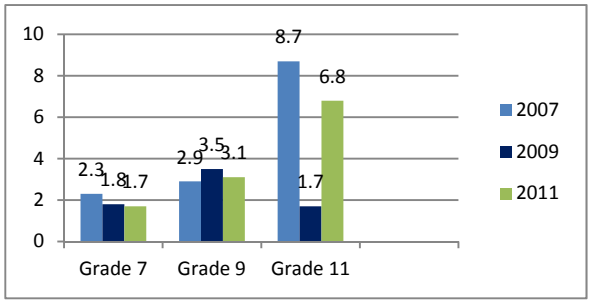
Source: TC Green, LE Grau, HW Carver, M Kinzly, R Heimer, Epidemiologic and geographic trends in fatal opioid intoxications in Connecticut, USA: 1997-2007. Drug and Alcohol Dependence (2011).

Pain Medication
(Oxycontin, Oxycodone, Oxy, non-medical use)
Used Past Year



(Source: VSAAC Survey of Student Needs)

Pain Medication
(Codeine, Darvocet, Demerol, Percocet, etc., non-medical use)
Used Past Year



(Source: VSAAC Survey of Student Needs)

Impact

According to the Office of National Drug Control and Policy (ONDCP), abusing prescription drugs for the first time before the age of 16 exposes a young person to greater dependence of substances later in life. There are many consequences and impact of prescription pill abuse and dependence include increase in property crime, increase in drug diversion, long and short term negative health effects and unintentional injury and death. Federal data shows that prescription drug abuse now sends twice as many people to the emergency room (ER) as it did five years ago — outstripping illegal drugs for the third year in a row, according to the Office of National Drug Control and Policy in January 2011 report.

According to the National Institute on Drug Abuse there are several factors that contribute to the abuse of pain medications including:

- Misperceptions about their safety
- Increasing availability
- Varied motivations for their abuse

Other risk factors include:

- Opioids (used to treat pain): highly addictive which can lead to addiction & overdose. In addition if the drug is being injected it increases risk of HIV and other infectious diseases.
- CNS Depressants (used to treat anxiety and sleep problems): *Addiction and dangerous withdrawal symptoms.* Overdose
- Stimulants (used to treat ADHD and narcolepsy): *Addiction and other health consequences.* These include psychosis, seizures, and cardiovascular complications.

Impact in Sub-Region 2B

According to the CT Department of Public Health Mortality Data Drug Induced Deaths in Region 2B totaled 139 between the years of 2007-2009.

CT Study Findings: Growing trend of prescription opioid use

- These deaths occur among 35-54 age range, primarily non-Hispanic Whites, increasingly female die at home (more than half female) (Ages 24-58 (primarily >35)
- Nearly all involved opioid medication prescribed to decedent
- Toxicology suggest involvement of other pharmaceuticals: anti-depressants, sedatives/hypnotics
- Limited alcohol involvement; heroin, alcohol, and/or cocaine more common combinations
- Died at home, often with others in house
- Deaths clustered in geographic areas of town
- Themes: drug &/or alcohol abuse/ dependence, SA/MH treatment, domestic violence, past suicide attempts, previous overdose, other chronic disease or conditions (diabetes, obesity, back problems, chronic pain), incarceration, recent acute events-surgery, work injury

Capacity

According to the 2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but the community is at a low level of readiness to allocate funding for substance abuse prevention, develop policies and identify barriers to substance abuse prevention. Among the Sub-Region 2B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that recover groups as well as adult and adolescent treatment are somewhat effective.

Among the residents who participated in the assessment, ranked prescription drugs as significant problem second to alcohol in the 26+ age group and 4th in the 18-25 age group with a last place ranking in the 12-17 year age group. In addition, participants stated that most residents somewhat disagree that drinking while taking prescription medication is risky. Overall, participants feel that the residents in Sub-Region 2B feel that 1) limited financial resources, 2)Substance Abuse is a personal problem, 3) Lack of community buy in are the perceived barriers to substance abuse prevention within our region. Key informants felt that the community is most ready to raise community awareness about substance abuse and least likely to allocate funds for substance abuse prevention.

Members of the Community Needs Assessment Workgroup stated that they felt the sub-region is at a high stage of readiness to address prescription pill abuse because of recent activities by VSAAC including the Overdose Prevention Project through the CDC study, the Symposium for Health Care Professionals held last March, and the implementation of the Medication Drop Boxes and local police departments. They stated that in the past year our collaborative work with the Local Prevention Councils have helped to raise the awareness. These activities include medication drop boxes, speakers talking about the topic at community presentations, statewide conference, and overdose prevention trainings throughout the region.

Heroin

Magnitude

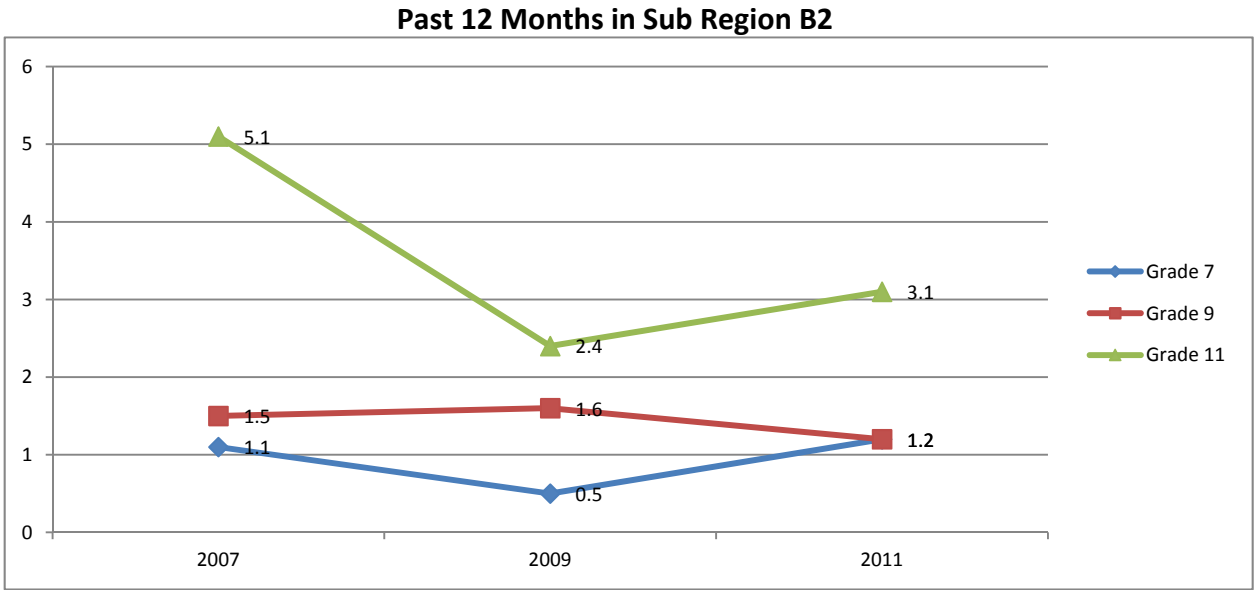
- In 2009, 605,000 Americans age 12 and older had abused heroin at least once in the year prior to being surveyed. *Source: National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration Web Site).*
- In the most recent survey from NSDUH, 8.23 percent of Connecticut residents reported using illicit drugs in the past month. The national average was 8.02 percent. Additionally, 3.26 percent of Connecticut residents reported using an illicit drug other than marijuana in the past month. (The national average was 3.58 percent).
- *According to* 2010-2011 National Survey on Drug Use and Health (NSDUH), *Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older,* In Connecticut is 2.70%-2.80%.

According to the 2009 National Survey on Drug Use and Health, the number of students who used in the past year compared to the number of students who used in Sub Region 2B was lower than the Lower Naugatuck Valley students. In 2009 the VSAAC Survey of Student Needs results are much higher than the nation average of students who have used.

Heroin Use Students, 2009: Monitoring the Future Survey National Results

	8th Grade	10th Grade	12th Grade
Past Year	0.7%	0.9%	0.7%

National Survey on Drug Use and Health (NSDUH)***



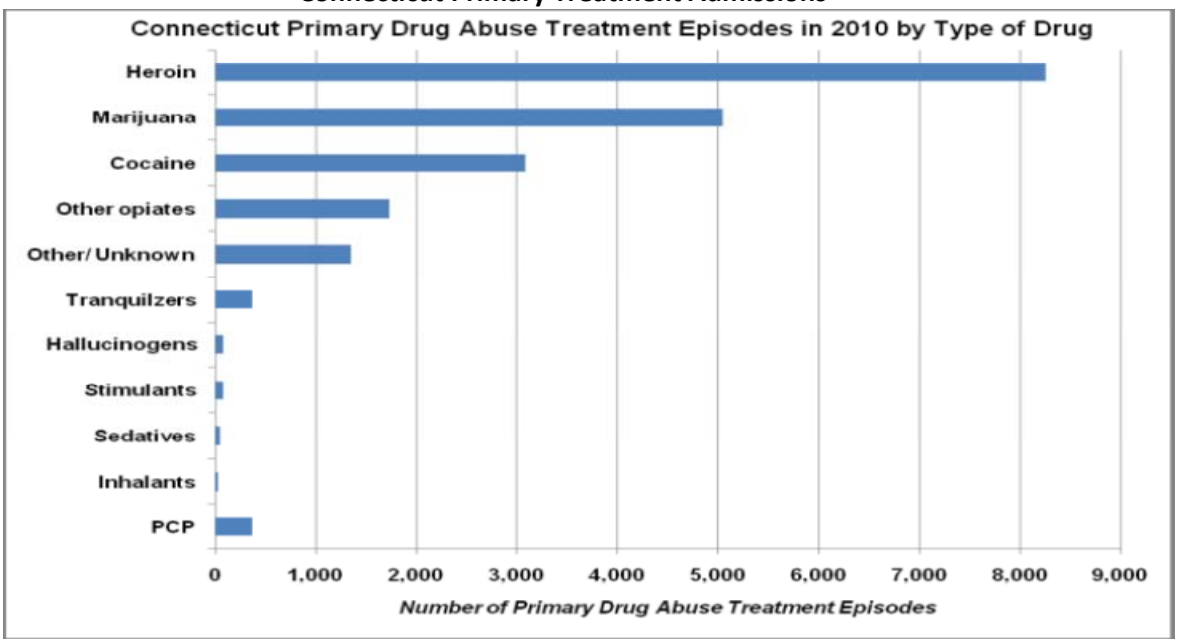
VSAAC Survey of Student Needs 2011)

Impact

- Heroin abuse is associated with serious health conditions, including fatal overdose, spontaneous abortion, and—particularly in users who inject the drug—infectious diseases, including HIV/AIDS and hepatitis. Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, and liver or kidney disease. Pulmonary complications, including various types of pneumonia, may result from the poor health of the abuser as well as from heroin's depressing effects on respiration. In addition to the effects of the drug itself, street heroin often contains toxic contaminants or additives that can clog blood vessels leading to the lungs, liver, kidneys, or brain, causing permanent damage to vital organs
- With regular heroin use, tolerance develops, in which the user's physiological (and psychological) response to the drug decreases, and more heroin is needed to achieve the same intensity of effect. Heroin users are at high risk for addiction—it is estimated that about 23 percent of individuals who use heroin become dependent on it.
- Chronic use of heroin leads to physical dependence, a state in which the body has adapted to the presence of the drug. If a dependent user reduces or stops use of the drug abruptly, he or she may experience severe symptoms of withdrawal. These symptoms—which can begin as early as a few hours after the last drug administration—can include restlessness, muscle and bone pain, insomnia, diarrhea and vomiting, cold flashes with goose bumps ("cold turkey"), and kicking movement ("kicking the habit").
- Heroin abuse during pregnancy, together with related factors like poor nutrition and inadequate prenatal care, has been associated with adverse consequences including low birth weight, an important risk factor for later developmental delay

Heroin was reported as the primary substance of abuse for 14 percent of TEDS admissions aged 12 and older in 2009. Most primary heroin admissions (77 percent) had been in treatment prior to the current episode, and 27 percent had been in treatment five or more times.

Connecticut Primary Treatment Admissions



Source: Substance Abuse Treatment Admissions by Primary Substance of Abuse 2009 http://wwwdasis.samhsa.gov/webt/quicklink/TN09.htm

The graph at above depicts substance abuse primary treatment admissions in Connecticut in 2010. The data show heroin is the most commonly cited drug among primary drug treatment admissions in Connecticut.

Capacity

According to the 2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.

Among the Sub-Region 3B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that recover groups as well as adult and adolescent treatment are somewhat effective.

VSAAC'S Community Needs Assessment Work Group for region 2B ranked the magnitude of the heroin problem in our community a 3.4 out of a 5 (scale: 1-5, with 5 being the highest). The impact of the problem in the community ranked 3.7 out of 5 and, the community perception in our changeability scored a 3.7

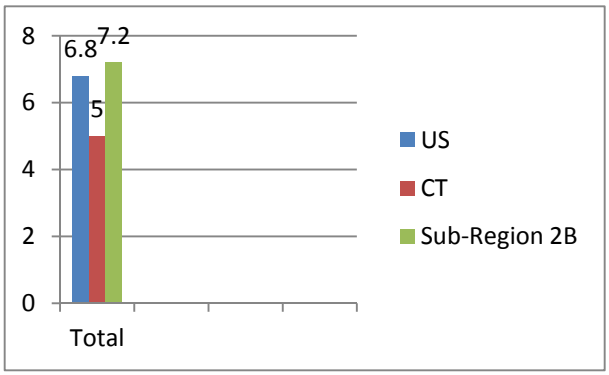
VSAAC continues to provide education around the dangers of using heroin. Education through schools and community programs heighten the awareness of the growing concern in the area of increased heroin use. The direct correlation between prescription pills and heroin continues to a main focus in the sub region. Disseminating information to youth, older adults, business professionals on how prescription pill abuse can lead to a heroin addiction due to the lower cost of heroin than prescription pills and availability

Cocaine

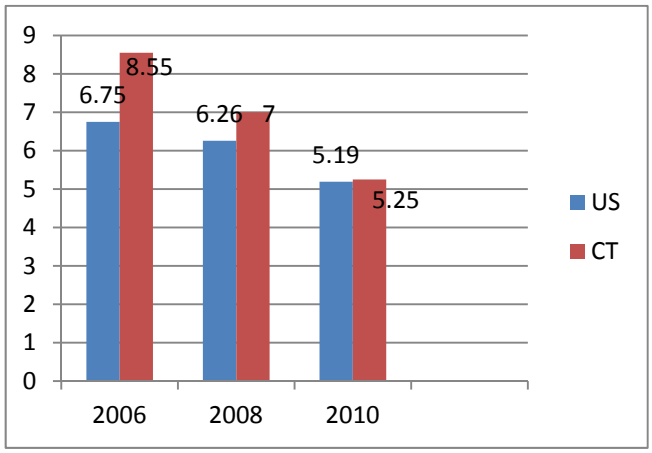
Magnitude

Cocaine continues to be a readily available drug in the US, in CT, and also in sub-region 2B. The National Survey on Drug Use and Health (NSDUH) estimates that in 2008, there were 1.9 million current cocaine users (past 30 day use). The highest users of cocaine according to the NSDUH data include adult's ages 18-25 years old with men reporting higher rates than women. According to the CDC Youth Risk Behavior Survey cocaine use among males is also higher than females in self reported surveys among 9-12th graders in the US and in CT. As you can see in the chart below cocaine use among students in sub-region 2B is comparable to the US and higher than the state average in CT.

Used any form of cocaine one or more times grades 9-12.



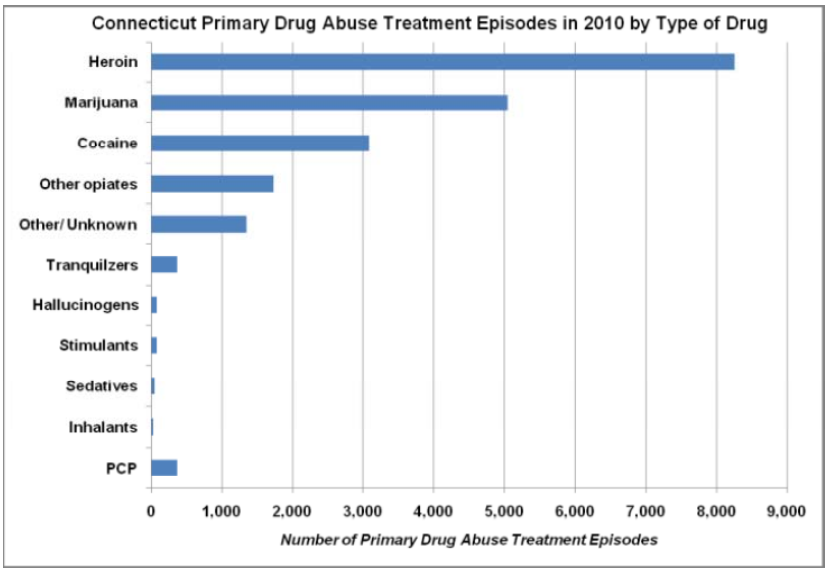
Cocaine use in the past year among 18-25 year olds (NSDUH)



Impact

Connecticut is one of the top ten states for dependence on illicit drugs among young adults age 18 to 25. (National Survey on Drug Use and Health 2007-2008) Cocaine use over time leads to addiction which impacts communities throughout the State. The impact cocaine use and abuse causes can be classified into two categories: criminal justice and health consequences. According to CT 2009 arrest data, sub-region 2B had 195 drug arrests for youth between the ages of 10-17 with 2,083 for adults ages 18 and older. 103 students in sub-region 2B were suspended or expelled from school in 2009 for illegal drugs. Many times people addicted to cocaine can spend more than $200 a week to fuel their addiction which leads them to committing property crimes in search of funding their addiction. This leads to increase use of the juvenile justice system and incarceration costs. Health consequences are also broad and far reaching. Health consequences include disability, increased costs for hospital / emergency room visits, as well as specialized treatment. Other health consequences include: cardiovascular disease, including hypertension, arrhythmia, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction, erosion of dental enamel, rhinitis, perforation of nasal septum, seizures, lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in pregnant women, and infections (HIV, hepatitis B or C, tetanus) from sharing needles. In addition to physical health consequences, psychological consequences include: anxiety, depression, suicidal feelings and behaviors, insomnia, emotional instability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder, depression, or mania can be triggered or exacerbated by cocaine use or withdrawal.

Treatment admission data from the Substance Abuse & Mental Health Services Administration Treatment Episode Data Set (TEDS) states: cocaine admissions declined from 14 percent in 1999 to 9 percent in 2009. Smoked cocaine (crack) represented 72 percent of all primary cocaine admissions in 2009, down from 73 percent in 1999. The graph at right depicts substance abuse primary treatment admissions in Connecticut in 2010. The data show more than 3,000 admissions for cocaine.



Capacity

According to the 2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but the community is at a low level of readiness to allocate funding for substance abuse prevention, develop policies and identify barriers to substance abuse prevention. Among the Sub-Region 2B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that recover groups as well as adult and adolescent treatment are somewhat effective.

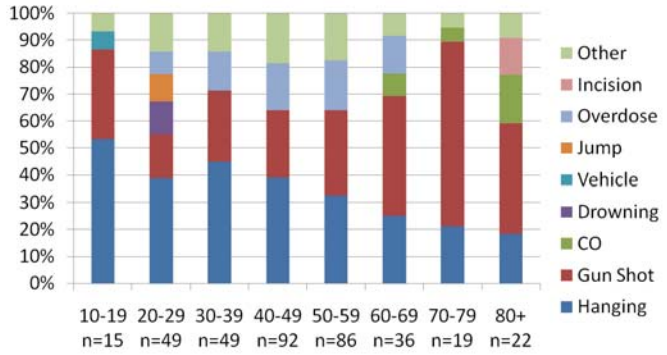
While we know cocaine use is occurring in the sub-region, there is a lack of willingness to discuss the issue and lack of resources working on cocaine prevention strategies. The Community Needs Assessment Workgroup was somewhat surprised by the cocaine information shared in the meeting and were unaware that cocaine is still a somewhat popular drug in the area.

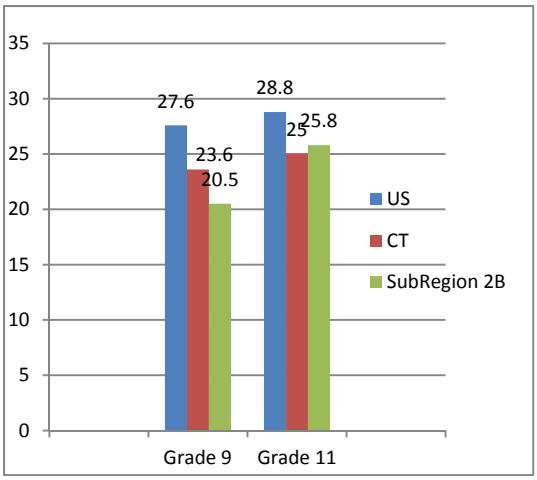
Suicide

Magnitude

Suicide is defined as the act or an instance of taking one's own life voluntarily and intentionally. According to the Centers for Disease Control (CDC) it is the 10th leading cause of death in 2012 in the United States. However, it is important to note that more people survive suicide attempts than actually die. More than 36,000 people complete suicide in the US and more than 376,000 people are treated in emergency rooms each year with self inflicted injuries (CDC, 2010). Connecticut's Office of the Chief Medical Examiner (OCME) reported that Connecticut had 368 suicides in 2011 with the average age of the descendent to be 48 years old. Suicide has been one of the top 5 leading causes of death for 10-54 year olds in CT, and second for young adults in college in the ten year span of 199-2009. According to data provided by University of CT Health Center (UCHC) and OCME the CT averages 308 suicides per year with more men then female completing suicide. The 11 towns in Sub-Region 2B are part of New Haven County which has the second highest rate of suicide in CT.

The chart below illustrates the method of suicide in CT by age in 2011 (n=368)





CT and Sub-Region 2B youth appear to have comparable problems with other US youth when utilizing the data from the 2011 CDC Youth Risk Behavior Survey (YRBS) among students in grades 9-12. The following charts illustrates the percent of students who self reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

Impact

Suicide has no single cause or group of causes that can give a complete explanation to it and affects the health of various communities in which the suicide occurred. People who know someone who has completed suicide many times need help in dealing with the shock, anger, guilt and depression especially those close to the descendent. The medical and lost wages also impact a community in many ways. According to the CDC, 85% of suicides are among people ages 25-65. This has a great impact on our economy because many of these people are in the prime of their lives working and raising families. In addition those people contemplating suicide or previously attempted many times end up disabled due to injuries sustained from attempting such as brain injury or other mental health problems. Disability impacts quality of life for many individuals as it disrupts their ability to engage in satisfying relationships, daily activities or work.

While suicide affects everyone, some groups are at a higher risk than others. Men are four times more likely than women to die from suicide but women are three times more likely to attempt according to the CDC. Other risk factors include: previous attempt, history of depression or other mental illness, family history of suicide / violence, alcohol or drug use, physical illness, and feeling alone. In addition, suicide rates are high among middle aged and older adults.

Capacity

According to the2012 Connecticut Community Readiness Assessment for Substance Abuse Prevention, the overall readiness for Substance Abuse Prevention in Sub-Region 2B is 4.43. Respondents feel that 1) a lack of funding, 2) limited financial resources, 3) the perception that substance abuse is a personal problem is the largest barriers to substance abuse prevention activities within the sub-region. Key informants feel that the community recognizes a substance abuse problem and leaders on the issue are identifiable, but the community is at a low level of readiness to allocate funding for substance abuse prevention, develop policies and identify barriers to substance abuse prevention. Among the Sub-Region 2B residents who participated in the assessment, the largest numbers of individuals in all age groups believe that recover groups as well as adult and adolescent treatment are somewhat effective.

The new Statewide Suicide Prevention Initiative has been working to increase capacity across the state. Awareness of suicide prevention in sub-region 2B is currently mostly among human service providers and schools which are partnering with us to increase capacity within the communities we serve. We are fortunate to have Question, Persuade, and Respond (QPR) trainers and CONNECT (suicide prevention) trainers in our sub-region. These trainers have been working to promote the ONE WORD, ONE VOICE, ONE LIFE campaign throughout the region as well as conduct trainings. The majority of cities and towns in sub-region 2B are aware of the new suicide prevention efforts. However, in our Community Needs Assessment Workgroup members felt that we need to continue to raise awareness on this important issue while stressing the importance of good emotional and mental health across the lifespan. Members stated that most people only access service when it has become a crisis and have missed the prevention aspect of good mental health.

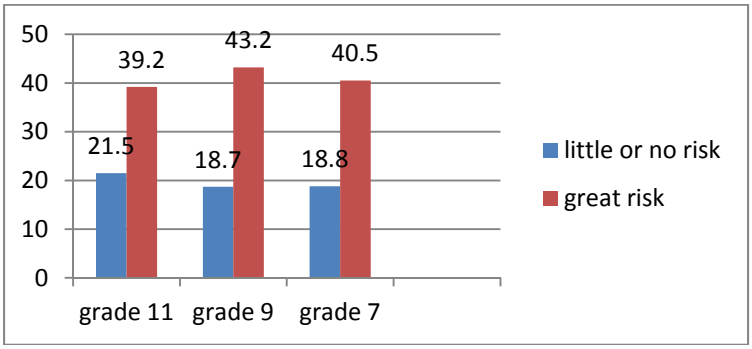
Gambling

Magnitude

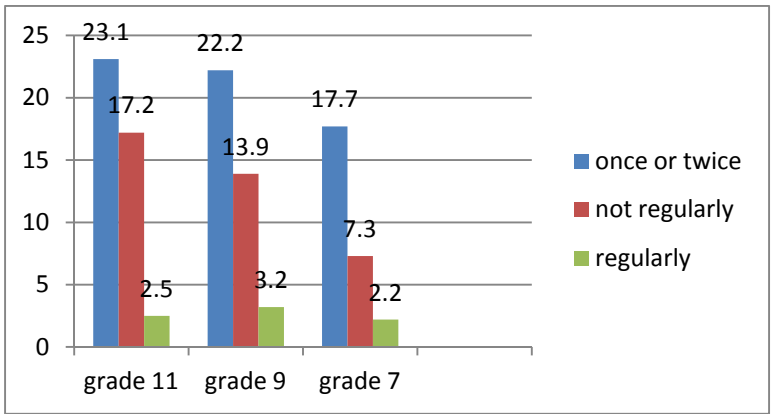
The State of CT supports gambling. The CT Lottery Corporation was created in 1971 to provide "benefits to the state". To date more than 7 Billion dollars has been contributed to the General Fund. Lottery tickets can be purchased in most retail outlets where food and beverages are sold. The state is also part of the multi-state Mega-Millions and Powerball. CT has two of the largest casinos in the world, Mohegan Sun and Foxwoods - the largest casino resort in North America.

According to the Student Survey of Needs, 2011:

How much djo you think teenagers risk harming themselves?



Have you ever placed a bet/gambled?



According to findings from Youth gambliong in CT, 2008, 90% ofstudents gambled in the past year; 42% received lottery tickets as gifts, and 13% who gamble can be classified as problem or pathological gamblers. According to the CT Ssschool Hwealth Survey, 2011, 25.2 % of High School students gambled for money or possessions in the past year. Males gambled at a higher rate than females-38.2 % to 11.8%.

At the CT college level the problem gambling rate was found to be 11%. (CCPG 2005) About 15 of college students are at risk for develjoping gambling problems (Shaffer & Hall 2001)and College athletes have higher rates of problem gambling than non athletes.(CCPG 2005)

A CT Study of 2733 higgh school students found problem gambling associated with depression, aggression, cigarette smoking, marijuana use, other drug use, heavier alcohol use, greater caffeine consumption and lower academic performance. This study also suggests that 8 years is the onset of gambling. (Yip et al., 2011)
These signs are similar to those found in adults. We also find that there is a link to crime when gamblers attempt to support their gambling after their own funds have run out. Suicide is a major concern with problem or pathological gamblers, more commonly seen around the area of the casinos.

Impact

The Connecticut Council on Problem Gambling is a key education organization in the State. They work with the casinos to promote problem gambling awareness. They are a key provider of pamphlets and booklets for education purposes.

The State Dept of Mental Health and addiction Services Problem Gambling Services works closely with the RAC's to provide timely information and funds to support both school and community programs. One prominent program-The Bettor Choice program is available in many areas. There is a state hotline and some gamblers' anonymous meetings through-out the state.

Most gamblers do not seek treatment. There are many fewer treatment programs for gamblers than for drug addiction and many fewer certified counselors.
It would be rare for an insurance company to cover treatment for problem gamblers unless it was found to be a co-occurring disorder.

Capacity

VSAAC's CNAW does not believe the communities of VSAAC's service area consider gambling a problem, rating it a 2 out of 5. They also do not believe that gambling problems have an impact in these communities (2.1) The CNAW did not believe the community would be willing to make any changes considering they do not believe gambling is a problem issue.

To address the problem of gambling with youth, more educational organizations need to take steps to provide education and training for youth and the adults who work with them. VSAAC has infused gambling into most of their community presentations and trainings. However, more statewide infusion needs to happen especially within treatment providers.

Appendix 1 – Data Sources

Census Data

Definitions

Age: The age of the person in complete years at the time of census interview.

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.

Source

2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Arrests for Driving Under the Influence

Definition

Arrests recorded for driving or operating any motor vehicle or common carrier while drunk or under the influence of liquor or narcotics.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths

Driving under the influence (DUI) is a direct consequence of alcohol or drug 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 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.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

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.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

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-Involved Motor Vehicle Accidents

Definition:

Motor vehicle accidents for which the driver had consumed alcohol (Blood Alcohol Concentration >0.00)

Source:

Connecticut Department of Transportation Traffic Accident Viewing System

Newington CT

Strengths:

Alcohol motor vehicle involved accidents are a direct consequence of alcohol misuse. The information is routinely collected as part of the Department of Transportation's Traffic Accident Viewing System.

Limitations:

The rates may underestimate the actual occurrence due to underreporting. A person involved in an accident in particular town may not reside in that town.

Fatal Motor Vehicle Accidents while Under the Influence of Alcohol or Drugs

Definition

Motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source

National Highway Traffic Safety Administration (NHTSA), Fatal Accident Reporting System (FARS)

Strengths

Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations

Alcohol Test Result statistical data obtained from this database should be interpreted with caution. Alcohol Test Results included in this database are actual state-reported data. Estimates obtained by use of this query system may differ from NHTSA's published reports. NHTSA's published estimates are based on data from the Fatality Analysis Reporting System (FARS). Unfortunately, known BAC test results are not available for all drivers and non-occupants involved in fatal crashes. "Property Damage Only" accidents, which occurred on locally maintained roadways from 01/01/2007 to the present, are included in the DOT accident file; prior to that date, they were not included in the file. The rates may underestimate the actual occurrence due to underreporting, and also a person involved in an accident in particular town may not reside in that town.

Motor Vehicle Accident Fatalities while Under the Influence of Alcohol or Drugs

Definition

Total fatalities in motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source

National Highway Traffic Safety Administration (NHTSA), Fatality Analysis Reporting System (FARS)

Strengths

Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations

This indicator may be unstable for less populated areas that have low numbers of annual fatal crashes. While considerable effort has been made to obtain the BAC values for all drivers involved in fatal crashes, these data are not complete. Therefore, NHTSA estimates driver BAC for cases missing data.

Lung Cancer Deaths

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes C34 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

Eighty to 90% of all lung cancer is attributable to cigarette smoking. Data on lung cancer deaths are readily available for many years.

Limitations

Death from lung cancer reflects long-term, chronic cigarette smoking, and lung cancer has a long latency period. Therefore, it may be many years before changes in smoking affect population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur and may be unstable for less populated states or when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death.

Alcohol-Attributable Chronic Liver Disease and Cirrhosis Deaths

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes K70, K73, or K74 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

Long term, heavy alcohol consumption is the leading cause of chronic liver disease, in particular cirrhosis, one of the 12 leading causes of death. According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 40% of deaths from cirrhosis in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations:

This indicator is only based on deaths; cases of cirrhosis morbidity are not reflected in this indicator. Alcohol-related cirrhosis may have a long latency; there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups.

Alcohol-Attributable Suicides

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X60-X84, Y87.0 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 23% of suicides in Connecticut were attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations:

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as suicide, are best used at the state or regional levels.

Alcohol-Attributable Homicides

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X85-Y09 and Y87.1 as the underlying cause of death. Homicide includes injuries inflicted by others that result in death.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 47% of homicides in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations:

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as homicide, are best used at the state or regional levels.

Alcohol-Induced Death

Definition

Alcohol-induced deaths include alcohol-induced pseudo-Cushing's syndrome; mental and behavioral disorders due to alcohol use; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol-induced acute pancreatitis; alcohol-induced chronic pancreatitis; finding of alcohol in blood; accidental poisoning by and exposure to alcohol; intentional self-poisoning by and exposure to alcohol; and poisoning by and exposure to alcohol, undetermined intent. Alcohol-induced causes exclude accidents, homicides, and other causes indirectly related to alcohol use, as well as newborn deaths associated with maternal alcohol use.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

These deaths are a direct consequence of alcohol misuse.

Limitations

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Drug-Induced Death

Definition

Drug-induced deaths include all deaths for which drugs is the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs (e.g., heroin or cocaine), as well as legal prescription drugs and over-the-counter drugs; alcohol is not included. The majority of deaths are unintentional drug poisoning deaths, with suicidal drug poisoning and drug poisoning of undetermined intent comprising the majority of the remainder. Adverse effects from drugs taken as directed and infections resulting from drug use are not included. In 2007, drug-induced deaths were more common than alcohol-induced or firearm-related deaths in the United States.

Source

Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths

These deaths are a direct consequence of drug misuse.

Limitations

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

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.

Source

Connecticut State Department of Education disciplinary offense records

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.

Overall school attendance in past year

Definition

Overall school attendance is the number of students attending public school each day of the school year, divided by the number of days school was in session during the school year.

Source

Connecticut State Department of Education & School attendance records

Strengths

Researchers have found that truancy itself seems to contribute to or at least correlate with a diverse array of problems among young people. Studies have established lack of commitment to school and truancy as risk factors for substance abuse, teen pregnancy, delinquent behavior, and school dropout.

Limitations

This indicator is an indirect measure of substance abuse and its consequences.

Tobacco Retailer Violation

Definition

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

Data Source

Connecticut Department of Mental Health and Addiction Services 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 sub region. After preparing the eight Sub regional 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

RACs then add the scores to determine the priority ranking for each problem.