New Jersey State Epidemiological Profile for Substance Abuse

Strategic Prevention Framework State Incentive Grant (SPF SIG)

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New Jersey Department of Human Services
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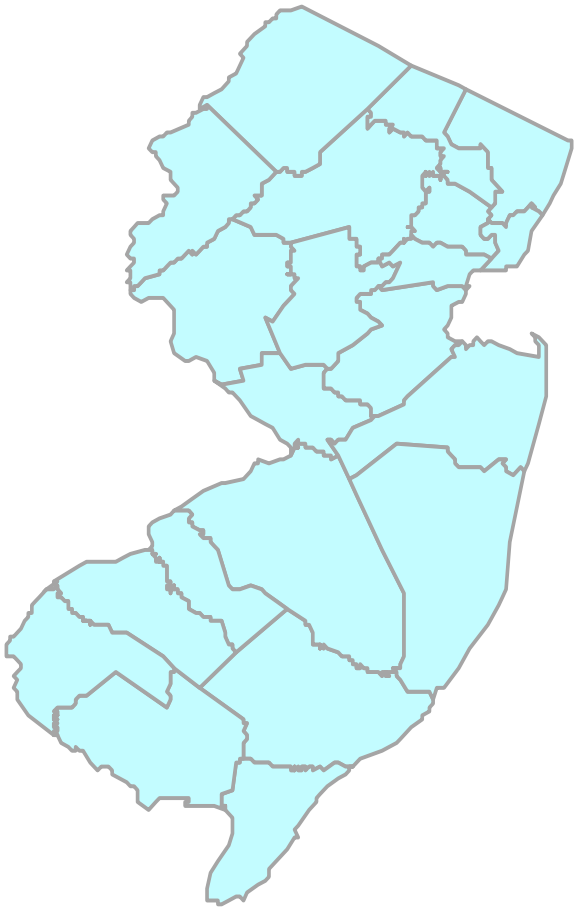

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Acknowledgements

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Addendum

This profile was originally prepared in April 2007 and revised in November 2007. This report is the first annual update.

May 26, 2008

Executive Summary

State Epidemiological Profile

The New Jersey State Epidemiological Outcomes Workgroup (SEOW) was charged with collecting and analyzing epidemiological data to assess the magnitude of substance use-related consequences and substance use patterns related to these consequences. The aim is to profile population needs, resources, and readiness to address the problems and gaps in service delivery. The purpose of the profile should serve to:

- Support the Strategic Prevention Framework State Incentive Grant (SPF-SIG) implementation by New Jersey Department of Human Services (NJDHS), Division of Addiction Services (DAS) provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA);
- Help in the selection of prevention priorities, by highlighting consumption patterns problem outcomes;
- Establish recommendations for resource allocation based on needs assessment data;
- Identify data gaps and establish recommendation to include methods of addressing these gaps; and
- Establish a baseline for ongoing data monitoring efforts.

Data Reviewed:

The contents of this document focus on constructs which include mortality, morbidity, crime, consumption, and education, and indicators including general risks relating to each construct, Alcohol and Other Drug (AOD) related fatal car crashes, AOD attributable deaths, homicide deaths, chronic liver disease, HIV/AIDS, pedestrian fatalities, child abuse and neglect, treatment episodes, treatment admissions, Driving Under the Influence (DUI) offenders, AOD dependence, arrests under the age of 18, on campus college arrests, liquor law violations, DUI arrests, possession of drugs, use of AOD by 12 years and up, use of AOD by middle school students, use of AOD by college students, binge drinking by college students, ATOD early use/age of onset, current tobacco use by middle school students, current use of ATOD by high school students, current tobacco use by high school students, ATOD lifetime use by high school students, and general risk taking behaviors among youth.

In addition, many other indicators were identified, for which data was unattainable, mostly due to lack of data collection, lack of accessibility to the public or lack of appropriate technological data tracking systems. Data gaps have been identified, which the SEOW and SPF SIG Advisory Council will be responsible for in terms of developing

formal recommendations to the Governor's Office. Formal recommendations will include but not be limited to recommendations for methods of improving data collection statewide to address these issues. Data gaps identified include: older adult risk factors, general older adult data, medical examiners data on AOD in homicide victims; secondary cause of death via alcohol, pedestrian fatalities and non-fatalities by age and substance, AOD related child abuse and neglect, DWI convictions, ABC citations/fines, wholesale and retail alcohol sales, AOD related industrial/residential accident, higher education referrals, AOD attributable domestic violence cases, hepatitis-drug related communicability of hepatitis, investigated unattended deaths-AOD related, AOD related crash data (non-fatal), AOD related ambulatory care, ER visits, higher education all cause referrals, current use of ATOD by high school students, sales of ethanol, prescription usage patterns (misuse/abuse), general education referrals to school substance awareness coordinators, general education referrals to treatment, and high school drop out rate.

Although the SEOW will continue its research on various sub-populations across the lifespan, special attention is being given to the older adult population due to the SEOW's many conversations and concerns. These have focused on the overwhelming lack of data relating to substance use, which needs to be collected in order for New Jersey to address the growing issues and concerns of this ever increasing population across the state.

Data are organized by substance, construct, indicator, and by consequence or consumption. Definitions are included within the document. Criteria for inclusion used in finalizing the selection of the data sources for this process include: availability of data, validity of data, periodic collection over the past three to five years, consistency, sensitivity, data no older than 10 years, and relationship to substance use.

The New Jersey SEOW will continue its efforts in addressing dimensions of the data in order to better define the magnitude of problems here in New Jersey. A major focus will be to identify data trends to provide a more thorough comparison to national figures and for comparison with local municipal and county data. The identification of the severity of problems by consequences and consumption will also be continued. The most challenging tasks the SEOW will have are deciding what problems have potential for changeability, and defining economic cost.

Additional tasks the SEOW will be focusing on in the immediate future include, but are not limited to, the following: identification of New Jersey's priority problems based on the epidemiological analyses; identification of target communities to implement the Strategic Prevention Framework; assessment of risk and protective factors in the communities associated with substance abuse in New Jersey; assessment of community assets and resources; identification and recommendation of gaps in services and capacity; assessment of readiness to act and specification of baseline data against which progress and outcomes of the Strategic Prevention Framework can be measured.

1 Introduction and Background

Role of the State Epidemiological Outcomes Work Group

The mission of the New Jersey State Epidemiological Outcome Workgroup (SEOW) is to collect and organize multiple sources of data to guide relevant and effective prevention strategies and inform policy decision making by first understanding the prevalence and patterns of problems and the factors that contribute to them.

The New Jersey SEOW was created in March 2006 in response to an award granted by the Center for Substance Abuse Prevention. The group has remained active throughout the life of the grant. In October 2006 New Jersey was awarded the Strategic Prevention Framework-State Incentive Grant (SPF-SIG). The SEOW will continue to provide support and guidance to this latest grant. The goals and objectives for the SEOW include:

Goal 1: Creation of a State Epidemiological Profile

Objective 1- Collect and organize multiple sources of data- Identify source data.
Objective 2 - Summarize consumption patterns and consequences of substance use in New Jersey
Objective 3 - Highlight indicators used to identify consequences
Objective 4 - Write draft Epidemiological Profile
Objective 5 - Write final Epidemiological Profile.

Goal 2: Submission of data used for Epidemiological Profile

Objective 1 - Collect copies of, or references to, sources used to generate all data values in the Epidemiological Profile.
Objective 2 - Collect copies of, or references to, sources used for methodologies, codebooks and programs used to develop Epidemiological Profile.

Goal 3: Development of Work Plan and Goal Statement

Objective 1 - Develop a mission statement for the SEOW.
Objective 2 - Develop SEOW principles, functions and organization.
Objective 3 - Develop specific goals and objectives: guide relevant and effective prevention strategies; inform policy decision making by first understanding the prevalence and patterns of problems and the factors that contribute to them; infuse data into state decision making, provide ongoing recommendations to the Advisory Council, participate on Advisory Workgroups to ensure cross collaboration.
Objective 4 - Identify sources and forms of data that will be used.

Goal 4: Collection of National Outcome Measures data and Performance Measurement
Objective 1 - Decide methods to collect National Outcome Measures
Objective 2 - Incorporate methods with approved Substance Abuse and Mental Health Services Administration methodologies and data collection tools.

The SEOW has met nine times since the inception of the Strategic Prevention Framework State Incentive Grant and will continue to meet as other data sources are explored. The New Jersey SEOW meets monthly to discuss data, analysis, and profile production. The next meeting is always scheduled at the conclusion of the previous month's meeting. However, in order to meet the deliverable of developing an EPI Profile, the group has been meeting weekly.

Dr. Robert Pandina from the Center of Alcohol Studies at Rutgers University serves as the Chairperson of the New Jersey SEOW. However, all day-to-day operating concerns of the New Jersey SEOW are handled by the Division of Addiction Services, Office of Prevention and Training Services. Statistical and GIS support is provided by the Office of Research, Planning and Evaluation within DAS.

Both governmental and community agencies are represented on the New Jersey SEOW.

Member Organizations:

❖ Childhood Drinking Coalition ❖ County Alcohol and Drug Directors ❖ Division of Addiction Services, Department of Human Services (Lead Agency) ❖ Department of Education ❖ Department of Health and Senior Services ❖ Division of Highway Traffic Safety ❖ Drug Enforcement Administration	❖ Governor's Council on Alcoholism and Drug Abuse ❖ Juvenile Justice Commission ❖ New Jersey State Police ❖ New Jersey Prevention Network ❖ Northeast Center for Applied Prevention Technologies ❖ Princeton House Behavioral Health ❖ Rowan University ❖ Rutgers University

Initial Steps Taken

Process for Developing the Epi-Profile

Initially, New Jersey developed a matrix of data sources organized by National Outcome Measures (NOMS) for Prevention. In terms of the process and how New Jersey chose the data and what data were examined, the first question was asked about the varying differences among data sources and broken down into three categories: 1) ongoing surveillance of the past 30 days, 2) regularly scheduled assessments/surveys, and 3) periodic data collection. Also focused upon was the validity and reliability of the data

that was accessible and which data offered/revealed the most significant information on constructs such as mortality, morbidity or injury, consequence and consumption, and crime.

In terms of available **ongoing** surveillance (last 30 days), initially examined were data trends including: SEDS; UCR (maintained by the Federal Bureau of Investigation); NJ-SAMS; ER Visits, The Treatment Episode Data Set (**TEDS**) (data from treatment facilities), and the Drug Abuse Warning Network (**DAWN**) which collects data on two types of drug-related events - drug-related emergency department (ED) visits and illicit drug-related deaths investigated by medical examiners and coroners (ME/Cs). Also reviewed were all highway traffic safety data including DUI and IDRC data; the number of Division of Youth and Families Services (DYFS) AOD Caseloads; college UCR in New Jersey; seizure data with arrests; United States Customs Service and its system to retrieve information on drug evidence and other information on drug seizures, price, and purity from the DEA; and the Arrestee Drug Abuse Monitoring program, funded by the National Institute of Justice (NIJ).

Also examined were **regularly scheduled assessments/surveys** that take place in New Jersey for more local survey data such as, New Jersey 2005 Youth Risk Behavior Survey for Middle School Students; and New Jersey 2005 High School Youth Risk Behavior Survey. Also reviewed were national survey data such as Monitoring the Future. Despite not surveying in New Jersey, it was thought it would still be significant to review. In addition, the group had access to New Jersey college surveys implemented by the CORE Institute, as well as the 2005 National College Health Assessment Survey. The group also reviewed the National Household Survey on a national level, and data that are specific to New Jersey.

Lastly, the SEOW looked at **periodic** data that could provide a snapshot of information taken in time. Surveillance data that might be collected regularly or somewhat frequently but are part of a systematic routine was also considered. This category of data reviewed included New Jersey's Social Indicators Chart Book, which includes Municipal level Social and Health Indicators data from 2000.

The next step was organizing data sources by constructs: mortality, morbidity, crime, consumption and education, and by indicators. Identifying indicators and agreeing upon a final list was an ongoing process. Indicators that might have been initially listed were considered and then discarded and new ones might have been added later depending on new discoveries made during the research process. From there, criteria were identified for keeping or adding data sources, such as date published; data by substances (Alcohol, Tobacco, Illicit Drugs and Prescription Drugs); data by collection frequency (on-going, daily, monthly, quarterly, annually); by demographics (age, sex, race, other); and lastly by geographic coverage (municipal, county, state, national). All sections were scored, added up and then data sources were identified as primary or secondary based upon all initial criteria listed above and their final scores.

Once the Epi-Profile Workgroup agreed to the data sources, sub-workgroups were formed by constructs that analyzed the data assigned to their construct and indicators. Yohannes Hailu, Ph.D. developed a chart which each workgroup would complete by construct/indicators and consequences/consumption with brief trend comments included on each chart. From this point forward, Dr. Hailu used the information provided to complete the many charts included at the end of this document.

Through this process, the Epi-Profile Workgroup was able to identify several data gaps, which will be presented to the SPF SIG Advisory Council, along with recommendations and strategies to address these data gaps in the future.

Prevalence of Substance Use/Abuse Problems

Annual data from the New Jersey Substance Abuse Monitoring Treatment System (NJ-SAMS) for 2006 indicated that there were 56,261 admissions into treatment programs. The most common primary drug was heroin and other opiates (40%), followed by alcohol (29%), marijuana (13%) and cocaine (11%). Regarding age, 6% were under 18 years, 19% were 18 to 24 years, 25% were 25 to 34 years and 52% were 35 or older. The majority of individuals admitted were male (68%). The most common race/ethnicity was non-Hispanic white (58%), followed by non-Hispanic black (25%) and Hispanic (14%).

Data from SAMHSA's "State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health (NSDUH)" indicated that in New Jersey a substantial portion of youth (ages 12 to 17) reported drinking alcohol (18.8%), binge drinking (10.5%), smoking cigarettes (11.2%), or using marijuana (6.5%). There was 5.7% of youth who reported alcohol dependence/abuse and 5.2% reporting illicit drug dependence/abuse. Rates of use, abuse, and dependence were higher for young adults (ages 18-25) than the other two age groups on every measure assessed. Data are presented in Table 1-1.

Table 1-1
Prevalence Rates of Substance Use, Dependence, and Abuse in New Jersey
2004-2005 National Surveys on Drug Use and Health State Estimates

Measure	% Youth (Aged 12-17)	% Young Adult (Aged 18-25)	% Adult (Aged 26 or Older)
Alcohol, past month use	18.8	62.4	58.1
Binge drinking, past month use*	10.5	42.2	19.7
Cigarettes, past month use	11.2	37.6	21.3
Illicit drugs, past month use	9.6	20.5	4.9
Marijuana, past month use	6.5	16.0	3.3
Illicit drug dependence or abuse	5.2	8.3	1.4
Alcohol dependence or abuse	5.7	15.5	5.3
Non-medical use of pain relievers	6.3	11.4	2.8

* Drinking 5 or more drinks in a row on at least 1 day in the past 30 days.

Source: SAMHSA State Estimates of Substance Use from the 2004 – 2005 National Surveys on Drug Use and Health

The New Jersey Division of Addiction Services (DAS) also conducts its own household survey every four years to assess the prevalence of legal and illegal substance use and identify the need and demand for substance abuse treatment. A stratified random sample of 14,660 households was selected and adults over the age of 17 years were interviewed by telephone. Consistent with the national survey data, the New Jersey DAS survey found that the use of substances was higher among the young adults (18-24 years of age) than among residents 25 years or older, except for past month alcohol use. Generally, the New Jersey proportions are similar to the national proportions except for the disclosure of past month illicit drug use and marijuana use where the national proportions are roughly twice those of the state. Results are presented in Table 1-2.

Table 1-2

Prevalence Rates of Substance Use, Dependence, and Abuse in New Jersey 2003 NJ Household Survey on Drug Use and Health

Measure	% Young Adult (Aged 18-24)	% Adult (Aged 25 or Older)
Alcohol, past month use	55.6	58.6
Heavy drinking, past month use*	12.5	5.2
Cigarettes, past month use	32.1	19.9
Illicit drugs, past month use	11.1	2.4
Marijuana, past month use	8.8	1.6
Illicit drug dependence or abuse	7.5	.8
Alcohol dependence or abuse	15.4	6.1
Non-medical use of pain relievers	13.6	8.6

Source: 2003 New Jersey Household Survey of Drug Use and Health

* Drinking 5 or more (4 or more for females) drinks in a 24-hour period at least once a week or on four or more days in the past month. New Jersey defined "binge drinking" as drinking two or more days straight without sobering up, which does not match the Federal definition.

The New Jersey Division of Addiction Services conducts a Middle School Survey every two years to assess the prevalence of legal and illegal substance use. Data are collected from 7th and 8th grade students regarding their use of multiple substances. From 1999 through 2003, the prevalence rates for past 30 day use of alcohol, cigarettes, marijuana and other illicit drugs has declined. For 2003, past 30 day use of alcohol was 14% compared to 16% for 2001 and 25% for 1999. Any illicit drug use was down to 5% in 2003 from 6 % in 2001 and 12% in 1999. Results are presented in Table 1-3.

Table 1-3

Prevalence Rates of Middle School Students' Substance Use in New Jersey
New Jersey Middle School Substance Use Survey Report

Measure	1999	2001	2003
Alcohol, past month use	24.6	16.0	13.8
Binge drinking, past month use	9.7	7.6	6.4
Cigarettes, past month use	12.5	7.2	4.8
Marijuana, past month use	6.6	2.9	2.4
Any illicit drug use, past month	11.5	6.3	4.5

Source: 2003 New Jersey Middle School Substance Use Survey Report, NJ Division of Addiction Services

The New Jersey Department of Education's (DOE) Youth Risk Behavior Survey (YRBS) surveyed New Jersey middle school students for the first time in 2005. DOE reported 17% for past 30 day alcohol use, 5% for past 30 day cigarette use and 4% for marijuana use in the past month. Results are presented in Table 1-4.

Table 1-4

Prevalence Rates of Middle School Students' Substance Use in New Jersey
2005 NJ Student Health Survey, Middle School

Measure	2005
Alcohol, past month use	17.1
Cigarettes, past month use	5.1
Marijuana, past month use	4.1

Source: New Jersey 2005 Student Health Survey, NJ Department of Education

The DOE also administers this survey to high school students bi-annually. The rates for 2005 are slightly higher than those for 2003; however, 2003 and 2005 prevalence rates are lower than those from 2001 for alcohol, cigarette and marijuana use. Only past 30 day cigarette use declined from 2003 to 2005 (21% and 20%, respectively). Results are displayed in Table 1-5.

Table 1-5

Prevalence Rates of Substance Use, Dependence, and Abuse in New Jersey
NJ Student Health Survey, High School

Measure	2001	2003	2005
Alcohol, past month use	56	45.1	46.5
Binge drinking, past month use	34	24	27
Cigarettes, past month use	29	21.2	19.8
Marijuana, past month use	41	19.1	19.9

Source: New Jersey Student Health Survey, 2005, NJ Department of Education

2 Data Processes

Data Sources

Data sets that collected information on alcohol, drug, and tobacco use and consequences of substance use were identified through group discussion by the Epi-Profile Workgroup. Data were collected from some national and many state level sources to examine consumption patterns and consequences of alcohol, tobacco, and drug use in New Jersey.

A list of sources identified is included in Table 2-1. The sources included surveys, compilations of state data, data found in agency reports and data from administrative data systems. In this phase of the Workgroup's data process, the focus was on the overall State as the unit of analysis. As work continues, the Workgroup will begin to examine the data at various subgroup levels, such as county, age group, gender, etc., to better refine its analysis.

This section will discuss the sources of the data and how the data were used.

Table 2-1

State Level Data Sets

Source	Data	Year
NJ Center for Health Statistics (NJCHS)	• Alcohol-related: mortality, suicide, homicide, death from unintentional injuries • Drug-related: mortality • Chronic liver disease and cirrhosis	2001-2003
NJDHSS	• HIV	2001-2005
Fatal Accidents Reporting System (FARS)	• Alcohol-related: motor vehicle fatalities, pedestrian fatalities	2001-2005
National Survey of Drug Use and Health (NSDUH)	• Alcohol dependence, alcohol use • Drug dependence, drug use • Non-medical use of prescription drugs, pain relievers	2001-2005
Treatment Episodes Data Set (TEDS)	• Admissions for alcohol treatment • Admissions for illicit drug use treatment	2001-2005
Division of Youth and Family Services (DYFS)	• Abuse/neglect involving prenatal substance abuse • Alcohol abuse referrals (child and parent) • Substance-exposed newborns	2002-2005
Uniform Crime Report (UCR)	• Alcohol attributable arrests, DUI arrests, liquor law violation arrests	2001-2005

	• Drug-related arrests, possession/use arrests, drug law violations	
Middle School Substance Use Survey (MSSUS)	• Alcohol consumption, binge drinking • Drug use	1999, 2001, 2003
NJ Youth Tobacco Survey (NJYTS)	• Tobacco use	1999, 2001, 2004
NJ College Survey of Norms (CORE)	• Alcohol consumption, binge drinking • Drug use	2002-2006
Intoxicated Driver Program (IDP)	• DUI offenders completing IDRC program • Number of alcohol-related MV offenses • Illicit drug use by IDP clients • Referral to treatment/self help	2002-2005
Youth Risk Behavior Survey(YRBS)/ NJSHS	• Alcohol use, binge drinking • Drug use	1995, 2001, 2005
Commissioner's Report on Violence, Vandalism and Substance Abuse (CRVV)	• School crime related to alcohol, substances • School crime related to substances	2002-2006

Identification and Selection of Criteria

Selecting indicators to describe the consequences of substance use and the consumption patterns associated with those consequences is a critically important aspect of the needs assessment process. The Epi-Profile Workgroup identified the various dimensions that might show the extent of a problem, including the size of the problem, its magnitude relative to other states' problems, the severity of the problem's impact on an individual and/or community, trend characteristics, attributable risk to substance abuse, and availability of data. In addition, the Epi-Profile Workgroup identified additional criteria that could impact efforts to address a problem, including capacity/resources, perceived gap between capacity/resources and need readiness (political will/public concern), economic impact, and social impact.

The selected criteria included the availability of data at the state level, the availability of data for the past 3-5 years, data that were readily available, validity of data, consistency of the data, sensitivity of the data, data no older than 10 years, its relationship to substance use, and finally, data sources not meeting requirements must be submitted with justification to the SEOW for approval.

Table 2-2
Data Criteria

Criteria	Definition
Availability of Data	The data should be readily available and accessible.
Validity of Data	The measure must meet basic criteria for validity.
Periodic collection over at least 3 to 5 past years	The measure should be available for the past 3 to 5 past years, preferably on an annual or at least biennial basis. This enables the State to determine not only the level of an indicator but also its trends.
Consistency	The measure must be consistent, i.e., the method or means of collecting and organizing data should be relatively unchanged over time.
Sensitivity	For monitoring, the measure must be sufficiently sensitive to detect change over time that might be associated with changes in alcohol, tobacco, or illicit drug use.
Data is no older than 10 years	Data cannot be older than 10 years, unless a survey that is deemed reliable by the SEOW.
Relationship to substance use	The extent to which an indicator was related to substance use (i.e., attributable risk).
Data sources not meeting requirements must be submitted with justification to the SEOW for approval.	

Dimensions of Data

The New Jersey Epi-Profile Workgroup continues to analyze available data, in order to better define the magnitude of the problem here in New Jersey; better identify trends – increases and decreases in use; provide a more thorough comparison not only to national figures but more importantly looking at the local municipal and county figures for comparisons; and to better identify the severity of problems by consequences and consumption.

Magnitude: New Jersey focused on "how big" the underlying problems are in terms of occurrence. New Jersey describes magnitude in terms of absolute numbers (total number

of cases) or relative numbers that adjust for the underlying population size (e.g., percentages, incidence rates, and prevalence rates).

- *Lifetime alcohol-related motor vehicle offenses:* Prevalence of lifetime use of marijuana, cocaine and heroin by IDP clients was more than double the levels reported by NJ Household Survey respondents.
- *Had 5 or more drinks in a row in the last two weeks/college students*: Though not the majority of college students, high risk or heavy drinking is a persistent and relatively large problem compared to other drug use. About 30% of students consume five or more drinks in a row on more than one occasion in a two week period.
- *Incidents of school crime-inhalants, narcotics, hallucinogens, cocaine, party drugs, amphetamines:* School-based incidents involving the possession/use of drugs other than marijuana and depressants have increased over the past four years.

Trends: New Jersey also focused on the extent to which a problem has increased or decreased. Examining time trends can help New Jersey detect any emerging or growing problems that may warrant increased attention.

Table 2-3
Data Trends

Indicator	Population	Population Increase/Decrease	Use Rates
Alcohol Use	12-17 years	⇧	⇧
Alcohol Use	18-25 years	⇧	⇧
Drug Dependence Treatment Admissions Illicit Drugs	12 + years	⇧	⇧
Drug Attributable Arrests / Adult Arrests	"At Risk" 18+ years	⇧	⇧

- While the 12 to 17 year-old population rose from 2000 to 2005, alcohol use rates per 100,000 population rose from 2000 to 2004 and appear to have exceeded the national rates.
- While the 18 to 25 year-old population rose from 2000 to 2005, alcohol use per 100,000 population rose by 6,110 from 2000 to 2003, but fell by 2,650 from 2003

to 2005, although still exceeding the national rates. A similar pattern applies to the 26 years-old and older population.

- *Drug dependence/admissions to treatment for illicit drug abuse by drug type*: While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 19 per 100,000 for users of other opiates.
- While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 13 per 100,000 for users of cocaine.
- While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 25 per 100,000 for users of marijuana.
- *Drug attributable arrests/adult arrests:* While "at risk" population rose from 2001 to 2005, adult arrest rates, roughly 500 per 100,000 higher than total arrest rates, also rose by 87 per 100,000, although not in a linear relationship.
- Overall possession/use arrests for opium or cocaine is on the rise while there is a decline for synthetic narcotic.

Relative Comparisons: Comparing individual State indicator estimates and trends to some standard reference population can provide additional information to assist New Jersey in data interpretation.

- *Alcohol consumption by 7th and 8th graders/total alcohol consumption by youth under 21 in New Jersey:* The New Jersey prevalence rates for 2001 and 2003 are below the national rate for 2002.
- *Alcohol consumption by high school students/total alcohol consumption and early use by youth under 21 in New Jersey*: Lifetime use of alcohol by high school students has remained unchanged over the ten-year period, failing to follow the national decline.
- For the 12 to 17 year-old population, the state rate per 100,000 rose initially by 1,340, then fluctuated, remaining below the national rates until 2004, and exceeding it in 2005.
- For the 18 to 25 population, the rate per 100,000 population exceeded the national rates in 2002, 2003 and 2005. Although fluctuating, the 25 year-old and older population grew from 2001 to 2005. The New Jersey rates grew by 450 per 100,000 population, while the national rates declined by 750.

Severity: Some consequences or consumption patterns across New Jersey are potentially more severe in nature and have greater impact on individuals and society than others.

- *Alcohol related mortality/alcohol as primary cause of death:* There were 73,410 deaths of New Jersey residents due to alcohol in 2003. The age-adjusted death rate was 791.7 per 100,000 population.

- *HIV and Hepatitis C diagnosis among hospital discharges/cumulative AIDS cases with tuberculosis:* A nearly two-fold increase in the rate per 100,000 of hospital discharges with dual HIV and Hepatitis C diagnoses.
- *Living with AIDS by gender/estimated number of females living with HIV/AIDS by exposure category*: Significant increase in the number of women with heterosexual exposure to HIV.
- *Living with AIDS by gender/estimated number of males living with HIV/AIDS by exposure category*: A nearly three-fold increase in the rate per 100,000 of men exposed to HIV through heterosexual contact

Data Organization

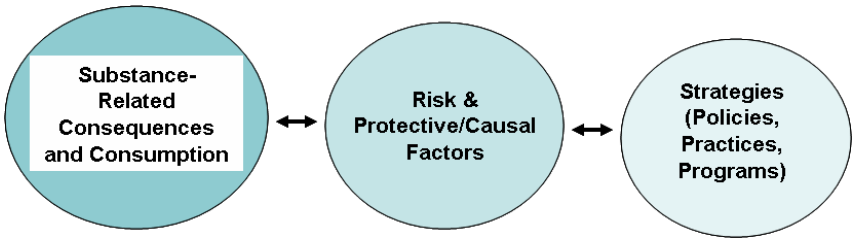
Data were first organized by ***Construct***: Mortality, Morbidity, Crime, Consumption and Other Risk; and within construct, by ***Substance*:** Alcohol, Drug and Tobacco. Indicators were then selected for each of the constructs. Appendix B presents the indicators within each construct.

3 Consequences and Consumption

As noted in the *Developing State Epidemiological Profiles for Substance Abuse Prevention: Guidance for State Epidemiological Workgroups*:

> "Substance abuse prevention planning begins with a clear understanding of alcohol, tobacco and other drug use and their chief consequences. In such an outcome-based approach, understanding the nature and extent of substance use and related problems (consumption and consequences) is critical for determining prevention priorities and aligning relevant and effective strategies to address them."

The Center for Substance Abuse Prevention (CSAP) recommends that State epidemiological profiles predominantly focus on substance related consequences and consumption as the first step in developing an outcomes-based approach to prevention. The figure below illustrates the outcomes based prevention model proposed by CSAP.



Outcomes Based Prevention Model
Figure 3-1

The *Guidance for State Epidemiological Workgroups* provides the following definitions:

CONSEQUENCES: Substance related consequences are defined as adverse social, health, and safety consequences associated with alcohol, tobacco, or illicit drug use.

Consequences include mortality and morbidity and other undesired events for which alcohol, tobacco, and/or illicit drugs are clearly and consistently involved. Although a specific substance may not be the single cause of the consequence, scientific evidence must support a link to alcohol, tobacco, or illicit drugs as a contributing factor to the consequence.

CONSUMPTION: Consumption is defined as the use and high-risk use of alcohol, tobacco, and illicit drugs.

Consumption includes patterns of use of alcohol, tobacco, and illicit drugs, including initiation of use, regular or typical use, and high-risk use.

Data were organized according to the schema suggested by CSAP and discussion of each area is provided below.

1. Alcohol

Consequences

Mortality

- *Alcohol related mortality/alcohol as primary cause of death:* There were 73,410 deaths of New Jersey residents in 2003. The age-adjusted death rate was 791.7 per 100,000 population.
- *Alcohol related mortality/alcohol as secondary cause of death-homicide:* New Jersey homicide rate was the 14th lowest in the nation in 2002. It increased sharply in 2003 to 4.9. The recent increase is concentrated among the 15-24 years-old and 25-34 years-old age group (11.8 and 10.8 /100,000 respectively)

Morbidity

- *Alcohol related morbidity/alcohol dependence 18-25 years*: New Jersey rates per 100,000 rose between 2001 and 2002 more sharply than the national rates, but fell from 2002 to 2004 while the national rates continued to rise.
- *Alcohol related morbidity/alcohol dependence 26 years and older:* New Jersey rates per 100,000 rose between 2001 and 2002 less sharply than the national rates, but fell from 2002 to 2004 more sharply than the national rates.
- *Alcohol related morbidity/treatment admissions by primary substance of abuse:* While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 62 although not as a linear relationship. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 17 among users of alcohol only although not as a linear relationship. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by eight for users of alcohol with secondary drug use. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 25 for all alcohol users although not as a linear relationship.
- *Alcohol related morbidity/intoxicated driving program (IDP) clients*: The most significant differences between IDP clients and the general population of New Jersey were: IDP clients were male, single, and worked full-time.
- *Lifetime alcohol-related motor vehicle offenses*: Prevalence of lifetime use of marijuana, cocaine and heroin by IDP clients was more than double the levels reported by NJ Household Survey respondents. Numbers of clients with first or second alcohol-related driving offenses attending IDRC classes rose from 2002 through 2005; however, the number of clients attending with three or more offenses declined slightly proportional to the numbers of New Jersey licensed

drivers. Female IDP clients had consistently higher reported lifetime marijuana, cocaine and heroin use than their male counterparts.

Crime

- *Alcohol attributable arrests/all arrests by age:* While the "at risk" population rose from 2001 to 2005, arrest rates per 100,000 also rose by 30/100,000 although not as a linear relationship. Also, in 2005, state arrest rates were lower than the national rate. While the "at risk" population rose from 2001 to 2005, adult arrest rates, roughly 500/100,000 higher than total arrest rates, also rose by 87/100,000 although not as a linear relationship. While the "at risk" population rose from 2001 to 2004, juvenile arrest rates per 100,000 declined by 210/100,000 from 2001 to 2005.
- *Alcohol attributable arrests/total alcohol attributable arrests:* While the "at risk" population rose from 2001 to 2005, the rates of arrests attributable to alcohol use per 100,000 population declined by 54/100,000 from 2001 to 2004 before rebounding by 41/100,000 in 2005. The "at-risk" population first rose from 2001 to 2003 and fell somewhat by 2004. However, the alcohol attributable juvenile arrest rates per 100,000 fell by 30/100,000. While the "at-risk" population first rose from 2001 to 2003, the rates of DUI arrests per 100,000 population fluctuated, ending the period up by just 1. While the "at-risk" population rose from 2001 to 2005, the rates of liquor law violations per 100,000 population declined by 34/100,000 to well below the national rate. The number of school-based incidents of use, possession and sale/distribution of alcohol has not changed significantly in the past four years.

Consumption

- *Current use of alcohol – General population/past month alcohol use*: While population rose from 2000 to 2005, alcohol use per 100,000 population rose by 6,260/100,000 from 2000 to 2003, but then fell by 3,250/100,000 from 2003 to 2005. While the 12 to 17 population rose from 2000 to 2005, alcohol use rates per 100,000 population rose from 2000 to 2004 and appear to have exceeded the national rates. While the 18 to 25 year-old population rose from 2000 to 2005, alcohol use per 100,000 population rose by 6,110/100,000 from 2000 to 2003, but fell by 2,650/100,000 from 2003 to 2005, although still exceeding the national rates. A similar pattern applies to the 26 year-old and older population.
- *Alcohol consumption by 7th and 8th graders/total alcohol consumption by youth under 21 in New Jersey:* The three year average of total alcohol lifetime use by 7th and 8th graders is above the 2002 national rate. The 30-day use has decreased since 1999 and is currently below the 2002 national average. Binge Drinking has decreased since 1999.
- *Alcohol consumption by high school students/total alcohol consumption and early use by youth under 21 in New Jersey*: Lifetime use of alcohol by high school students has remained unchanged over the ten-year period, failing to follow the national decline. Recent (30-day) use of alcohol by high school students has

declined, following the national trend. Episodic, heavy binge drinking by high school students has declined less than nationally. Early first use of alcohol has declined significantly among high school students.

- *Binge drinking by college students/consumes alcohol during the year*: Alcohol use in college populations is normative (almost nine out of ten students drink alcohol.
- *Had 5 or more drinks in a row in the last two weeks*: Though not the majority of students, high risk or heavy drinking is a persistent and relatively large problem compared to other drug use. About 30% of students consume five or more drinks in a row on more than one occasion in a two week period.

2. Illicit Drugs

Consequences

Morbidity

- *Drug dependence/population of specific age groups meeting DSM-IV criteria for drug dependence in past year*: While the 12 year-old and over population rose from 2001 to 2005, the rate of drug dependence per 100,000 population rose by 720 from 2001 to 2002, fluctuated thereafter and remained below the national rates. Similarly, the 12 to 17 year-old population rose with some fluctuation, the state rate per 100,000 rose initially by 1,340/100,000, then fluctuated, remaining below the national rates until 2004, exceeding it in 2005. The trend for the 18 to 25 year-old population followed the pattern of the 12 to 17 year-old population, except that the rate per 100,000 population exceeded the national rates in 2002, 2003 and 2005. Although fluctuating, the 25 years-old and older population grew from 2001 to 2005. The New Jersey rates grew by 450 per 100,000 population, while the national rates declined by 750.
- *Drug dependence/drug treatment admissions by primary substance of abuse:* While 12 years or older population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 62 although not as a linear relationship.
- *Drug dependence/admissions to treatment for illicit drug abuse:* While 12 year-old and older population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 160 among users of illicit drugs although not as a linear relationship.
- *Drug dependence/admissions to treatment for illicit drug abuse by drug type*: While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 83 for users of heroin. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 19 for users of other opiates. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 61 for users of cocaine. While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 13 for users of marijuana.

Crime

- *Drug attributable arrests/total arrest rates:* While the "at risk" population rose from 2001 to 2005, total arrest rates per 100,000 also rose by 30 although not as a linear relationship. Also, in 2005, state arrest rates were lower than the national rate.
- *Drug attributable arrests/adult arrests:* While the "at risk" population rose from 2001 to 2005, adult arrest rates, roughly 500 per 100,000 higher than total arrest rates, also rose by 87 although not as a linear relationship.
- *Drug attributable arrests/juvenile arrests:* While "at risk" population rose from 2001 to 2004, juvenile arrest rates per 100,000 declined by 210 from 2001 to 2005.
- *Drug attributable arrests/all drug related arrests:* While the "at risk" population rose from 2001 to 2005, the rates of arrests attributable to drug use per 100,000 population fluctuated and ended increased by three. While the "at risk" population rose from 2001 to 2003 before falling below baseline by 2005, juvenile arrest rates attributable to drug use per 100,000 declined steadily by 79. While the "at-risk" population remained constant from 2001 to 2003, drug law violations per 100,000 declined by 65 through 2003 and rebounded by 14 through 2005. While the "at-risk" population remained constant from 2001 to 2003, drug law violations per 100,000 declined by 65 through 2003 and rebounded by 14 through 2005.
- *Incidents of school crime/from substances*: While the "at-risk" population rose from 2003 to 2005, school crime from substance use dropped five per 100,000.
- *Incidents of school crime/from marijuana:* While the "at-risk" population rose from 2003 to 2006, school crime from marijuana use fluctuated, ending down 16 per 100,000.
- *Incidents of school crime/prescription drugs and depressants:* The number of school-based incidents involving depressants and prescription drugs decreased after having not changed in the prior three years.
- *Incidents of school crime/inhalants, narcotics, hallucinogens, cocaine, party drugs, amphetamines:* School-based incidents involving the possession/use of drugs other than marijuana and depressants have increased over the past four years.
- *Possession/use arrests:* Total arrests for possession/use of drugs accounted for 73% of all arrests, and the remaining 27% were for the sale/manufacturing of drugs. Arrests for opium or cocaine represent 47% of the possession/use category. Overall possession/use arrests for opium or cocaine is on the rise while there is a decline for synthetic narcotic.

Consumption

Any Illicit Drug Use

- *Drug use by 7th and 8th grade students/total:* Marijuana use has decreased since 1999 and is below the 2002 national average. Inhalant use has increased from 8% in 1999 to 8.4% in 2003. Illicit drug use has decreased since 1999.
- *Use of drugs on college campus:* Marijuana use has declined from over one-third of students to one-quarter. Other illicit drug use has declined from 15% to 8%. Weekly marijuana use has declined from 14% to 7%. About 2% of students use other illicit drugs on a weekly basis.

3. Other Risk Factors

Consequences

Morbidity

HIV/AIDS

- *HIV and Hepatitis C diagnosis among hospital discharges /cumulative AIDS cases with tuberculosis:* There was a nearly two-fold increase in the rate per 100,000 of hospital discharges with dual HIV and Hepatitis C diagnoses.
- *Living with AIDS by gender/estimated number of females living with HIV/AIDS by exposure category*: There was a significant increase in the number of women with heterosexual exposure to HIV.
- *Living with AIDS by gender/estimated number of males living with HIV/AIDS by exposure category*: There was a nearly three-fold increase in the rate per 100,000 of men exposed to HIV through heterosexual contact.

Consumption

Tobacco Use by Middle School and High School Students

- *Tobacco lifetime use by middle school – Grades 7-8:* Current use of any tobacco significantly decreased among middle school students from 1999 (18.9%) to 2004 (9.5%). There was also a significant decline in current use of any tobacco by high school students from 1999 (38.9%) to 2004 (26.8%).
- *Tobacco current use by middle school – Grades 7-8*: Between 1999 and 2004, Monitoring the Future documented a 47% decline in current cigarette use among 8th graders nationally while NJ's decline was 58%. Declines seen in youth smoking prevalence on the NJYTS are consistent with trends seen on Youth Risk Behavior Survey and Monitoring the Future Survey over the last several years.

4 Limitations

Rates vs. Absolute Numbers

Standardization by population size (e.g., number affected per 100,000 population) facilitates relative comparisons across different geographic units and populations or sub-populations, by identifying areas or groups where levels of problems or behaviors are atypically high in ways that cannot be explained simply by differences in population size. However, it may also be useful to know the absolute level of a problem in terms of actual numbers, and to compare these numbers across geographic units or population subgroups. A very large county, for example, that has only an average rate of a specific problem will likely contribute much more of the overall burden from that problem to the state than a very small county with a high rate. To overcome this problem, the data tables in this Epi-Profile include both the actual numbers and rates for the indicators selected.

Small Numbers

Drawing conclusions based on small numbers can be problematic. The SEOW will be carefully reviewing the data tables to exclude indicators where the sample size is too small at the State level, which would then be even more unreliable at the community level.

Identifying Meaningful Differences

The SEOW will need to develop guidelines to help determine what will be considered a "meaningful" difference. For example, what should be the minimum difference when comparing rates? When examining trends over time, what should be the minimum annual change?

Adjusting for Differences in Age

The solution to this is to calculate "age-adjusted" rates, which are calculated in a manner that removes the influence of variability in age structure across the populations being compared. This Epi-Profile includes age-adjusted rates whenever possible.

Differences in Attributable Fractions

Since a number of substance abuse-related consequences are only partially due to substance abuse, it is important to include the proportion of such consequences that are directly attributable, which is referred to as the attributable fraction (AF). Rates have been adjusted by their AF when they were known in order to more clearly represent the

relative magnitude of various substance abuse attributable consequences. This was particularly evident in the data tables on crime.

Use of response indicators for assessment

As CSAP notes, certain indicators (e.g., arrest, treatment data, school suspensions) are typically influenced by a variety of factors in addition to the underlying substance use patterns (e.g., funding, personnel/staff resources, and institutional priorities). As a result, they may reflect a 'response' to the problem rather than the underlying pattern of substance use or negative consequences. It will be important for the SEOW to examine legislation, laws, policies, etc. that may influence consumption and consequence patterns.

'Short' vs. 'Long' Term Consequences

The SEOW will evaluate the utility of some long term indicators in assessing the extent of negative consequences of substance use and/or underlying high risk substance use patterns before making any decision to exclude them from the profile.

Acknowledging Data Limitations

The SEOW will communicate methodological and reporting issues related to the data used in the preparation of this epidemiological profile and will be preparing recommendations for improving the various data collection systems.

5 Data Gaps

DATA GAPS:

Data Gaps are not listed in any specific order:

- Older adult risk factors
- Elderly data collection/sources need to be developed and implemented statewide
- Medical Examiners data - not all counties report to state; need to search for data on presence of AD in system of homicide victims; more collaboration / cooperation between New Jersey State Police and New Jersey Medical Examiners on ALL AOD related deaths
- Secondary cause of death via alcohol data needs to be collected
- Pedestrian fatalities and non-fatalities by age and substance need to be collected
- AOD related child abuse and neglect needs to be collected
- DWI convictions need to be available to public. Mandate courts to make convictions public information (DWI convictions)
- ABC needs to collect routine statistics on citations, fines, etc.
- Wholesale and retail alcohol sales need to be more readily available
- AOD related industrial/residential accident aggregates need to be collected on causes
- A uniform reporting system and a central repository of ALL Higher Education referrals needs to be developed. Universities/colleges could possibly need assistance with developing a system to collect and report their statistics to the central repository.
- AOD attributable domestic violence cases
- Hepatitis- drug related communicability of hepatitis needs to be collected
- Investigated unattended deaths - AOD related
- AOD related crash data (non-fatal)
- AOD related ambulatory care
- ER visits – not readily accessible
- Higher Education all cause referrals
- Current use of ATOD by high school students
- Sales of ethanol
- Prescription usage patterns (misuse/abuse) (if yes, move to hospital admissions)
- General education referrals to school Substance Awareness Coordinators
- General education referrals to treatment
- High school drop out rate

Special Population Data Gap – Older Adults

The Epi-Profile Workgroup will continue its research on various sub-populations across the lifespan. Special attention is being given to the older adult population due to the Epi-Profile Workgroup's many conversations and concerns, which have focused on the overwhelming lack of data relating to substance use. This data needs to be collected in order for New Jersey to address the growing issues and concerns of this increasing population across the state.

Research on Older Adults

The older population in New Jersey is increasing at a faster rate than any other segment of the population. The successive groups that have entered and are entering the older age groups (60 years of age and older) have evidenced an increased range of legal and illicit substances that are being used at an increased level. Information related to older individuals in treatment strongly indicates that one third of those who receive treatment did not have a problem until they reached their older years, and that the escalation of use into problematic abuse frequently coincided with factors related to life stage issues. Although often undocumented, the inappropriate use, whether intentional or accidental, dependent or addictive, of alcohol, prescriptions, over-the-counter medications, herbals and illicit drugs, singly or in combination with other substances, can have severe consequences on the physical, psychological, social and economic well-being of older adults.

According to the New Jersey State Strategic Plan on Aging: October 1, 2005 – September 30, 2008, the 60 years-old and older population is projected to increase from the 2003 figure of 1,495,460, or 17.2%, to nearly 2,500,000, or 23.6% of the state population by 2025, an increase of 6.4 percentage points. Two counties already exceed that projected percentage, Cape May at 25.8% and Ocean at 25.7%. In terms of distribution, 38% of New Jersey's older population lives in 4 counties: Bergen (11.9%), Ocean (9.4%), Essex (8.4%) and Middlesex (8.3%).

Nationally, it is estimated that 17% of older adults, aged 60 years-old and older, currently have problems related to the abuse of alcohol, and licit and illicit drugs. (Blow et. al. in Korper and Council). The number of older adults (50 years-old and older) with substance abuse problems will increase from 2.5 million in 1999 to 5.0 million in 2020 (Gfroerer et. al. in Korper and Council).

According to the CESAR FAX, May 29, 2006, the aging of the baby boomers will coincide with a dramatic increase in substance abuse in those 50 years-old and older. Comparing the use in the past year (1999-2001) and projecting to 2020, the use of any illicit drug will increase by 113%, marijuana use by 355% and non-medical use of prescription psychotherapeutics by 193%.

In consideration of the need for prevention among the current and future population of older adults, it is important to look at general risk factors that may play a role in the development of a problem related to substance use and abuse. Rarely does any risk factor exist in isolation but rather co-exists with other factors that precipitate the development of circumstances that may also serve to increase the risk for an individual. In looking at the following risk factors, it is obvious that the element of age cannot be eliminated, but goals related to understanding, minimizing and coping are crucial in the development of prevention programs.

A review of risk factors for older adults includes the following categories and specific elements:

***General Risks Associated with the Use of Substances*:** such as the acceleration of the normal decline of physiological functions, the elevation of the risk of injury and illness, the impact on cognitive functioning and possible cognitive impairment, and the precipitation of socio/economic decline.

Life Stage Related Events: widowhood; retirement; loss of family and friends, either by death or distance; loss of access to activities, organizations and institutions; economic decline; and becoming a caregiver.

Physical Risk Factors: change of body weight, decrease in body mass and body water, increase in body fat, decrease in the efficiency of the systems and organs of the body, decrease in tolerance of pain and its management, sensory loss, and declining or poor health.

Psycho/Social Risk Factors: loneliness; isolation; lack of community and family supports, depression, unresolved grief, feelings of worthlessness, lack of self esteem, and anxiety.

Environmental Risk Factors: change of residence or community, the loss of mobility in being able to leave the home; the loss of the ability to drive; lack of access to transportation; and living with a drinking / drugging spouse or companion.

There is documentation of some of these risk factors in publications by the New Jersey Department of Health and Senior Services (DHSS), Division of Aging and Community Services and the DHSS Center for Health Statistics. The Division on Aging and Community Services includes census material on living arrangement, economic status, disabilities and other factors in their report.

The Center for Health Statistics annual Behavioral Risk Factor Survey includes relevant risk factors and in some cases links the risks with consequences. In the report, "Older Pedestrian Fatalities in New Jersey, 1999-2000," it states, "Alcohol use has been shown

to significantly influence pedestrian injury… Even though younger males are more often involved in pedestrian incidents while intoxicated … additional research into pedestrian intoxication among older adults is needed" (Page 3). In the Center's report, "Suicide in New Jersey, 1999-2000", it is stated, "…depression is often a precursor to suicide, and many elderly men resort to alcohol and prescription drug over-use to self-medicate themselves for depression, a pattern of behavior which is highly conducive to suicide. TIP 26 (page 23) states, "The highest rate of completed suicide is in older white men who become excessively depressed and drink heavily following the death of their spouses."

The consequences of substance related problems are many and varied, and frequently undocumented although requiring the intervention of health and social service systems. Commonly referred to as the "hidden problem," these cases are under recognized, under addressed, and often substance use is not formally recorded as a part of the case record. Factors that may play a role in the practice of inadequate documentation are confusion of signs of substance problems with assumptions about the aging process, denial and/or shame on the part of the individual and the family, ageist views related to treatment and recovery, and a lack of resources to address the problem if formally recognized. Informal consequences include, but are not limited to, family alienation, withdrawal by friends and from normal practices, self-isolation, loss of social supports, depletion of resources, decreased self care, changes in eating and sleeping practices, and a series of unidentified and unresolved health problems.

More formal consequences are more likely to become a part of public record, such as DUI's. In the case of many consequences, there is not documentation of the underlying or contributing factors. Hospitalizations and emergency rooms visits by older adults are commonly documented by the primary presenting symptoms without reference to the contributing factors or circumstances, which may often include drinking alcohol or the use of medications.

Other examples of the more formal consequences that have the potential of providing a firmer basis of the need for prevention efforts on behalf of older adults include home accidents and falls, suicides and attempted suicides, qualifying for Adult Protective Service, untimely nursing home admissions, premature deaths, and mental health admissions for depression and anxiety.

An example of the undocumented impact that alcohol has on the health and well-being of some older adults and of the cost of this to the state of New Jersey may be considered. In 2000, it was estimated that osteoporosis caused 36,630 bone fractures in New Jersey residents, at the cost of $496 million. Medically, chronic alcohol use can result in decreased bone density, thus contributing to osteoporosis, a major factor in hip and other fractures. In addition, the use of alcohol and some medications, singly or in combination, can be a factor in lose of balance and muscular control, and thus a factor in falls and accidents. Hip and other fractures are one of the most frequent causes of disability among older adults, and often precipitate the necessity of a nursing home admission. Although the pieces of the puzzle are present, and there may be documentation in specific cases, it is not the practice to collect data that would substantiate the linkage of these

factors. It is not known what percentage of the resulting fractures are linked to alcohol, medications or other substance use, nor the actual cost of these specific cases to the state of New Jersey.

A similar situation exists in the instance of cases covered by Adult Protective Services. These are adults who have been found to be a danger to themselves or to others and thus receive care management services and in some cases are institutionalized. In 2004, 4787 cases were investigated and 2824 were validated. The issue of competency is crucial in many of these decisions. Informal estimates of case managers are that 50 to 70 percent of cases are related to substance use, either by the older individual, the caregiver or other individuals. Beginning in January 2007, for the first time, there is documentation of relevant substance information in the case record.

Evidence related to New Jersey SAMS indicates that the provision of treatment services does not begin to address the current need among the older population. In 2005-06, individuals 60 years-old and older represented only 1.3% of the treatment population. While there are many reasons for this, from lack of identification to the need for elder-specific treatment resources, the fact does highlight the need for prevention services to mitigate the increased pressure on the treatment system in the future.

In summary, whereas there is a lack of specific documentation related to older adults and substance use and abuse at this time in New Jersey, it is intended that the following will provide elder specific data in the coming year:

1. Adult Protective Services incorporated questions related to substance use into its record system as of January 2007.

2. Conversations have been initiated with the Department of Health and Senior Services MAPP (Mobilizing for Action through Planning and Partnership) Project to explore the possibility of accessing information specific to older adults and substance use and abuse through the MAPP assessment and prioritizing process.

3. The Division of Aging and Community Services recently identified substance abuse as a priority area. Conversations with that Division will focus on exploring the collection of information and data via the New Jersey EASE (Easy Access Single Entry) and other programs administered and funded through the State Division. Substance abuse issues related to the Global Options Nursing Facility Transition and the Aging and Disability Resource Connection will also be explored.

4. Exploratory conversations will be initiated with the Department of Community Affairs Senior Housing programs.

ADDITIONAL COMMENTS:

- Need to educate legislators on the negative impact that Active Consent vs. Passive Consent has had on data collection and analysis of youth substance use, which would in turn enable New Jersey to make more informed planning and decision making around prevention strategies for youth.
- Need to better coordinate inter-departmental funds for more efficient utilization of prevention funds.
- The Epi-Profile Workgroup will be revisiting Hospital Discharge with AOD as primary and secondary.

APPENDIX A
Acronyms and Abbreviations

ABC	Alcohol Beverage Control
A/R	Alcohol-Related
AOC	Administrative Offices of the Courts
AOD	Alcohol or Drug related
BAC	Blood Alcohol Content
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CSAP	Center for Substance Abuse Prevention
DCA	Department of Community Affairs
DCF	Department of Children and Families
DHHS	United States Department of Health and Human Services
DOJ	United States Department of Justice
DWI	Driving While Impaired
FARS	Fatality Analysis Reporting Systems
FBI	Federal Bureau of Investigation
MADD	Mothers Against Drunk Driving
NCANDS	National Child Abuse and Neglect Data System
NCHS	National Center for Health Statistics
NHTSA	National Highway Traffic Safety Administration
NJ DAS	New Jersey Division of Addiction Services
NJ DHSS	New Jersey Department of Health and Senior Services
NJ MVC	New Jersey Motor Vehicle Commission
NJPTA	New Jersey Parent Teacher Association
NJ SAMS	New Jersey Substance Abuse Management System
NSDUH	National Survey on Drug Use and Health
NVSS	The National Vital Statistics System
PIRE	Pacific Institute for Research and Evaluation
SAC	Substance Awareness Coordinator
SADD	Students Against Destructive Decisions
SAMHSA	Substance Abuse and Mental Health Services Administration
SEDS	State Epidemiological Data Set (developed by SAMHSA)
SEOW	State Epidemiological Outcomes Work Group
SIG	State Incentive Grant
SPF	Strategic Prevention Framework
TEDS	Treatment Episode Data Set
UCR	Uniform Crime Report
USDOT	United States Department of Transportation

APPENDIX B
Constructs, Indicators and Selection Scoring

Table B1 List of Constructs by Substance Type, Indicators Used to measure each Construct and Selection Scoring																
Construct	Indicator	Data Source	Available for at least 2-3 Years	Indicators			Frequency		Population			Geographic Coverage				Total Score
				Alcohol	Illicit Drugs	Prescription Drugs	Month	Year	Age	Sex	Race	Muni.	County	State	National	
Mortality																
	Fatal crash – AOD related	FARS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Primary and secondary causes of mortality- AOD related	NJCHS	1	1	1			1	1	1	1	1	1	1	1	11
	Chronic liver disease	NJCHS	1	1	1			1	1	1	1	1	1	1	1	11
	Suicide – AOD related	NJCHS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Homicide AOD related	NJCHS	1	1	1		1	1	1	1	1	1	1	1	1	12
	HIV/AIDS	NJCHS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Hepatitis	NJCHS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Pedestrian fatalities	NJCHS	1	1	1		1	1	1	1	1	1	1	1	1	12
	General Risks – other than listed	DAS	1	1	1			1	1	1	1	1	1	1	1	11
Morbidity/Injury and Illness																
	AOD dependence	NSDUH	1	1	1		1	1	1	1	1	1	1	1	1	
	Treatment admissions - AOD	TEDS	1	1	1	1	1	1	1	1	1	1	1	1	1	13
	Child abuse and neglect	DYFS	1	1	1		1	1	1	1	1	1	1	1	1	12
	DUI offenders (characteristics)	IDP	1	1	1		1	1	1	1	1	1	1	1	1	12
	DYFS families - AOD related	DYFS	1	1	1		1	1	1	1	1	1	1	1	1	12
	HIV/AIDS	NJAIDS	1	1	1		1	1	1	1	1	1	1	1	1	12
	General risks	DAS	1	1	1			1	1	1	1	1	1	1	1	11
Crime																
	Juvenile arrests – AOD related	UCR	1	1	1		1	1	1	1	1	1	1	1	1	12
	DUI arrests	UCR	1	1	1		1	1	1	1	1	1	1	1	1	12
	Liquor law arrests	UCR	1	1	1		1	1	1	1	1	1	1	1	1	12
	School crime – AOD related	CRVV	1	1	1	1	1	1	1	1	1	1	1	1	1	13
	Arrests for drug law violation	UCR	1	1	1		1	1	1	1	1	1	1	1	1	12
	Possession / use arrests – D/R	UCR	1	1	1		1	1	1	1	1	1	1	1	1	12
	General risks – other than listed	DAS	1	1	1			1	1	1	1	1	1	1	1	12

AOD (Alcohol and Other Drugs)
IDP (Intoxicated Driving Program)

Continued

Table B1 List of Constructs by Substance Type, Indicators Used to measure each Construct and Selection Scoring																
Construct	Indicator	Data Source	Available for at least 2-3 Years	Indicators			Frequency		Population			Geographic Coverage				Total Score
				Alcohol	Illicit Drugs	Prescription Drugs	Month	Year	Age	Sex	Race	Muni.	County	State	National	
Consumption																
	Use of AOD 12+	NSDUH	1	1	1	1	1	1	1	1	1	1	1	1	1	13
	Use of AOD by middle school students	MSSUS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Tobacco current use by middle school students	MSSUS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Use of AOD by high school students	YRBS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Tobacco current use by high school students	YRBS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Use of AOD by college students	CORE	1	1	1		1	1	1	1	1	1	1	1	1	12
	Binge drinking by college students	CORE	1	1	1		1	1	1	1	1	1	1	1	1	12
	Life time use AOD - total population	NSDUH	1	1	1		1	1	1	1	1	1	1	1	1	12
	Life time use AOD - high school students	YRBS	1	1	1		1	1	1	1	1	1	1	1	1	12
	General risks – other than listed	DAS	1			1		1	1	1	1	1	1	1	1	13
Other Risk Factors																
	Tobacco Use	NJYTS	1	1	1		1	1	1	1	1	1	1	1	1	12
	Non-medical use of Prescription Drugs	NSDUH	1	1	1	1		1	1	1	1	1	1	1	1	12
	General Risks – Other than listed	DAS	1	1	1			1	1	1	1	1	1	1	1	12
	HIV/AIDS	NJDHSS	1	1	1			1	1	1	1	1	1	1	1	11
AOD (Alcohol & other drugs) IDP (Intoxicated Driving Program)																

APPENDIX C
Alcohol Consequences

Table C-1 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Mortality								
Alcohol Related (A/R) Mortality								
Alcohol as primary cause of death	A/R mortality	NJCHS	2001	493	8,612,222	5.6	7.0	Between 2001 and 2003 the national death rate due to alcohol remained unchanged (7%) while it decreased by 1% in New. Jersey.
		NJCHS	2002	482	8,695,460	5.3	6.9	
		NJCHS	2003	428	8,640,028	4.7	7.0	
	Chronic liver disease and cirrhosis	NJCHS	2001	778	8,612,222	8.5	9.4	
		NJCHS	2002	730	8,695,460	7.9	9.5	
		NJCHS	2003	767	8,640,028	8.4	9.3	
Alcohol as secondary cause of death	Suicide death from all causes	NJCHS	2001	588	8,612,222	6.8	10.8	A/R suicide rate in New Jersey was lower than the national A/R suicide rate per 100,000.
		NJCHS	2002	553	8,695,460	6.3	11.0	
		NJCHS	2003	560	8,640,028	6.3	10.8	
	A/R suicide death	NJCHS	2001	165	8,612,222	1.9	4.9	
		NJCHS	2002	155	8,695,460	1.8	5.1	
		NJCHS	2003	157	8,640,028	1.8	5.0	
								New Jersey's homicide rate was the 14th lowest in the nation in 2002. It increased sharply in 2003 to 4.9. The recent increase is concentrated among the 15-24 and 25-34 age group (11.8 and 10.8 /100,000 respectively). A/R homicide rate in New Jersey is lower than the national rate.
	Homicide death from all causes	NJCHS	2001	1,051	8,612,222	12.2	8.9	
		NJCHS	2002	333	8,695,460	4.0	6.0	
		NJCHS	2003	406	8,640,028	4.9	6.1	
	A/R homicide death	NJCHS	2001	483	8,612,222	5.6	4.0	
		NJCHS	2002	153	8,695,460	1.8	3.9	
		NJCHS	2003	187	8,640,028	2.2	2.7	

Source: www.nj.gov/health/chs/muni.htm.
National Center for Health Statistics. http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_19.pdf

Table C-1 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Mortality (Continued)								
Motor Vehicle (M/V) Crashes								
Alcohol as secondary cause of death	All fatalities from MV crashes	FARS	2001	745	8,612,222	8.7	14.8	New Jersey motor vehicle fatalities remained relatively stable from 2001 to 2005, varying by 6/ 100,000 at-risk population. New Jersey rates were lower than the national rates.
		FARS	2002	771	8,695,460	8.9	14.9	
		FARS	2003	733	8,640,028	8.5	14.7	
		FARS	2004	725	8,685,166	8.3	14.7	
		FARS	2005	748	8,717,925	8.6	14.7	
								New Jersey alcohol-related motor vehicle fatalities remained relatively stable from 2001 to 2005, varying by 4 per 100,000 at-risk population. New Jersey rates were lower than the national rates, but this difference varied from 46% lower in 2001 to 34% lower in 2005.
	MV fatalities that were alcohol related	FARS	2001	225	6,655,459	3.4	6.1	
		FARS	2002	229	6,655,459	3.4	6.0	
		FARS	2003	228	6,704,596	3.4	5.9	
		FARS	2004	236	6,737,812	3.5	5.7	
		FARS	2005	254	6,737,812	3.8	5.7	
Alcohol Attributable Pedestrian Fatalities								
Alcohol as secondary cause of death	All pedestrian fatalities	FARS	2001	138	8,612,222	1.6	1.7	New Jersey pedestrian fatalities varied from a low of 1.6 in 2001per 100,000 at-risk population to a high of 2.1 in 2002, settling down to 1.8 by 2005. Also, state rates were, on average, 7.2% higher than the national rates.
		FARS	2002	183	8,695,460	2.1	1.7	
		FARS	2003	138	8,640,028	1.6	1.6	
		FARS	2004	156	8,685,166	1.8	1.6	
		FARS	2005	157	8,717,925	1.8	1.7	
								New Jersey alcohol attributable pedestrian fatalities varied from .4 per 100,000 at-risk population in 2001 to .5 from 2002 to 2004, returning to .4 in 2005. Also, state rates were, on average, 26% lower than the national rates.
	Alcohol attributable pedestrian fatalities	FARS	2001	34	8,612,222	0.4	0.6	
		FARS	2002	43	8,695,460	0.5	0.6	
		FARS	2003	43	8,640,028	0.5	0.6	
		FARS	2004	43	8,685,166	0.5	0.6	
		FARS	2005	35	8,717,925	0.4	0.6	
FARS (Fatal Accident Reporting System), National Highway Traffic Safety								

Table C-2 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Morbidity								
Alcohol Dependence[1]								
Population meeting the DSM-IV criteria for alcohol dependence in past year	Total population 12 years old and above	NSDUH	2001	141,000	6,746,411	2,090	2,370	New Jersey's alcohol dependency rate per 100,000 at-risk population rose most sharply from 2,090 in 2001 to 3,060 in 2002, declining slightly to 2,700 in 2004 and rising slightly to 2,840 in 2005. NJ rates were, on average, 14.1% lower than the national rates throughout the period.
		NSDUH	2002	216,000	7,058,824	3,060	3,500	
		NSDUH	2003	211,000	7,104,377	2,970	3,340	
		NSDUH	2004	193,000	7,148,148	2,700	3,330	
		NSDUH	2005	204,000	7,183,099	2,840	3,380	
	12-17 years old	NSDUH	2001	9,000	656,934	1,370	1,890	New Jersey rates per 100,000 at-risk population rose steadily by a total percent change of 51.1% between 2001 and 2005. State rates were, on average, 14.2% lower than national rates throughout the period.
		NSDUH	2002	13,000	714,286	1,820	2,130	
		NSDUH	2003	13,000	718,232	1,810	2,090	
		NSDUH	2004	13,000	710,383	1,830	2,080	
		NSDUH	2005	15,000	724,638	2,070	2,140	
	18-25 years old	NSDUH	2001	30,000	781,250	3,840	5,160	New Jersey rates per 100,000 rose between 2001 and 2002 more sharply than the national rates, but fell from 2002 to 2004 while the national rates rose from 2003 to 2005.
		NSDUH	2002	57,400	784,153	7,320	7,000	
		NSDUH	2003	52,000	791,476	6,570	6,870	
		NSDUH	2004	48,000	810,811	5,920	6,960	
		NSDUH	2005	50,000	838,926	5,960	7,210	
	26 years old and above	NSDUH	2001	103,000	5,336,788	1,930	1,960	New Jersey rates per 100,000 rose between 2001 and 2002 less sharply than the national rates, but fell from 2002 to 2004 more sharply than the national rates.
		NSDUH	2002	147,000	5,610,687	2,620	3,080	
		NSDUH	2003	146,000	5,593,870	2,610	2,900	
		NSDUH	2004	131,000	5,598,291	2,340	2,860	
		NSDUH	2005	139,000	5,791,667	2,400	2,870	
Source: SAMHSA Office of Applied Studies, National Survey on Drug Use and Health, 2001 – 2005								

[1] Dependence is based on the definition found in the 4th edition of DSM-IV

Table C-3 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate*	Trend across time and with respect to national data
Morbidity (Continued)								
Treatment Admissions by Primary Substance of Abuse								
Admissions to treatment for all substance of abuse	Population aged 12 years and above	TEDS	2001	54,687	6,124,572	893	741	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 62/100,000.
		TEDS	2002	54,524	6,462,372	844	779	
		TEDS	2003	55,589	6,514,671	853	755	
		TEDS	2004	54,040	6,566,049	823	743	
		TEDS	2005	55,003	6,617,420	831	721	
Treatment admissions alcohol only addiction	Population aged 12 years and above	TEDS	2001	8,951	6,124,572	146	216	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 17/100,000 among alcohol abusing clients.
		TEDS	2002	8,625	6,462,372	133	210	
		TEDS	2003	8,929	6,514,671	137	213	
		TEDS	2004	8,579	6,566,049	131	204	
		TEDS	2005	8,538	6,617,420	129	155	
Admissions to treatment for alcohol with secondary drug abuse	Population aged 12 years and above	TEDS	2001	6,306	6,124,572	103	148	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 8 for users of alcohol with secondary drug use.
		TEDS	2002	6,301	6,462,372	98	150	
		TEDS	2003	6,363	6,514,671	98	140	
		TEDS	2004	6,348	6,566,049	97	133	
		TEDS	2005	6,300	6,617,420	95	127	
Total admissions for alcohol treatment	Population aged 12 years and above	TEDS	2001	15,257	6,124,572	249	329	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 25/100,000 for all alcohol admissions.
		TEDS	2002	14,926	6,462,372	231	334	
		TEDS	2003	15,292	6,514,671	235	314	
		TEDS	2004	14,927	6,566,049	227	298	
		TEDS	2005	14,838	6,617,420	224	282	
TEDS (Treatment Episode Data Set) *Calculated from National Census Estimates for age 10+								

Table C-4 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Morbidity (Continued)								
Intoxicated Driving Program (IDP) Clients								
Lifetime alcohol-related motor vehicle offenses	One offense	DAS-IDP	2002	11,699	5,711,794	205	Not available	The number of offenses for New Jersey IDP clients completing the IDRC program remained fairly consistent from 2002 – 2005 with a slight decrease in those with 3 or more offenses attending classes.
		DAS-IDP	2003	12,727	5,728,975	222	Not available	
		DAS-IDP	2004	13,051	5,799,532	225	Not available	
		DAS-IDP	2005	14,138	5,870,720	241	Not available	
	Two offenses	DAS-IDP	2002	3,175	5,711,794	56	Not available	
		DAS-IDP	2003	3,455	5,728,975	60	Not available	
		DAS-IDP	2004	3,972	5,799,532	68	Not available	
		DAS-IDP	2005	3,783	5,870,720	64	Not available	
	Three or more offenses	DAS-IDP	2002	1,838	5,711,794	32	Not available	
		DAS-IDP	2003	2,000	5,728,975	35	Not available	
		DAS-IDP	2004	1,892	5,799,532	33	Not available	
		DAS-IDP	2005	1,792	5,870,720	31	Not available	
DAS-IDP (Division of Addiction Services-Intoxicated Driving Program) Population at Risk: Number of Licensed Drivers in NJ http://www.fhwa.dot.gov/policy/ohim								

Table C-4 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Morbidity (Continued)								
Intoxicated Driving Program (IDP) Clients								
Lifetime illicit drug use by IDP clients	Lifetime marijuana use	DAS-IDP	2002	8,836	5,711,794	155	Not available	
		DAS-IDP	2003	9,784	5,728,975	171	Not available	
		DAS-IDP	2004	10,157	5,799,532	175	Not available	
		DAS-IDP	2005	10,653	5,870,720	181	Not available	
	Lifetime cocaine use	DAS-IDP	2002	3,162	5,711,794	55	Not available	
		DAS-IDP	2003	3,438	5,728,975	60	Not available	
		DAS-IDP	2004	3,734	5,799,532	64	Not available	
		DAS-IDP	2005	3,525	5,870,720	60	Not available	
	Lifetime heroin use	DAS-IDP	2002	499	5,711,794	9	Not available	
		DAS-IDP	2003	542	5,728,975	9	Not available	
		DAS-IDP	2004	745	5,799,532	13	Not available	
		DAS-IDP	2005	587	5,870,720	10	Not available	
DAS-IDP (Division of Addiction Services-Intoxicated Driving Program) Population at Risk: Number of Licensed Drivers in NJ, Source: Office of Highway Traffic Safety http://www.fhwa.dot.gov/policy/ohpi/qfdrivers.htm								

Table C-5 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Morbidity (Continued)								
Alcohol Related DYFS Involved Families								
	Total child abuse/neglect cases involving prenatal substance abuse	DYFS	2002	969	2,119,139	46	Not available	
		DYFS	2003	935	2,136,179	44	Not available	
		DYFS	2004	859	2,150,267	40	Not available	
	Total child related alcohol abuse referrals	DYFS	2002	67	2,119,139	3	Not available	
		DYFS	2003	74	2,136,179	3	Not available	
		DYFS	2004	87	2,150,267	4	Not available	
	Total Parent-Related Alcohol Abuse Referrals	DYFS	2002	1,107	2,119,139	52	Not available	
		DYFS	2003	1,206	2,136,179	56	Not available	
		DYFS	2004	1,342	2,150,267	62	Not available	
	Total substance – exposed newborns	DYFS	2002	51	2,119,139	2	Not available	
		DYFS	2003	63	2,136,179	3	Not available	
		DYFS	2004*	46	2,150,267	2	Not available	
		DYFS	2005	53	2,135,195	2	Not available	
* Substance exposed newborns was not a valid family problem code as of 7/1/04. Regardless of prenatal exposure, only newborns that tested positive at birth were referred as maltreatment cases.								

Table C-6 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime								
Alcohol Attributable Arrests								
All arrests by age	Total arrests in New Jersey	UCR	2001	389,994	8,504,864	4,586	4,840	While "at risk" population rose from 2001 to 2005, arrest rates per 100,000 also rose by 30. Also, in 2005, state arrest rates were lower than the national rate.
		UCR	2002	396,254	8,576,089	4,620	5,972	
		UCR	2003	389,377	8,640,028	4,507	5,784	
		UCR	2004	396,296	8,685,166	4,563	4,752	
		UCR	2005	402,418	8,717,925	4,616	4,761	
	Adult arrests for all offenses	UCR	2001	325,074	6,402,576	5,077	3,705	While "at risk" population rose from 2001 to 2005, adult arrest rates, roughly 500 per 100,000 higher than total arrest rates, also rose by 84.
		UCR	2002	332,437	6,462,372	5,144	3,939	
		UCR	2003	326,814	6,514,671	5,017	3,813	
		UCR	2004	334,442	6,566,049	5,094	3,742	
		UCR	2005	341,701	6,617,420	5,164	Not available	
	Juvenile arrests for all offenses	UCR	2001	64,920	2,102,288	3,088	2,064	While "at risk" population rose from 2001 to 2004, juvenile arrest rates per 100,000 declined by 210 from 2001 to 2005.
		UCR	2002	63,817	2,113,717	3,019	2,033	
		UCR	2003	62,563	2,125,357	2,944	1,941	
		UCR	2004	61,854	2,119,117	2,919	1,958	
		UCR	2005	60,458	2,100,505	2,878	Not available	
	Total alcohol attributable arrests	UCR	2001	50,413	8,504,864	593	579	While "at risk" population rose from 2001 to 2005, the rates of arrests attributable to alcohol use per 100,000 population declined by 46 from 2001 to 2004 before rebounding by 41 in 2005.
		UCR	2002	49,253	8,576,089	574	623	
		UCR	2003	48,594	8,640,028	562	596	
		UCR	2004	47,478	8,685,166	547	598	
		UCR	2005	51,277	8,717,925	588	Not available	
New Jersey Department of Law & Public Safety, Uniform Crime Report. "Juvenile" includes total population of NJ age 0 – 17, therefore rate per 100,000 may be skewed								

Table C-6 Substance Abuse Constructs and Indicators: Alcohol Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime (Continued)								
Alcohol Attributable Arrests								
Alcohol attributable arrests	Total juvenile arrests attributable to alcohol	UCR	2001	4,754	2,102,288	226	266	The "at-risk" population first rose from 2001 to 2003 and fell somewhat by 2004. However, the alcohol attributable juvenile arrest rates fell by 30/100,000.
		UCR	2002	4,535	2,113,717	215	222	
		UCR	2003	4,320	2,125,357	203	202	
		UCR	2004	4,153	2,119,117	196	201	
		UCR	2001	4,754	2,102,288	226	Not available	
	DUI arrests	UCR	2001	28,929	5,715,089	506	331	While the number of licensed drivers rose from 2001 to 2005, the rates of DUI arrests per 100,000 population fluctuated, ending the period down by 10/100,000.
		UCR	2002	28,135	5,711,794	493	353	
		UCR	2003	29,048	5,728,975	507	345	
		UCR	2004	28682	5,799,532	495	345	
		UCR	2005	29,143	5,870,720	496	Not available	
	Liquor law violation arrests	UCR	2001	10,366	8,504,864	122	143	While "at-risk" population first rose from 2001 to 2003, the rates of liquor law violations declined by 34/100,000, well below the national rate.
		UCR	2002	9,955	8,576,089	116	161	
		UCR	2003	8,581	8,640,028	99	148	
		UCR	2004	7,693	8,685,166	89	149	
		UCR	2005	7,462	8,717,925	86	Not available	
A/R Juvenile crime in schools	Incidents of school crime related to alcohol	CRVV	2002-03	540	557,215	97	Not available	The number of school-based incidents of use, possession and sale/distribution of alcohol has dropped steadily as the population at risk rose.
		CRVV	2003-04	520	572,532	91	Not available	
		CRVV	2004-05	546	587,136	93	Not available	
		CRVV	2005-06	537	594,206	90	Not available	
New Jersey Department of Law & Public Safety, Uniform Crime Report. "Juvenile" includes total population of NJ age 0 – 17; therefore the rate per 100,000 may be skewed. CRVV: NJ Department of Education Commissioner's Annual Report to the Education **C**ommittees of the Senate and General Assembly on Violence, Vandalism and Substance Abuse **i**n New Jersey Public Schools								

APPENDIX D
Alcohol Consumption

Table D-1 Substance Abuse Constructs and Indicators: Alcohol Consumption								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Current Use of Alcohol – General Population								
Past month alcohol use	Persons age 12 years and older reporting any use of alcohol	NSDUH	1999 - 2000	3,446,000	6,695,162	51,470	46,250	While population rose from 2000 to 2005, alcohol use per 100,000 population rose by 6,260 from 2000 to 2003, but then fell by 3,250 from 2003 to 2005.
		NSDUH	2000 - 2001	3,606,000	6,747,754	53,440	47,590	
		NSDUH	2002 - 2003	4,097,000	7,096,830	57,730	50,500	
		NSDUH	2003 - 2004	3,806,000	7,147,418	53,250	50,170	
		NSDUH	2004 - 2005	3,914,000	7,184,288	54,480	51,050	
	Persons age 12 - 17 years reporting any use of alcohol	NSDUH	1999 - 2000	111,000	627,473	17,690	16,400	While the 12 to 17 population rose from 2000 to 2005, alcohol use rates per 100,000 population rose from 2000 to 2004 and appear to have exceeded the national rates.
		NSDUH	2000 - 2001	115,000	651,558	17,650	16,830	
		NSDUH	2002 - 2003	135,000	719,233	18,770	17,670	
		NSDUH	2003 - 2004	138,000	733,262	18,820	17,750	
		NSDUH	2004 - 2005	140,000	745,871	18,770	17,060	
	Persons age 18 - 25 years reporting any use of alcohol	NSDUH	1999 - 2000	460,000	780,322	58,950	56,810	While the 18 to 25 population rose from 2000 to 2005, alcohol use per 100,000 population rose by 6,110 from 2000 to 2003, but fell by 2,650 from 2003 to 2005, although still exceeding the national rates. A similar pattern applies to the 26 and older population.
		NSDUH	2000 - 2001	470,000	768,728	61,140	57,480	
		NSDUH	2002 - 2003	515,000	791,577	65,060	60,910	
		NSDUH	2003 - 2004	521,000	816,742	63,790	60,920	
		NSDUH	2004 - 2005	520,000	833,200	62,410	60,690	
	Persons age 26 years and older reporting any use of alcohol	NSDUH	1999 - 2000	2,876,000	5,290,655	54,360	48,550	
		NSDUH	2000 - 2001	3,021,000	5,326,164	56,720	50,110	
		NSDUH	2002 - 2003	3,448,000	5,586,520	61,720	53,220	
		NSDUH	2003 - 2004	3,147,000	5,595,661	56,240	52,780	
		NSDUH	2004 - 2005	3,255,000	5,606,269	58,060	54,030	
NSDUH (National Survey on Drug Use & Health), Office of Applied Studies, SAMHSA								

Table D-2 Substance Abuse Constructs and Indicators: Alcohol Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Population at Risk	National Average Rate	Trend across time and with respect to national data
Alcohol Consumption by 7th and 8th Graders								
Total alcohol consumption by youth under 21 in New Jersey	Total alcohol lifetime use by 7th and 8th graders	MSSUS	1999	7,860	52.8%	174,590	47.0%	The NJ prevalence rates for 2001 and 2003 are below the national rate for 2002.
		MSSUS	2001	14,567	44.6%	189,322		
		MSSUS	2003	10,604	46.4%	206,079		
	Total alcohol 30-day use by 7th and 8th graders	MSSUS	1999	7,926	24.6%	174,590	19.6%	30 day use has decreased since 1999 and is below the 2002 national average for 2001 and 2003.
		MSSUS	2001	14,538	16.0%	189,322		
		MSSUS	2003	10,614	13.8%	206,079		
	Total alcohol binge drinking by 7th and 8th graders	MSSUS	1999	7,944	9.7%	174,590	Not available	Binge Drinking has decreased since 1999.
		MSSUS	2001	14,465	7.6%	189,322		
		MSSUS	2003	10,604	6.4%	206,079		
MSSUS (New Jersey Middle School Substance Use Survey) 2002 Monitoring the Future used for national rate								

Table D-3 Substance Abuse Constructs and Indicators: Alcohol Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Population at Risk	National Average Rate	Trend across time and with respect to national data
Alcohol Consumption by High School Students								
Total alcohol consumption and early use by youth under 21 in New Jersey	Lifetime alcohol use by high school students	YRBS	1995	3,529	79.7	296,490	80%	Lifetime use of alcohol by high school students has remained unchanged over the ten-year period, failing to follow the national decline.
		YRBS	2001	2,142	83.9	322,551	78%	
		NJSHS	2005	1,495	79.3	378,142	74%	
	30-Day use of alcohol by high school students	YRBS	1995	3529	51.1	296,490	52%	Recent use of alcohol by high school students increased, then recently declined.
		YRBS	2001	2,142	55.7	322,551	47%	
		NJSHS	2005	1,495	46.5	378,142	43%	
	Binge drinking by high school students	YRBS	1995	3,529	30.6	296,490	33%	Episodic, heavy drinking by high school students has declined less than nationally.
		YRBS	2001	2,142	32.6	322,551	30%	
		NJSHS	2005	1,495	27.2	378,142	26%	
	First drink by Age 12 or Younger	YRBS	1995	3,529	37.4	296,490	32%	Early use of alcohol has declined significantly among high school students.
		YRBS	2001	2,142	32.5	322,551	29%	
		NJSHS	2005	1,495	20.1	378,142	26%	
NJSHS (New Jersey Student Health Survey)								

Table D-4 Substance Abuse Constructs and Indicators: Alcohol Consumption							
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Number of Colleges Surveyed	Trend across time and with respect to national data
Binge Drinking by College Students							
Use of alcohol by college students	Consumes alcohol during the year	CORE	2002	3,462	88.3%	8	Alcohol use in college populations is normative (almost nine out of ten students drink alcohol
		CORE	2003	4,570	87.1%	10	
		CORE	2004	3,312	89.5%	9	
		CORE	2005	3,702	88.3%	9	
		CORE	2006	2,301	86.2%	9	
Binge drinking by college students (defined as 5 or more drinks per sitting for males; 4 or more drinks per sitting for females)	Had 5 or more drinks in a row in the last two weeks	CORE	2002	3,462	45.4%	8	Though not the majority of students, high risk or heavy drinking is a persistent and relatively large problem compared to other drug use.
		CORE	2003	4,570	42.6%	10	
		CORE	2004	3,312	48.3%	9	
		CORE	2005	3,702	46.7%	9	
		CORE	2006	2,301	43.3%	9	
	Had 5 or more drinks in a row in last two weeks more than once	CORE	2002	3,462	30.1%	8	About 30% of students consume five or more drinks in a row on more than one occasion in a two week period.
		CORE	2003	4,570	28.0%	10	
		CORE	2004	3,312	32.5%	9	
		CORE	2005	3,702	31.0%	9	
		CORE	2006	2,301	28.6%	9	
CORE: Core Institute, Southern Illinois University Carbondale							

Table D-4 Substance Abuse Constructs and Indicators: Alcohol Consumption							
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Number of Colleges Surveyed	Trend across time and with respect to national data
Binge Drinking by College Students continued							
Binge drinking by college students (defined as 5 or more drinks per sitting for males; 4 or more drinks per sitting for females)	Consumes 5 or more drinks at parties and bars	CORE	2002	3,462	38.3%	8	The prevalence of students consuming 5 or more and 7 or more drinks at parties and bars has remained steady from 2002 through 2006.
		CORE	2003	4,570	36.4%	10	
		CORE	2004	3,312	39.4%	9	
		CORE	2005	3,702	37.6%	9	
		CORE	2006	2,301	38.5%	9	
	Consumes 7 or more drinks at parties and bars	CORE	2002	3,462	19.4%	8	
		CORE	2003	4,570	17.8%	10	
		CORE	2004	3,312	19.1%	9	
		CORE	2005	3,702	18.6%	9	
		CORE	2006	2,301	20.3%	9	
CORE: Core Institute, Southern Illinois University Carbondale							

APPENDIX E
Drug Consequences

Table E-1 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Mortality								
Drug Related (D/R) Mortality								
	D/R mortality	NJCHS	2001	796	8,612,222	9.2	Not available	Within the time period of 2001-2003, drug related mortality in New Jersey peaked in 2002 but in 2003 it dropped below the 2001 level.
		NJCHS	2002	884	8,695,460	10.1	Not available	
		NJCHS	2003	751	8,640,028	8.7	Not available	

Table E-2 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Drug Dependence[2]								
Population of specific age groups meeting DSM-IV criteria for drug dependence in past year	Total population 12 years old and above	NSDUH	2001	71,000	6,746,411	1052	2,370	While the 12 and over population rose from 2001 to 2005, the rate of drug dependence per 100,000 population rose by 720 from 2001 to 2002, fluctuated thereafter and remained below the national rates.
		NSDUH	2002	126,000	7,058,824	1785	1,970	
		NSDUH	2003	122,000	7,104,377	1717	1,910	
		NSDUH	2004	123,000	7,148,148	1721	1,930	
		NSDUH	2005	128,000	7,183,099	1782	1,980	
	12-17 years old	NSDUH	2001	11,000	656,934	1674	1,890	Similarly, the 12 to 17 population rose with some fluctuation, the state rate per 100,000 rose initially by 1,340, then fluctuated, remaining below the national rates until 2004, exceeding it in 2005.
		NSDUH	2002	22,000	714,286	3080	3,160	
		NSDUH	2003	20,000	718,232	2785	2,970	
		NSDUH	2004	21,000	710,383	2956	2,850	
		NSDUH	2005	23,000	724,638	3174	2,800	
	18-25 years old	NSDUH	2001	31,000	781,250	3968	5,160	The trend for the 18 to 25 population followed the pattern of the 12 to 17 population, except that the rate per 100,000 population exceeded the national rates in 2002, 2003 and 2005.
		NSDUH	2002	50,000	784,153	6376	5,520	
		NSDUH	2003	44,000	791,476	5559	5,360	
		NSDUH	2004	44,000	810,811	5427	5,380	
		NSDUH	2005	48,000	838,926	5722	5,700	
	26 years old and above	NSDUH	2001	29,000	5,336,788	543	1,960	Although fluctuating, the 25 and older population grew from 2001 to 2005. Likewise, the New Jersey rates grew by 450 per 100,000 population while the national rates declined by 750.
		NSDUH	2002	54,000	5,610,687	962	1,200	
		NSDUH	2003	58,000	5,593,870	1037	1,160	
		NSDUH	2004	59,000	5,598,291	1054	1,200	
		NSDUH	2005	57,000	5,791,667	984	1,210	

Continued

[2] Dependence is based on the definition found in the 4th edition of DSM-IV

Table E-3 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Drug Treatment Admissions by Primary Substance of Abuse								
Admissions to treatment for all substance of abuse	Population 12 years old and above	TEDS	2001	54,687	6,124,572	893	741	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 62.
		TEDS	2002	54,524	6,462,372	844	779	
		TEDS	2003	55,589	6,514,671	853	755	
		TEDS	2004	54,040	6,566,049	823	743	
		TEDS	2005	55,003	6,617,420	831	721	
Admissions to treatment for illicit drug abuse	Population 12 years old and above	TEDS	2001	39,430	6,124,572	644	Not available	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 160 among users of illicit drugs.
		TEDS	2002	23,152	6,462,372	358	Not available	
		TEDS	2003	26,437	6,514,671	406	Not available	
		TEDS	2004	29,916	6,566,049	456	Not available	
		TEDS	2005	32,039	6,617,420	484	Not available	
Admissions to treatment for illicit drug abuse by drug type	Heroin	TEDS	2001	26,637	6,124,572	435	137	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 declined by 83 for users of heroin.
		TEDS	2002	26,492	6,462,372	410	140	
		TEDS	2003	26,051	6,514,671	400	137	
		TEDS	2004	23,452	6,566,049	357	133	
		TEDS	2005	23.289	6,617,420	352	Not available	
	Other opiates	TEDS	2001	848	6,124,572	14	16	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 19 for users of other opiates.
		TEDS	2002	1,124	6,462,372	17	18	
		TEDS	2003	1,256	6,514,671	19	21	
		TEDS	2004	1,689	6,566,049	26	25	
		TEDS	2005	2,196	6,617,420	33	Not available	

Continued

Table E-4 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Drug Treatment Admissions								
Admissions to treatment for illicit drug abuse by drug type	Cocaine	TEDS	2001	1,850	6,124,572	30	99	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 61 for users of cocaine.
		TEDS	2002	5,310	6,462,372	82	104	
		TEDS	2003	5,678	6,514,671	87	107	
		TEDS	2004	5,864	6,566,049	89	105	
		TEDS	2005	6,043	6,617,420	91	Not available	
	Marijuana	TEDS	2001	5,700	6,124,572	93	115	While population rose from 2001 to 2005, rates of treatment admissions per 100,000 increased by 13 for users of marijuana.
		TEDS	2002	5,862	6,462,372	91	123	
		TEDS	2003	6,319	6,514,671	97	122	
		TEDS	2004	6,462	6,566,049	98	122	
		TEDS	2005	7,015	6,617,420	106	Not available	

Table E-5 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime								
Drug Attributable Arrests								
Arrests	Total arrests in New Jersey	UCR	2001	389,994	8,504,864	4,586	4,840	While "at risk" population rose from 2001 to 2005, arrest rates per 100,000 also rose by 30. Also, in 2005, state arrest rates were lower than the national rate.
		UCR	2002	396,254	8,576,089	4,620	5,972	
		UCR	2003	389,377	8,640,028	4,507	5,784	
		UCR	2004	396,296	8,685,166	4,563	4,752	
		UCR	2005	402,418	8,717,925	4,616	4,761	
	Adult arrests	UCR	2001	325,074	6,402,576	5,077	3,705	While "at risk" population rose from 2001 to 2005, adult arrest rates, roughly 500 per 100,000 higher than total arrest rates, also rose by 84.
		UCR	2002	332,437	6,462,372	5,144	3,939	
		UCR	2003	326,814	6,514,671	5,017	3,813	
		UCR	2004	334,442	6,566,049	5,094	3,742	
		UCR	2005	341,701	6,617,420	5,164	Not available	
	Juvenile arrests	UCR	2001	64,920	2,102,288	3,088	2,064	While "at risk" population rose from 2001 to 2004, juvenile arrest rates per 100,000 declined by 210 from 2001 to 2005.
		UCR	2002	63,817	2,113,717	3,019	2,033	
		UCR	2003	62,563	2,125,357	2,944	1,941	
		UCR	2004	61,854	2,119,117	2,919	1,958	
		UCR	2005	60,458	2,100,505	2,878	Not available	
Drug related arrests	All drug related arrests	UCR	2001	70,204	8,504,864	825	836	While "at risk" population rose from 2001 to 2005, the rates of arrests attributable to drug use per 100,000 population fluctuated and ended up by 3.
		UCR	2002	71,250	8,576,089	831	909	
		UCR	2003	68,251	8,640,028	790	923	
		UCR	2004	69,264	8,685,166	797	808	
		UCR	2005	70,477	8,717,925	808	Not available	

Continued

Table E-5 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime (Continued)								
Drug related arrests	Drug related juvenile arrests	UCR	2001	11,405	2,102,288	543	322	While "at risk" population rose from 2001 to 2003 before falling below baseline by 2005, juvenile arrest rates attributable to drug use per 100,000 declined steadily by 80/100,000.
		UCR	2002	10,934	2,113,717	517	303	
		UCR	2003	9,661	2,125,357	455	282	
		UCR	2004	9,825	2,119,117	464	144	
		UCR	2005	9,718	2,100,505	463	Not available	
	Total drug law violation	UCR	2001	7676	2,123,725	361	362	While "at-risk" population remained constant from 2001 to 2003, drug law violations per 100,000 declined by 65/100,000 through 2003 and rebounded by 14 through 2005.
		UCR	2002	7299	2,123,725	344	303	
		UCR	2003	6288	2,123,725	296	403	
		UCR	2004	6532	2,123,725	308	482	
		UCR	2005	6593	2,123,725	310	Not available	
Incidents of school crime	Incidents of school crime: Substances	CRVV	2002-03	2,754	557,215	494	Not available	While "at-risk" population rose from 2003 to 2005, school crime from substance use dropped 5 per 100,000.
		CRVV	2003-04	2,648	572,532	463	Not available	
		CRVV	2004-05	2,725	587,136	464	Not available	
	Incidents of school crime: Marijuana	CRVV	2002-03	1,883	557,215	338	Not available	While "at-risk" population rose from 2003 to 2006, school crime from marijuana use fluctuated, ending down 16 per 100,000.
		CRVV	2003-04	1,833	572,532	320	Not available	
		CRVV	2004-05	1,898	587,136	323	Not available	
		CRVV	2005-06	1,794	594,206	302	Not available	
CRVV: NJ Department of Education Commissioner's Annual Report to the Education Committees of the Senate and General Assembly on Violence, Vandalism and Substance Abuse in New Jersey Public Schools								

Table E-5 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime (Continued)								
Incidents of school crime	Prescription drugs and depressants	CRVV	2002-03	162	557,215	29	Not available	The number of school-based incidents involving depressants and prescription drugs decreased after having not changed in the prior three years.
		CRVV	2003-04	162	572,532	28	Not available	
		CRVV	2004-05	166	587,136	28	Not available	
		CRVV	2005-06	132	594,206	22	Not available	
	Inhalants, narcotics, hallucinogens, cocaine, party drugs, amphetamines	CRVV	2002-03	182	557,215	33	Not available	School-based incidents involving the possession/use of drugs other than marijuana and depressants have increased over the past four years.
		CRVV	2003-04	189	572,532	33	Not available	
		CRVV	2004-05	224	587,136	38	Not available	
		CRVV	2005-06	246	594,206	41	Not available	

Table E-6 Substance Abuse Constructs and Indicators: Drug Consequences								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Crime (Continued)								
Possession / use arrests	Total arrests	UCR	2001	39,276	8,504,864	462	Not available	Arrests for possession/use of drugs accounted for 73% of all arrests, and the remaining 27% were for the sale/manufacturing of drugs.
		UCR	2002	39,196	8,576,089	457	Not available	
		UCR	2003	38,644	8,640,028	447	Not available	
		UCR	2004	40,632	8,685,166	468	Not available	
	Opium or cocaine and their derivatives	UCR	2001	17,186	8,504,864	202	Not available	Arrests for opium or cocaine represent 47% of the possession/use category. Overall possession/use arrests for opium or cocaine is on the rise while there is a decline for synthetic narcotic.
		UCR	2002	17,801	8,576,089	208	Not available	
		UCR	2003	17,269	8,640,028	200	Not available	
		UCR	2004	18,966	8,685,166	218	Not available	
	Marijuana and hashish	UCR	2001	19,335	8,504,864	227	Not available	
		UCR	2002	18,631	8,576,089	217	Not available	
		UCR	2003	18,915	8,640,028	219	Not available	
		UCR	2004	18,939	8,685,166	218	Not available	
	Synthetic narcotics	UCR	2001	839	8,504,864	10	Not available	
		UCR	2002	765	8,576,089	9	Not available	
		UCR	2003	608	8,640,028	7	Not available	
		UCR	2004	739	8,685,166	9	Not available	
	Other dangerous non-narcotic drugs	UCR	2001	1,916	8,504,864	23	Not available	
		UCR	2002	1,999	8,576,089	23	Not available	
		UCR	2003	1,852	8,640,028	21	Not available	
		UCR	2004	1,988	8,685,166	23	Not available	
New Jersey Department of Law & Public Safety, Uniform Crime Report								

APPENDIX F
Drug Consumption

Table F-1 Substance Abuse Constructs and Indicators: Drug Consumption								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Any Illicit Drug Use								
Past month drug use	Persons age 12 years and older reporting any use of illicit drugs	NSDUH	1999 - 2000	410,000	6,688,418	6,130	Not available	The curve of reported use per 100,000 in this age group shows a reversal of the direction of change in each succeeding time interval, with an overall upward trend of 1.08% peaking in 2004/2005.
		NSDUH	2000 - 2001	390,000	6,735,751	5,790	Not available	
		NSDUH	2002 - 2003	494,000	7,087,518	6,970	Not available	
		NSDUH	2003 - 2004	490,000	7,142,857	6,860	8,060	
		NSDUH	2004 - 2005	517,000	7,170,596	7,210	8,020	
	Persons age 12 - 17 years reporting any use of illicit drugs	NSDUH	1999 - 2000	59,000	627,660	9,400	Not available	The curve of reported use per 100,000 for 12-17 year olds shows a decline in the second year followed by a peak in 2002/2003 and successive decreases in the last two intervals. The overall trend was upward by 0.24%.
		NSDUH	2000 - 2001	58,000	656,109	8,840	Not available	
		NSDUH	2002 - 2003	75,000	719,770	10,420	Not available	
		NSDUH	2003 - 2004	76,000	737,864	10,300	10,920	
		NSDUH	2004 - 2005	72,000	746,888	9,640	10,250	
	Persons age 18 - 25 years reporting any use of illicit drugs	NSDUH	1999 - 2000	140,000	708,502	19,760	Not available	Reported use for young adults showed a down, peak, down, down trend as for adolescents, with an overall upward trend of 0.69%.
		NSDUH	2000 - 2001	144,000	767,591	18,760	Not available	
		NSDUH	2002 - 2003	169,000	791,199	21,360	Not available	
		NSDUH	2003 - 2004	174,000	815,370	21,340	19,830	
		NSDUH	2004 - 2005	170,000	831,296	20,450	19,760	
	Persons age 26 years and older reporting any use of illicit drugs	NSDUH	1999 - 2000	212,000	5,683,646	3,730	Not available	Reported use for those over 25 years showed a down, up, down, peak trend as for all persons, with an overall upward increase of 1.18%.
		NSDUH	2000 - 2001	188,000	5,164,835	3,640	Not available	
		NSDUH	2002 - 2003	250,000	5,580,357	4,480	Not available	
		NSDUH	2003 - 2004	238,000	5,560,748	4,280	5,600	
		NSDUH	2004 - 2005	275,000	5,600,815	4,910	5,650	
NSDUH (National Survey on Drug Use & Health), Office of Applied Studies, SAMHSA								

Table F-2 Substance Abuse Constructs and Indicators: Drug Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Population at Risk	National Average Rate	Trend across time and with respect to national data
Drug Use by 7th and 8th Grade Students								
Total drug use by 7th and 8th grade students in NJ	Marijuana lifetime use	MSSUS	1999	7,864	11.8%	174,590	19.2%	Marijuana use has decreased since 1999 and is below the 2002 national average.
		MSSUS	2001	14,646	6.4%	189,322		
		MSSUS	2003	10,730	6.2%	206,079		
	Inhalants lifetime use	MSSUS	1999	7,807	8.0%	174,590	15.2%	Inhalant use has increased from 8% in 1999 to 8.4% in 2003.
		MSSUS	2001	14,507	9.1%	189,322		
		MSSUS	2003	10,704	8.4%	206,079		
	Any illicit drug use, lifetime	MSSUS	1999	7,606	20.7%	174,590	Not available	Illicit drug use has decreased steadily since 1999, by 6.4%.
		MSSUS	2001	14,740	15.6%	189,322		
		MSSUS	2003	10,767	14.3%	206,079		
MSSUS (New Jersey Middle School Substance Use Survey) 2002 Monitoring the Future used for national rate								

Table F-3 Substance Abuse Constructs and Indicators: Drug Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Population at Risk	National Average Rate	Trend across time and with respect to national data
Drug Use by High School Students								
Total use and early use by youth under 21 years old in New Jersey	Lifetime marijuana use by high school students	YRBS	1995	3,529	39.1%	296,490	42%	Use of marijuana by NJ high school students was less than the national average. Lifetime use has declined slightly as has the national rate.
		YRBS	2001	2,142	41.4%	322,551	42%	
		NJSHS	2005	1,495	35.7%	378,142	38%	
	Use of marijuana before 13 years old	YRBS	1995	3,529	5.0%	296,490	8%	In 2005, early onset of marijuana use returned to its 1995 figure after having nearly doubled in 2001.
		YRBS	2001	2,142	9.2%	322,551	10%	
		NJSHS	2005	1,495	4.6%	378,142	9%	
	Past 30 days marijuana by high school student	YRBS	1995	3,529	24.3%	296,490	25%	Past 30-day marijuana use in New Jersey declined as did the national rate.
		YRBS	2001	2,142	24.9%	322,551	24%	
		NJSHS	2005	1,495	19.9%	378,142	20%	
	Lifetime inhalant use by HS students	YRBS	1995	3,529	19.6%	296,490	20%	Lifetime inhalant use declined over the 10-year period in parallel with the national decline reported
		YRBS	2001	2,142	12.7%	322,551	15%	
		NJSHS	2005	1,495	10.1%	378,142	12%	
YRBS: Youth Risk Behavior Surveillance System								

Table F-4 Substance Abuse Constructs and Indicators: Drug Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Number of Colleges Surveyed	National Average Rate	Trend across time and with respect to national data
Use of Drugs in College Campus								
Use of marijuana by college students	Marijuana use during the year	CORE	2002	3,462	39.2%	8	Not available	Past year marijuana and other illicit drug use by college students has steadily declined from 2002 through 2006. Weekly marijuana use has also declined in the same time period by almost half (14.1% down to 7.4%)
		CORE	2003	4,570	36.7%	10	Not available	
		CORE	2004	3,312	35.1%	9	Not available	
		CORE	2005	3,702	34.2%	9	Not available	
		CORE	2006	2,301	25.5%	9	Not available	
	Monthly marijuana use	CORE	2002	3,462	23.1%	8	Not available	
		CORE	2003	4,570	21.8%	10	Not available	
		CORE	2004	3,312	18.7%	9	Not available	
		CORE	2005	3,702	18.7%	9	Not available	
		CORE	2006	2,301	13.1%	9	Not available	
	Weekly marijuana use	CORE	2002	3,462	14.1%	8	Not available	
		CORE	2003	4,570	13.4%	10	Not available	
		CORE	2004	3,312	10.8%	9	Not available	
		CORE	2005	3,702	11.2%	9	Not available	
		CORE	2006	2,301	7.4%	9	Not available	
Survey of Social Norms, CORE Institute, Southern Illinois University								continued

Table F-4 Substance Abuse Constructs and Indicators: Drug Consumption								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students)	Number of Colleges Surveyed	National Average Rate	Trend across time and with respect to national data
Use of Drugs in College Campus (continued)								
Frequency of drug use other than marijuana by college students	Other illicit drug use during the year	CORE	2002	3,462	15.00%	8	Not available	Past year illicit drug use has steadily declined by 7.1% over a 5 year period.
		CORE	2003	4,570	12.40%	10	Not available	
		CORE	2004	3,312	10.90%	9	Not available	
		CORE	2005	3,702	10.40%	9	Not available	
		CORE	2006	2,301	7.90%	9	Not available	
	Use other illicit drugs monthly	CORE	2002	3,462	5.2%	8	Not available	Monthly illicit drug use has fallen from 2002 through 2006 by almost 2%.
		CORE	2003	4,570	5.2%	10	Not available	
		CORE	2004	3,312	4.8%	9	Not available	
		CORE	2005	3,702	3.9%	9	Not available	
		CORE	2006	2,301	3.5%	9	Not available	
	Uses other illicit drugs weekly	CORE	2002	3,462	1.5%	8	Not available	About 2% of college students use other drugs on a weekly basis.
		CORE	2003	4,570	1.8%	10	Not available	
		CORE	2004	3,312	1.6%	9	Not available	
		CORE	2005	3,702	1.8%	9	Not available	
		CORE	2006	2,301	1.6%	9	Not available	

APPENDIX G
Other Risk Factors

Table G-1 Other Risk Factors: Non Medical Use of Prescription Drugs								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Past year non-medical use of prescription drugs	12 and older	NSDUH	2002-2004	295,000	7,170,596	4,114	5,200	
	12-17 years old			56,000	746,888	7,498	9,100	
	18-25 years old			91,000	798,246	11,400	14,500	
	25 and older			147,000	5,600,815	2,625	4,400	
Past year non-medical use of pain relievers	12 and older	NSDUH	2002-2003	258,141	7,170,596	3,600	4,790	
	12-17 years old			43,992	746,888	5,890	7,510	
	18-25 years old			88,685	798,246	11,110	11,700	
	25 and older			135,540	5,600,815	2,420	3,200	
	12 and older	NSDUH	2003-2004	283,999	7,170,596	3,961	4,790	
	12-17 years old			45,000	746,888	6,025	7,510	
	18-25 years old			91,000	798,246	11,110	11,700	
	25 and older			147,000	5,600,815	2,420	3,200	
	12 and older	NSDUH	2004-2005	296,000	7,170,596	4,128	4,790	
	12-17 years old			47,000	746,888	6,293	7,530	
	18-25 years old			91,000	798,246	11,400	11,910	
	25 and older			158,000	5,600,815	2,821	3,160	

Table G-2 Other Risk Factors: Tobacco Use by Middle School and High School Students								
Construct	Indicator	Source	Year	Number of Students Surveyed	Prevalence (percent of surveyed students	Population at Risk	National Average Rate	Trend across time and with respect to national data
Tobacco Use								
Tobacco use by middle school and high school students	Tobacco lifetime use middle school grades 7-8	NJYTS	1999	8798	Not available	174,590	Not available	Current use of any tobacco significantly decreased among middle school students from 1999 (18.9%) to 2004 (9.5%).
		NJYTS	2001	5413	32.1%	189,322	Not available	
		NJYTS	2004	2187	25.5%	206,079	Not available	
	Tobacco current use middle school grades 7-8	NJYTS	1999	8798	18.9%	174,590	Not available	Declines seen in youth smoking prevalence on the NJYTS are consistent with trends seen on YRBS over the last several years.
		NJYTS	2001	5413	11.8%	189,322	Not available	
		NJYTS	2004	2187	9.5%	206,079	Not available	
	Tobacco lifetime use high school grades 9-12	NJYTS	1999	7318	Not available	312,428	Not available	There was a significant decline in current use of any tobacco by high school students from 1999 (38.9%) to 2004 (26.8%)
		NJYTS	2001	4176	64.5%	332,427	Not available	
		NJYTS	2004	2390	539.%	364,533	Not available	
	Tobacco current use high school grades 9-12	NJYTS	1999	7318	38.9%	312,428	Not available	
		NJYTS	2001	4176	33.6%	332,427	Not available	
		NJYTS	2004	2390	26.8%	364,533	Not available	
New Jersey Youth Tobacco Survey – Middle School & High School Only past 30 day rates reported in the 1999 NJYTS								

Table G-3 Other Risk Factors: HIV/AIDS								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Mortality and Morbidity								
Mortality	HIV/AIDS death	NJCHS	2001	785	8,612,222	8.8	Not available	
		NJCHS	2002	762	8,695,460	8.5	Not available	
		NJCHS	2003	764	8,640,028	8.6	Not available	
HIV Co-morbidity	HIV and Hepatitis C diagnosis among hospital discharges	NJDHSS	2001	1,184	8,414,350	14.1	Not available	A nearly two-fold increase in the rate per 100,000 of hospital discharges with dual HIV and Hepatitis C diagnoses
		NJDHSS	2003	1,656	8,638,396	19.2	Not available	
		NJDHSS	2005	2,507	8,698,879	28.8	Not available	
	Cumulative AIDS cases with tuberculosis	NJDHSS	2001	2,490	8,414,350	29.6	Not available	
		NJDHSS	2004	2,634	8,638,396	30.5	Not available	
		NJDHSS	2005	2,667	8,698,879	30.7	Not available	
NJ Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services								

Table G-3 Other Risk Factors: HIV/AIDS								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Living with HIV/AIDS								
Estimated number of females living with HIV/AIDS by exposure category	Injection drug use (IDU)	NJDHSS	2000	3,621	4,331,537	83.6	Not available	Significant increase in the number of women with heterosexual exposure to HIV from 2000 to 2005
		NJDHSS	2004	3,555	4,434,784	80.2	Not available	
		NJDHSS	2005	3,414	4,463,026	76.5	Not available	
	Heterosexual contact	NJDHSS	2000	3,732	4,331,537	86.2	Not available	
		NJDHSS	2004	6,927	4,434,784	156.2	Not available	
		NJDHSS	2005	7,063	4,463,026	158.3	Not available	
NJ Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services								

Table G-3 Other Risk Factors: HIV/AIDS								
Construct	Indicator	Source	Year	Number of Cases	Population at Risk	Rate per 100,000 Population at Risk	National Average Rate	Trend across time and with respect to national data
Living with HIV/AIDS								
Estimated number of males Living with HIV/AIDS by exposure category	Male-to-male sex	NJDHSS	2000	4,916	4,082,813	120.4		
		NJDHSS	2004	6,100	4,203,612	145.1		
		NJDHSS	2005	6,263	4,235,853	147.9		
	Injection drug use (IDU)	NJDHSS	2000	6,696	4,082,813	164		
		NJDHSS	2004	6,484	4,203,612	154.2		
		NJDHSS	2005	6,190	4,235,853	146.1		
	Men who have sex with men/IDU	NJDHSS	2000	845	4,082,813	20.7		
		NJDHSS	2004	860	4,203,612	20.5		
		NJDHSS	2005	843	4,235,853	19.9		
	Heterosexual contact	NJDHSS	2000	1,797	4,082,813	44.0		A nearly three-fold increase in the rate per 100,000 of men exposed to HIV through heterosexual contact
		NJDHSS	2004	5,298	4,203,612	126.0		
		NJDHSS	2005	5,499	4,235,853	129.8		
NJ Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services								

APPENDIX H
Data Sources and Descriptions

The **Behavioral Risk Factor Surveillance System (BRFSS)** is a large telephone survey that is coordinated by the Centers for Disease Control and Prevention (CDC). Each month, state health departments conduct surveys of non-institutionalized adults to obtain data on behaviors associated with increased risk for chronic diseases and other health related factors (CDC, 2005). The BRFSS collects annual data on alcohol and cigarette consumption. In both 1997 and 1999 they also collected information on people driving while intoxicated.

The Core Alcohol and Drug Survey (CORE) was developed under a grant from the U.S. Department of Education and conducted annually by the Core Institute, a not-for-profit organization. The survey is used by universities and colleges to determine the extent of substance use and abuse on their campuses. The survey is now administered by the CORE Institute at Southern Illinois University - Carbondale (SIUC).

Violence, Vandalism and Substance Abuse in New Jersey Public Schools. The Commissioner's Annual Report to the Education Committees of the Senate and General Assembly (CRVV). The Commissioner's report provides the Legislature with data in four broad categories of incidents: violence, vandalism, weapons and substance abuse. Analysis of trends yields indications of progress and of concern and provides guidance to the department as it endeavors to focus its resources appropriately. In this report, the department also notifies the Legislature and the public of the actions taken by the Commissioner, State Board of Education and the Department of Education (DOE) to address the problems indicated in the data.

The **New Jersey Division of Youth and Family Services (DYFS)** collects data on child abuse and neglect that is reported to the National Child Abuse and Neglect Data System (NCANDS), the Children's Bureau, Administration on Children, Youth and Families in the Administration of Children and Youth, U.S. Department of Health and Human Services.

The National Highway Traffic Safety Administration (NHTSA) created the **Fatality Analysis Reporting Systems (FARS)** to collect data on severe traffic crashes nationally. To be included in FARS, a crash must involve a motor vehicle traveling on a road open to the public, and must result in the death of an occupant of a vehicle or a non-motorist within 30 days of the crash (USDOT, 2004). This data includes alcohol-related crash information for crashes involving a fatality.

The Intoxicated Driver Program (IDP) is a unit of the Division of Addiction Services of the New Jersey, Department of Human Services. The IDP receives reports of conviction from the courts and schedules convicted Driving While Intoxicated (DWI) offenders for Intoxicated Driving Resource Center (IDRC) participation. The IDP recommends suspension or restoration of driving privileges as appropriate. The IDP also monitors the compliance of out-of-state residents and residents convicted of DUI out-of-state with the requirements of the law. The IDP is also responsible for oversight of the Intoxicated Driving Resource Centers. This program compiles an Annual Statistical

Summary Report on all IDP clients who attend the 12 and 48-hour IDRC education and evaluation sessions.

The **National Survey on Drug Use and Health (NSDUH),** funded by SAMHSA, is data collected via in-person interviews, incorporating additional procedures to ensure respondents' cooperation and willingness to report honestly about their behavior. Confidentiality is stressed in all written and oral communications with potential respondents, respondents' names are not collected with the data, and computer-assisted interviewing (CAI) methods, including audio computer-assisted self-interviewing (ACASI), are used to provide a private and confidential setting in which to complete the interview (SAMHSA, 2003). Data is available in two-year groups about reported substance use, abuse, dependency, and treatment received.

The New Jersey Center for Health Statistics (NJCHS) collects, researches, analyzes and disseminates New Jersey health data and information and serves as a resource to the Department in development of health data policy. produces annual reports of vital events: births, deaths, fetal deaths, and marriages. The agency collects data and prepares reports on induced terminations of pregnancy and health-related behaviors. It provides baseline and trend data to measure the impact of public health strategies for disease prevention and health promotion. NJCHS disseminates health insurance coverage data. Maintains the NJSHAD state data query system. It houses the Office of Injury Surveillance and Prevention (OISP) which is the central source for injury statistics and information on injury prevention and control efforts in New Jersey. OISP is also home to several special injury projects such as a central nervous system injury registry and a violent death reporting system. NJCHS responds to requests for state vital events and other health data.

The New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (NJDHSS) coordinates all State-government activities related to HIV/AIDS. collects, manages, reviews, analyzes, interprets, and disseminates information from HIV/AIDS surveillance activities. These activities include case finding epidemiologic investigations and HIV incidence and behavioral studies. The data containing all the confidential HIV and AIDS case reports from field investigations, health care providers and laboratories is analyzed, interpreted and maintained in the confidential HIV/AIDS registry. Summary reports are disseminated through the HIV/AIDS semi-annual summaries.

The New Jersey Middle School Substance Use Survey (MSSUS) is conducted by DAS bi annually to provide scientifically sound information to state-level, county-level and community-level prevention planners and policy makers. It is administered to 7^{th} and 8^{th} graders in New Jersey. It assesses the current prevalence of both problem behaviors related to alcohol, tobacco and other drug (ATOD) use and other delinquent behaviors in the surveyed population, as well as the degree to which risk and protective factors exist in the community, family, school and peer and individual environments.

The **Treatment Episode Data Set (TEDS)**, compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA), is an annual compilation of data on

substance abuse treatment events (admissions and discharges) that are routinely collected by states in monitoring their individual substance abuse treatment systems. It includes, primarily, information on clients admitted to programs that receive public funds (SAMHSA, 2005). This is one of the only sources of data on substance abuse admissions and therefore an important source, but it is not an exhaustive report, and not all cases are reported.

The Uniform Crime Report (UCR) is an annual report completed by the FBI to look at crime happening at a national and state level. The FBI provides local agencies with a classification guide so that they can report crime happening in their area in a standardized way, and this data can be compiled by the national government. Arrest data was examined from these reports.

The New Jersey Uniform Crime Reporting (UCR) Program is part of a nationwide, cooperative statistical effort administered by the Federal Bureau of Investigation. Law enforcement agencies throughout New Jersey voluntarily submit data to the State Bureau of Investigation on specific crimes committed in their areas of jurisdiction. The state of NJ then produces an annual report on the collected data, called the NJ Annual Crime Report. This source includes specific information on drug law offenses in the state.

The Youth Risk Behavior Survey (YRBS) is another large survey conducted by the CDC, of 9th to 12th graders in United States high schools. The survey is conducted every other year to obtain information on priority adolescent health issues including unintentional injury, violence, tobacco use, and alcohol and drug use (CDC, 2004). This data set was an effective way to ascertain state and national data on teen behavior.

New Jersey Student Health Survey (NJSHS) is a survey administered to high school and middle school students by the New Jersey Department of Education (NJDOE).The survey questions are based on the Youth Risk Behavior Survey (YRBS) which is one component of the Youth Risk Behavior Surveillance System.

The New Jersey Youth Tobacco Survey (NJYTS) is based on The Centers for Disease Control and Prevention's (CDC) National Youth Tobacco Survey (YTS) to provide states with the data necessary to support the design, implementation, and evaluation of comprehensive tobacco control programs, including state population-based estimates of the prevalence of tobacco use among middle and high school students. This report focuses on current patterns of tobacco use among New Jersey youth. The NJYTS was first conducted in 1999 and was repeated in 2001, 2004 and 2006.