2015 Interim

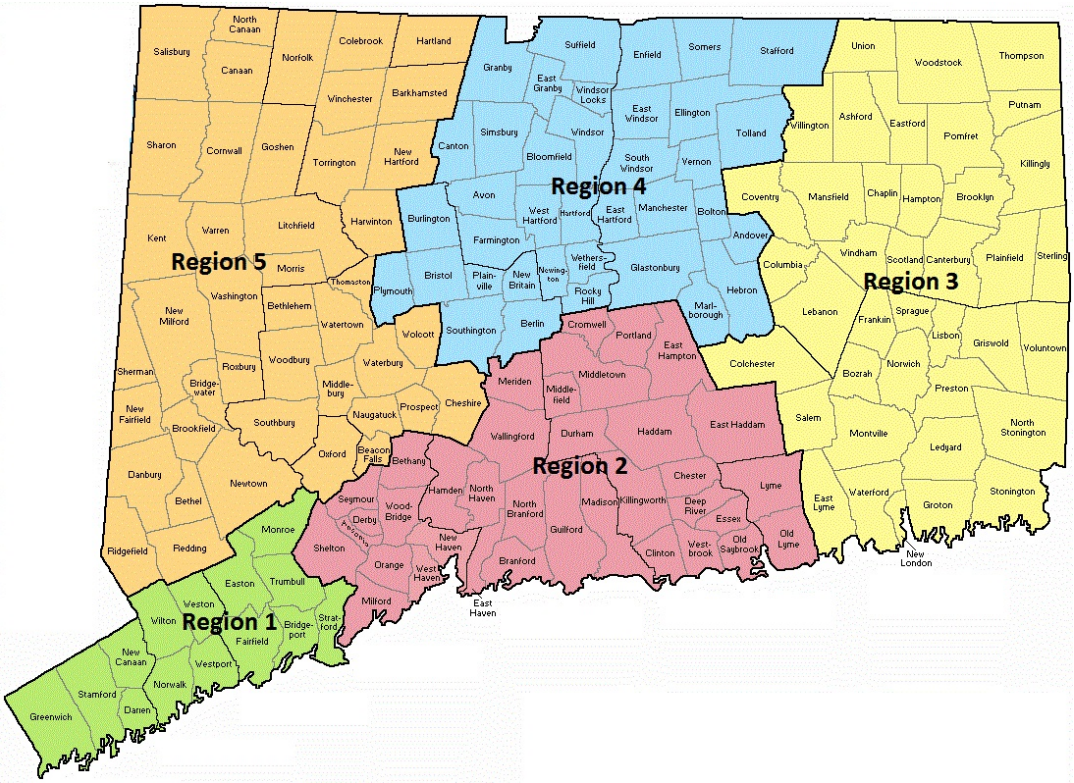
Report on Regional and State

Priorities Related to Substance Use

Compiled by DMHAS

Evaluation, Quality Management and Improvement Division in

Collaboration with the Regional Action Councils



January 25, 2016

Introduction

The thirteen substance-use focused Regional Action Councils (RACs) were created by Connecticut General Statute and play a fundamental role in planning, prevention and advocacy efforts. RACs work in their local communities and are organized into the Connecticut Prevention Network. Through regular contact with persons in recovery, evaluations, and special studies, RAC members monitor ongoing services and assess the need for services. Through these efforts, they identify service gaps and deficiencies. Members of RACs are selected to represent all constituent groups – consumers of services, family members of consumers, municipalities, private and public providers of services, including community services. RACs examine issues from the varied perspectives of these constituent groups. In that role, they also touch upon a variety of concerns related to behavioral health including stigma/discrimination, primary health and wellness, public safety, criminal justice, education, housing and employment. Within the communities they serve, RACs profile needs and response capacity. They raise awareness about substance use, problem gambling and suicide by presenting evidence from various data sources, treatment professionals, school personnel, law enforcement, and student surveys. In previous years, the DMHAS Prevention Unit aggregated this data into a report, describing each region's status with respect to substance use and related conditions. For this interim report, the DMHAS Evaluation, Quality Management and Improvement (EQMI) Unit has aggregated data into state and regional findings using DMHAS data, state level data based on federal surveys/data collection, school surveys involving over fifteen thousand middle and high school students, and other recent statistics available related to substance use.

There are a number of limitations on the data in this report. First, some of the regional data reported is older data (2010-2012) because of the time required to accumulate sufficient numbers to make accurate estimates for smaller areas. This means the same NSDUH sample used to make national estimates may be as recent as 2014, while the most recent available regional data goes back to 2010-2012. Second, arrest-related data may reflect law enforcement practice or personnel concerns rather than, or in addition to, substance use variables. Third, the school survey data included in this report is not acquired uniformly across all Connecticut school districts or regions. Additional limitations are that some school districts do not participate or share survey results, at least 3 different surveys are used asking different questions with little cross-survey consistency, and there is also inconsistency in terms of which grades (9^{th} – 12^{th}, 7^{th} – 12^{th} or 6^{th} – 12^{th}) within a school district are surveyed. Surveys including younger students tend to have less reported substance use than those surveying older students. The total number of students surveyed included in this report was 15,129 over the period 2013 - 2015. Due to limitations related to the school surveys, this data is only presented as statewide averages.

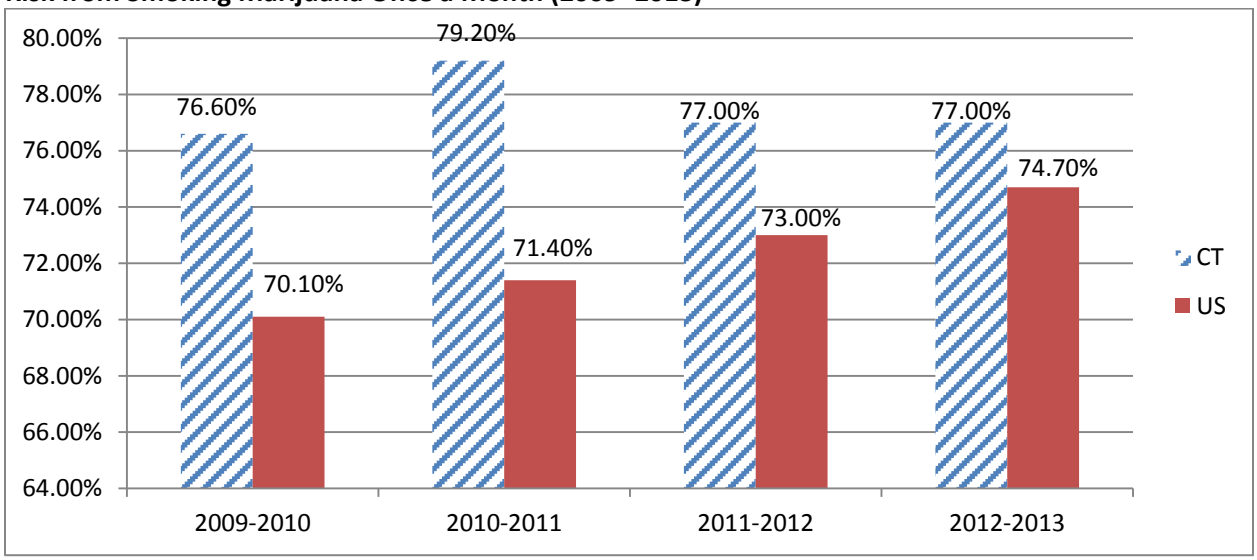
Substance Use

The priority substances of abuse across the state for 2015 are alcohol, opioids (heroin, synthetic and prescription opioids), and marijuana. Other potential substances of abuse simply don't reach the threshold of concern engendered by these three. Support for this conclusion is based on a variety of sources: the 2014 Priority Setting Process undertaken by the Regional Mental Health Boards (RMHBs) and the Regional Action Councils (RACs), DMHAS Regional Profile and Admission Data, the 2014 National Survey of Drug Use and Health (NSDUH) regional data, and Connecticut state data from the Behavioral Health Barometer provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Marijuana

10% of adolescents (12 – 17 years of age) in Connecticut used an illicit drug in the past month, comprised primarily of marijuana and/or opioids in 2014, based on the Behavioral Health Barometer. Marijuana continues to be the number one most used illicit substance across the nation and in our home state. In Connecticut, passage of the medical marijuana law has many concerned about the impact this legislation may have on perception of risk related to marijuana use and actual use itself. 2014 Behavioral Health Barometer data found that 3 out of every 4 (77%) adolescents perceived no great harm from monthly smoking of marijuana. With low perceived risk, many expect increased use.

Figure 1: Adolescents (12 -17 years old) in Connecticut and the United States Who Perceive No Great Risk from Smoking Marijuana Once a Month (2009 -2013)



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, national Survey on Drug Use and Health, 2009 – 2013

School surveys (2013-2015) asking students about marijuana use in the past 30 days, revealed a statewide average of 14% with a range from 7% to 23%.

As can be seen in Figure 2 which follows, marijuana use is more widespread among young adults (18 – 25). The 2010-2012 NSDUH data included in this table revealed past month marijuana use among 18 – 25 year olds as 23.0%, up slightly from 22.2% in the previous report, and past year use at 38.9%, up from

36.9%. It also found rates of marijuana use in Region 2 to be higher than in other regions across the age groups.

Figure 2: Marijuana Use across Regions by Age Group (2010 -2012)

Area	Marijuana Use in the Past Month (%)					Marijuana Use in the Past Year (%)				
	Age Group					Age Group				
	12-17	18-25	12+	18+	26+	12-17	18-25	12+	18+	26+
Total U.S.	7.5	18.7	7.0	7.0	4.9	13.9	30.7	11.7	11.5	8.1
Connecticut	9.0	23.0	8.3	8.3	6.0	16.6	38.9	13.8	13.5	9.6
Region 1	8.3	*	7.2	7.1	5.2	14.9	*	11.9	11.5	8.1
Region 2	10.4	27.4	10.1	10.0	7.2	18.1	42.4	15.4	15.1	10.7
Region 3	8.3	19.4	7.9	7.8	5.3	14.8	33.2	13.3	13.1	8.8
Region 4	8.2	23.9	8.3	8.3	6.0	16.9	41.5	14.6	14.3	10.3
Region 5	9.5	*	7.4	7.2	5.4	17.2	*	12.9	12.4	8.9

***low precision, no estimate reported**

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010-2012

Figure 3: Trends in Past Month Marijuana Use across Regions, Age 12 and Older

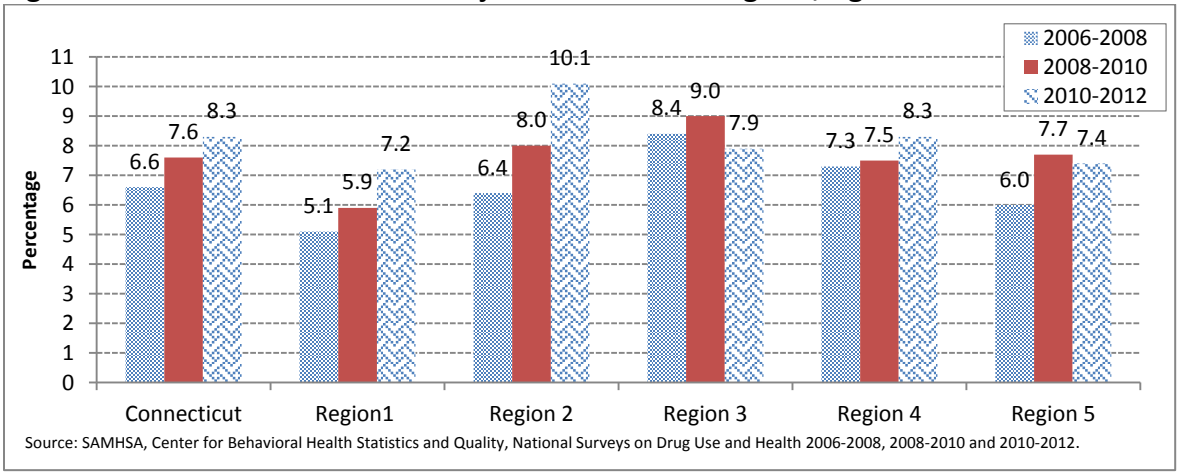
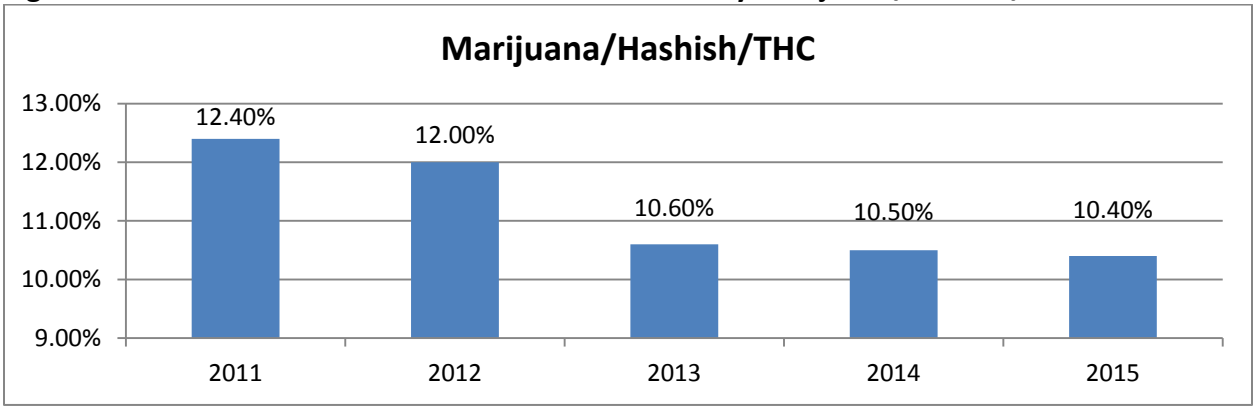


Figure 4: Substance Use Services Admissions for Primary Marijuana/Hashish/THC Use



Source: DMHAS EQMI

A review of Figure 4 above shows that DMHAS admissions to substance use services for primary marijuana/hashish/THC use declined over the period from 2011 to 2015. As of the most recent data (FY 2015), about 10% of substance use services admissions are for some form of cannabis.

Summary for Marijuana:
As the country moves toward broader access through medical and recreational marijuana laws, both school and national surveys find decreasing rates of perceived risk associated with marijuana use. Outcomes associated with legalization are unknown at this time, but Connecticut will benefit from the experiences of states which have already legalized as such information will inform our state's expectations and strategies.

Prescription and Synthetic Opioids/Heroin

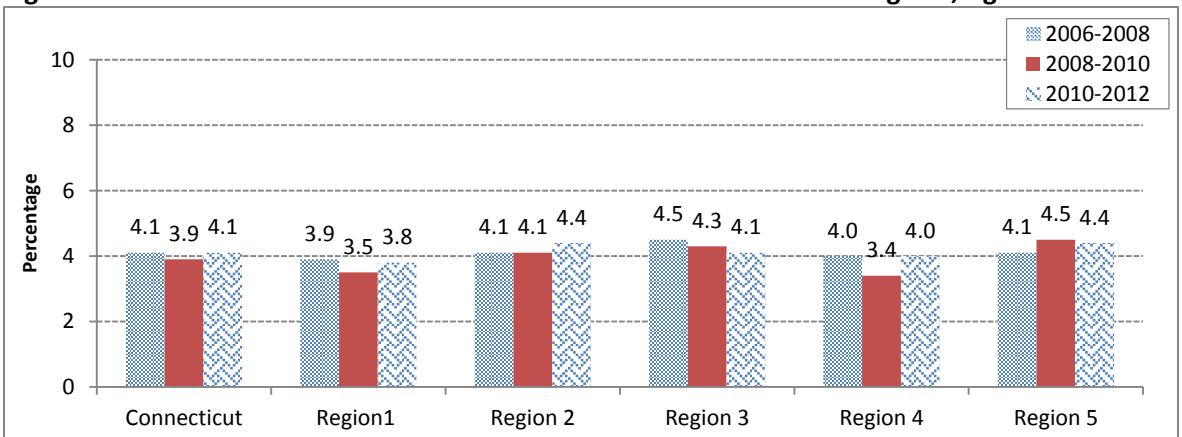
Across the country, misuse of prescription medications is second only to marijuana as the nation's most prevalent illicit drug problem. School survey results on past 30 day prescription drug use (including opioids/painkillers, tranquilizers, stimulants and sedatives) without a prescription averaged 5% statewide and ranged from 2% to 12% among students. The associated students' perception of moderate to great risk related to use of prescription medications without a prescription averaged 85% across the surveys, suggesting that 15% of students surveyed perceived no or little risk associated with the misuse of prescription medications.

The 2010 – 2012 NSDUH estimates for Connecticut show that 9.6% of 18 – 25 year olds reported past year nonmedical use of pain relievers. Regional estimates ranged from a low of 8.6% in Region 1 to 10.3% in Regions 2 and 5.

Figure 5: Past Year Nonmedical Pain Reliever Use across Regions by Age Group, 2010-2012

Area	Age Group (%)				
	12 - 17	18 - 25	26+	12+	18+
Total U.S.	5.9	10.3	3.5	4.6	4.5
Connecticut	4.7	9.6	3.2	4.1	4.1
Region 1	4.4	8.6	3.0	3.8	3.7
Region 2	5.0	10.3	3.4	4.4	4.3
Region 3	4.6	8.9	3.1	4.1	4.1
Region 4	4.3	9.6	3.1	4.0	4.0

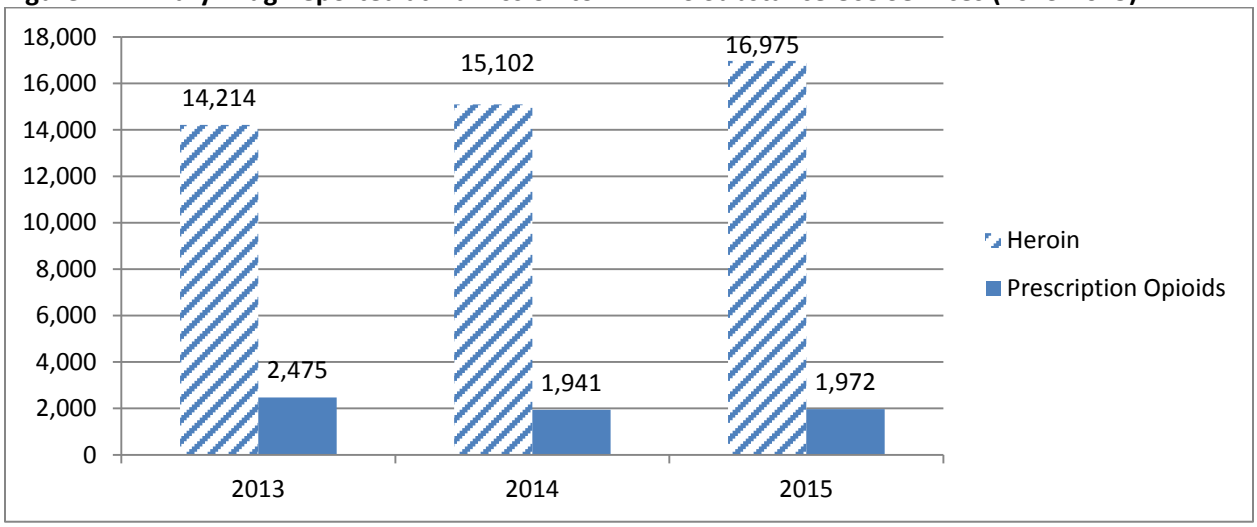
Figure 6: Trends in Past Year Nonmedical Use of Pain Relievers Across Regions, Age 12 or Older



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2006-2008, 2008-2010

Admissions to DMHAS substance use services over the period from 2013 to 2015 revealed that the primary problematic substance being reported was opioids (45%) compared to those primarily being admitted for alcohol (35%). The following figure reveals that while admissions for prescription opioids has leveled off, admissions for heroin continue to rise each year. In fact, the CDC now describes misuse of prescription opioids as the greatest risk factor for heroin use, indicating that prescription opioids are serving as a gateway to heroin, which is readily available and inexpensive.

Figure 7: Primary Drug Reported at Admission to DMHAS Substance Use Services (2013-2015)



Source: DMHAS Admission Data 2013-2015

The percent of Connecticut students reporting use of heroin/narcotics in the past 30 days based on school surveys averaged 2% statewide and ranged from <1% to 7%. This 2% is about half the 5% of students reporting misuse of prescription medications.

Of particular concern related to opioids at present is the addition or substitution of synthetic fentanyl for heroin. The CDC reported in December 2015 that synthetic fentanyl-involved overdose deaths increased by 80% across the country from 2013 – 2014. For Connecticut, drug overdose deaths, the majority of which are opioid-involved, increased by 10% from 2013 to 2014. On average, one to two people in our state die every day from an opioid-involved overdose.

Figure 8: Number and Age-adjusted rates of Drug Overdose Deaths for Connecticut (2013-2014)

2013		2014		% change (2013-2014)
Number	Rate	Number	Rate	
582	16.0	623	17.6	+10.0

Source: CDC: MMWR Early Release/Vol. 64 Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014, December 18, 2015

Summary of Prescription and Synthetic Opioids/Heroin

Heroin use is rising in the state and appears largely due to prior misuse of prescription opioids. The misuse of prescription medications appears to be stabilizing. Law enforcement personnel report increasing purity of heroin and inclusion of synthetic fentanyl with or for heroin contributing to more overdoses and deaths.

Alcohol

Young adults aged 18 – 25 in Connecticut reported the greatest amount of past month drinking of all age groups, as well as the highest prevalence of binge drinking based on NSDUH 2010-2012 data. Binge drinking is defined by SAMHSA as having 5 or more drinks on a single occasion. Across the regions, estimates of past month drinking by 18 – 25 year olds ranged from 68% in Region 4 to 71.4% in Region 2; estimates for binge drinking among 18 – 25 year olds ranged from 44% to 49%. No estimates for these indicators were reported for Regions 1 or 5.

Figure 9: Alcohol Use across Regions by Age Group, 2010-2012

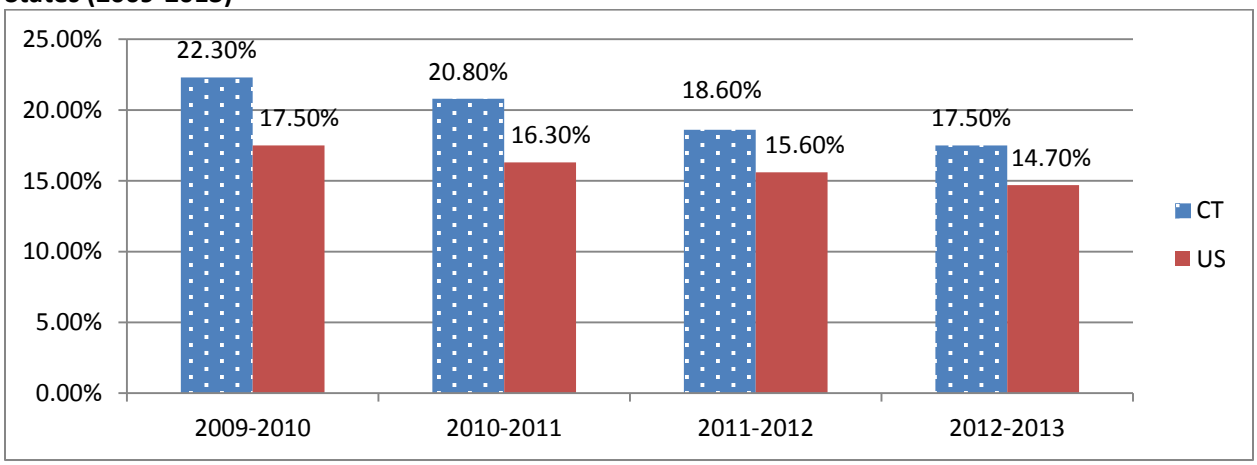
Area	Alcohol Use in the Past Month (%)				Binge Alcohol Use in the Past Month (%)			
	Age Group				Age Group			
	12-17	12-20	18-25	18+	12-17	12-20	18-25	18+
Total U.S.	13.3	25.0	60.7	55.9	7.5	15.9	39.8	24.5
Connecticut	18.0	31.3	68.9	65.6	8.6	19.1	46.6	27.0
Region 1	17.9	29.2	69.5	67.2	9.1	17.7	*	27.4
Region 2	20.2	35.1	71.4	68.0	9.9	21.8	49.3	29.9
Region 3	18.8	36.8	68.1	63.1	8.4	22.2	47.9	27.1
Region 4	16.1	28.5	68.0	63.2	7.3	17.8	44.2	24.8
Region 5	17.8	28.3	*	66.1	8.8	16.7	*	26.1

*** Low precision; no estimate reported.**

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2010-2012

Connecticut's percentage of binge alcohol use among underage drinkers (12 – 20) continues as it has for several years to exceed the national average; however, the trend has been declining noticeably since at least 2009 as can be seen in Figure 10 below.

Figure 10: Past Month Binge Alcohol Use among People Aged 12 – 20 in Connecticut and the United States (2009-2013)



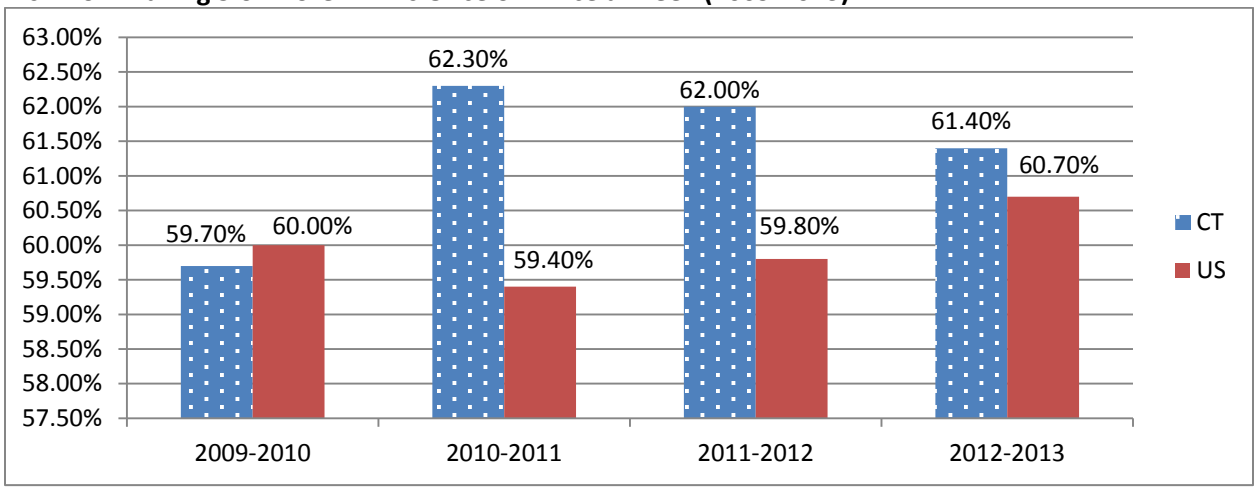
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2009-2013.

The percent of youth, based on school surveys, who reported alcohol use at least once in the last 30 days averaged 22%, basically one in 5 students. The range was from 7% to 36% and younger students were less likely to have used alcohol than older students. Questions about heavy drinking and binge drinking were asked in different ways, but at a minimum, when asked about at least 4 drinks on at least one occasion in the last 2 weeks/30 days, the average was

14% and the range was 5% to 27%. This percentage reflects a continuation of the pattern of decreasing binge drinking reflected in Figure 10 above.

Six in 10 adolescents (61.4%) in Connecticut perceived no great risk from drinking five or more drinks once or twice a week, a perception that may be associated with a greater willingness to binge drink among 12 – 17 year olds.

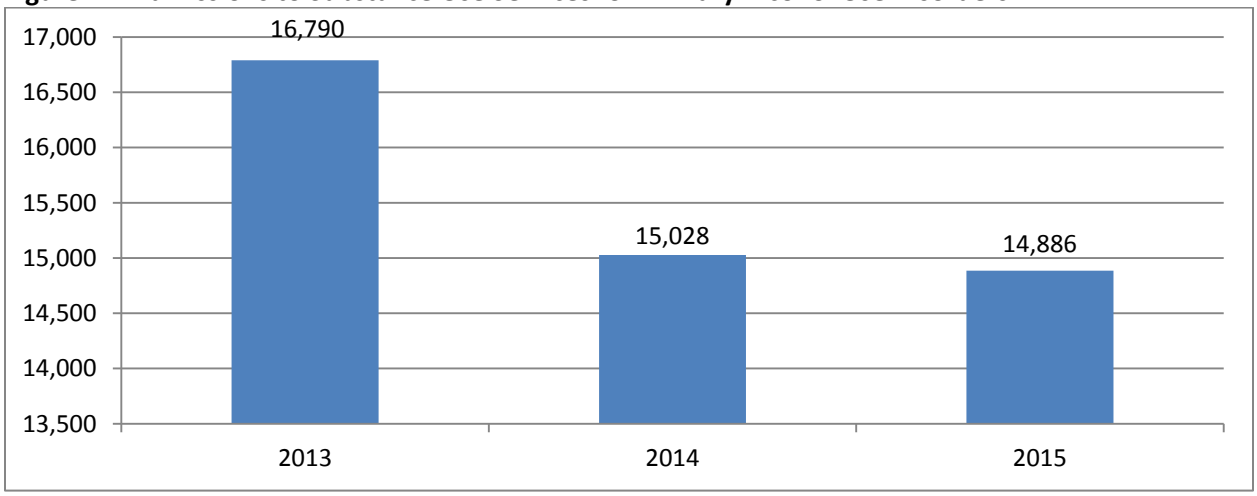
Figure 11: Adolescents Aged 12 – 17 in Connecticut and the United States who Perceived No Great Risk from Having 5 of more Drinks Once or Twice a Week (2009-2013)



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2009-2013

As can be seen in Figure 12 below, the number of persons admitted to DMHAS primarily for Alcohol Use Disorders has decreased over time (at the same time that the numbers for opioid admissions have been increasing). In 2013, 39% of admissions to substance abuse services were for Alcohol, but by 2015 that percentage had decreased to 35%.

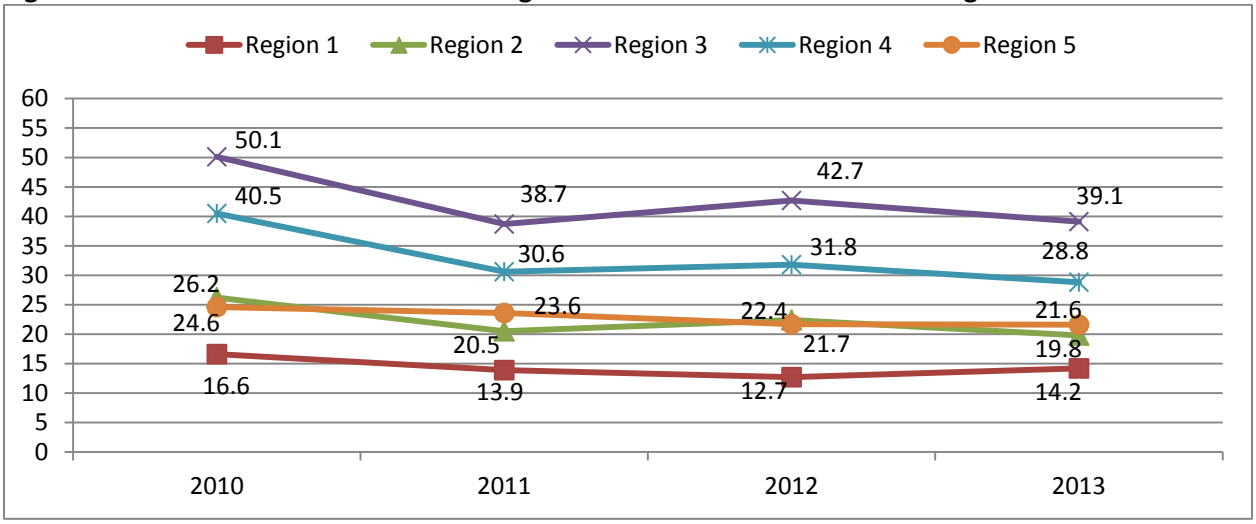
Figure 12: Admissions to Substance Use Services for Primary Alcohol Use Disorders



Source: DMHAS Admission Data 2013-2015.

A number of statistics are reflecting a downward trend in alcohol related issues. A review of Connecticut DUI outcomes for 2013-14 found 10,308 total, the smallest amount in 15 years of data collection and nearly 700 less than the prior year. A review of Uniform Crime Reporting data from 2010 – 2013 revealed a similar trend toward decreasing numbers of liquor-related arrests over that period from a total of 1144 in 2010 to 412 in 2013. Alcohol Related Motor Vehicle Crashes likewise dropped significantly over the last few years.

Figure 13: Trends in Rates of DUI Arrests Age 10 or Older across Connecticut Regions



Source: Connecticut Department of Emergency Services and Public Protection, Crime in Connecticut, 2010-2013

Figure 14: Trends in Rate of Alcohol-Related Motor Vehicle Crashes, Age 10 or Older *

Area	Alcohol-Related Motor Vehicle Accidents				Alcohol-Related Motor Vehicle Fatalities			
	2010	2011	2012	2013	2010	2011	2012	2013
Connecticut	6.6	1.2	1.5	1.8	3.2	1.3	1.8	2.1
Region 1	4.4	1.5	1.0	1.6	1.1	1.6	1.3	1.7
Region 2	6.3	0.8	1.6	1.3	4.4	1.1	1.7	1.7
Region 3	10.8	1.6	1.4	2.1	5.1	1.6	1.9	2.1
Region 4	7.5	1.5	2.2	2.1	3.7	1.6	2.9	2.5
Region 5	4.9	0.8	1.0	2.3	1.9	0.8	1.0	2.7

***Rate per 10,000**
Source: National Traffic Highway Safety Administration, Fatality Analysis Reporting System, http://www-fars.nhtsa.dot.gov

Summary of Alcohol

In general, problematic alcohol use has either held steady or trended downward in the last few years, although underage drinking and binge drinking in particular exceed the national average and remain a cause for concern.

Suicide

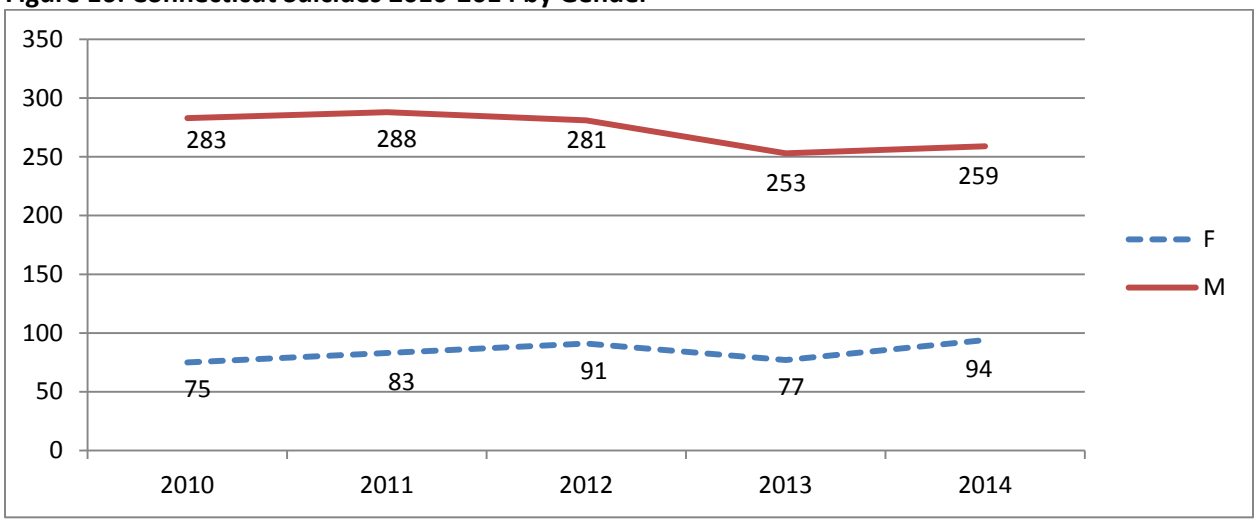
There were a total of 358 suicides in 2010 in Connecticut and 353 in 2014. From 2013 to 2014 the numbers did increase for men (2%) and for women (22%), but there has been variability in the intervening years from a high of 372 (2012) to a low of 330 (2013). Each year more males commit suicide than females at a ratio between 2.8 to 3.8 males for every female, depending on the year.

Figure 15: Connecticut Suicides 2010-2014 by Age Category and Gender

Age	1 - 9		10 - 19		20 - 29		30 - 39		40 - 49		50 - 59		60 - 69		70 - 79		80+		Total	
Gender	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
2010	0	0	2	9	9	47	10	34	23	71	16	63	9	31	2	19	4	9	75	283
2011	0	0	2	13	14	36	13	37	21	71	19	68	5	31	3	16	6	16	83	288
2012	0	0	5	14	10	32	12	44	19	75	22	54	14	35	7	19	2	8	91	281
2013	0	0	7	8	7	28	9	32	18	61	23	79	7	24	4	13	2	8	77	253
2014	0	0	8	7	7	37	7	38	21	40	32	72	13	41	6	24	0	0	94	259
Total	0	0	24	51	47	180	51	185	102	318	144	336	48	162	22	91	14	41	420	1364

Source: OCME 2014

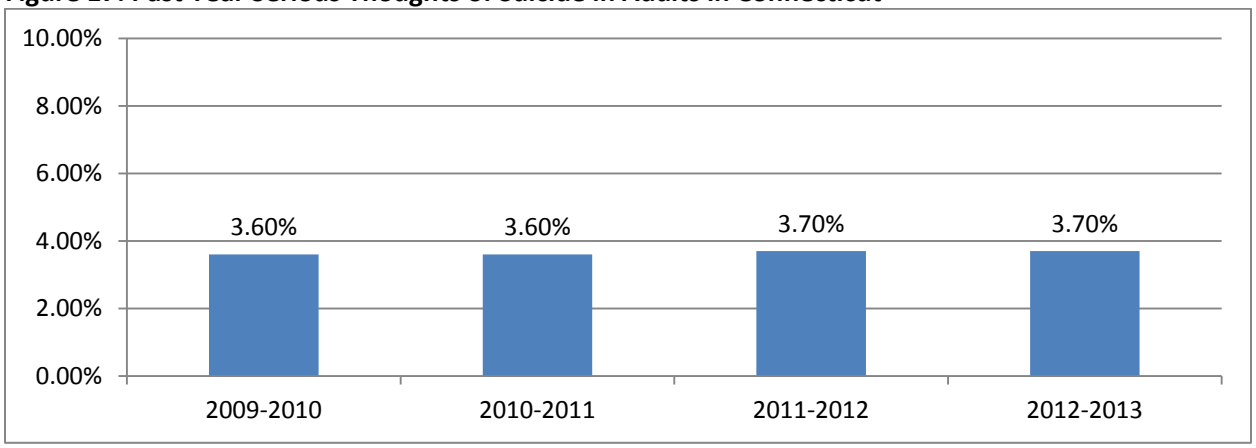
Figure 16: Connecticut Suicides 2010-2014 by Gender



Source: OCME 2014

Data is also available on serious thoughts of suicide, which since 2009 have not changed significantly.

Figure 17: Past Year Serious Thoughts of Suicide in Adults in Connecticut



Source: 2014 Connecticut Behavioral Health Barometer

The regional data provided below on serious thoughts of suicide and Major Depressive Episodes (MDEs) finds Connecticut's rates below the national rates in all categories and little variability across state regions. It also highlights the fact that while young adults (18-25) continue to be the most vulnerable group when it comes to experiencing depression and suicidal thoughts, it is actually older adults (Figure 15) that are more likely to commit suicide. In particular, males ages 40 – 69 and females 40 – 59 are far more likely to commit suicide than younger persons.

According to the 2010-2012 NSDUH, 3.69% of adults in Connecticut had serious thoughts of suicide in the past year. At the state level, 6.49% of adults had a MDE in the past year. Across the regions the lowest prevalence was found in Region 1 (5.56%) and the highest in Region 5 (7.20%).

Figure 18: Thoughts of Suicide and Major Depressive Episodes across Regions, 2010-2012

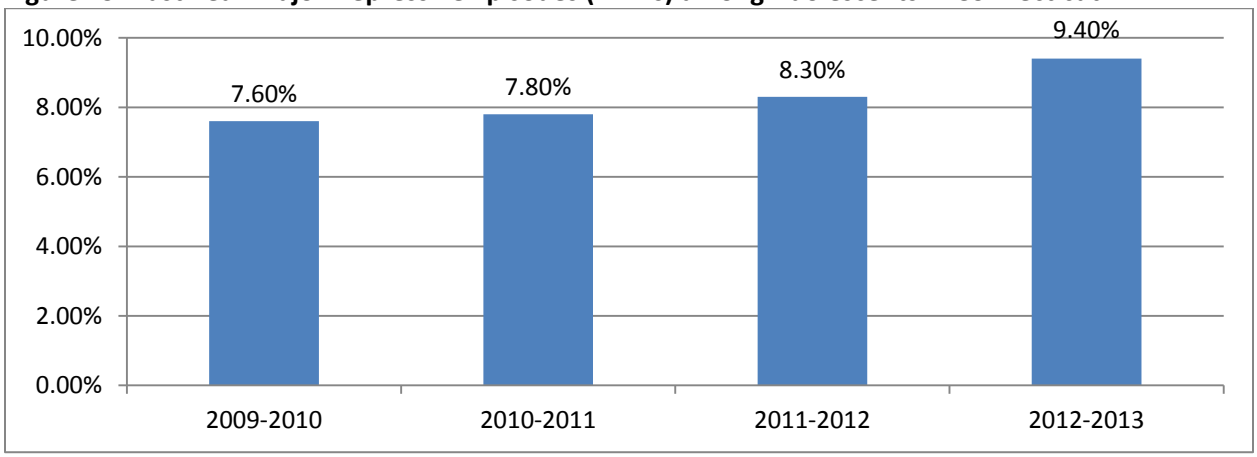
Area	Had Serious Thoughts of Suicide in the Past Year (%)			Had at Least One Major Depressive Episode in the Past Year (%)		
	AGE GROUP			AGE GROUP		
	18-25	18 or Older	26 or Older	18-25	18 or Older	26 or Older
Total U.S.	6.91	3.78	3.24	8.51	6.74	6.44
Connecticut	6.31	3.69	3.28	8.01	6.49	6.25
Region 1	6.13	3.34	2.95	7.38	5.56	5.30
Region 2	6.17	3.76	3.37	8.49	6.85	6.59
Region 3	5.95	3.82	3.36	7.90	6.46	6.15
Region 4	6.64	3.75	3.32	7.59	6.38	6.20
Region 5	6.56	3.79	3.42	8.82	7.20	6.98

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health 2010-2012.

The data above is for adults 18 and older, but the 2014 Behavioral Health Barometer for Connecticut reflects a concerning increase in MDEs in Adolescents. It is not clear whether this increase in diagnosing MDE indicates positive change by way of earlier intervention with the service system or a greater

willingness on the part of adolescents to seek help or, conversely, a negative change reflecting an actual increase in prevalence of MDE in this age group.

Figure 19: Past Year Major Depressive Episodes (MDEs) among Adolescents in Connecticut



Source: 2014 Connecticut Behavioral Health Barometer

Summary of Suicide: While there was an increase in suicides from 2013 to 2014, the amount of variability in this data over the past 5 years suggests the need for caution in interpreting trends prematurely. There has been an increase in MDEs for adolescents from 2009 – 2013, however, which bears monitoring.

Problem Gambling

Each of the five regions has outpatient services for problem gambling located within it. In FY 2014, these programs admitted 195 persons and a total of 482 unduplicated persons received services. In FY 2015, 142 persons were admitted to these same programs and 406 unduplicated persons received services.

According to the Connecticut Council on Problem Gambling (CCPG) *2013 Annual Helpline Report*, there were 492 calls made to the 24-hour problem gambling helpline in 2013. Eighty percent of the calls were from Connecticut and 20% were from out of state. Additionally, 75% of the callers were persons who were problem gamblers themselves while the remaining 25% were significant others of persons who were problem gamblers.

Of the 297 problem gamblers who called from Connecticut, those under age 45 were 1.5 times more likely to be men, while those 45 or older were 1.2 times more likely to be women. Twenty-eight percent of the callers were ages 55 – 64 and two-thirds of callers were Caucasian.

Figure 20: Average Age of Gambling, Problem Gambling, and Contacting Helpline by Gender

	Female	Male	Total
Average Age began Gambling	34	24	27
Average Age Gambling Became a Problem	43	33	36
Average Age at which Helpline Called	49	38	41
Years from Start of Gambling to Helpline Call	15	14	14
Years of Problem Gambling before Helpline Call	6	5	5

Source: CCPG Annual Helpline Report 2013

Figure 20 above indicates that females begin gambling and identify themselves as problem gamblers an average of 10 years later than males. With respect to obtaining treatment for their problem gambling, 223 of the 297 callers (75%) reported receiving treatment/support for problem gambling at some point. Male helpline callers receive professional treatment for gambling at 4 times the rate of females and receive some type of treatment/support at three times the rate of females.

Figure 21: Types of Treatment/Support received for Problem Gambling by Helpline Callers

	Female	Male	Total
Gamblers Anonymous (GA)	8%	30%	23%
Professional Treatment for Gambling	3%	12%	9%
Alcoholics Anonymous (AA)	2%	3%	3%
Mental Health	16%	25%	22%
Sexual Orientation	0%	18%	13%
Other	0%	2%	2%
Other Dependence	1%	4%	3%
Total	31%	94%	75%

Source: CCPG Annual Helpline Report 2013

Summary of Problem Gambling: Concerns about problem gambling were raised with the introduction of Keno and recent discussions about building new casinos in Connecticut or nearby Massachusetts. DMHAS data found the number of persons receiving treatment for problem gambling actually decreased over the period from 2014 – 2015. Data from the CCPG indicates that 75% of those contacting them have received some prior treatment/support with their problem gambling.