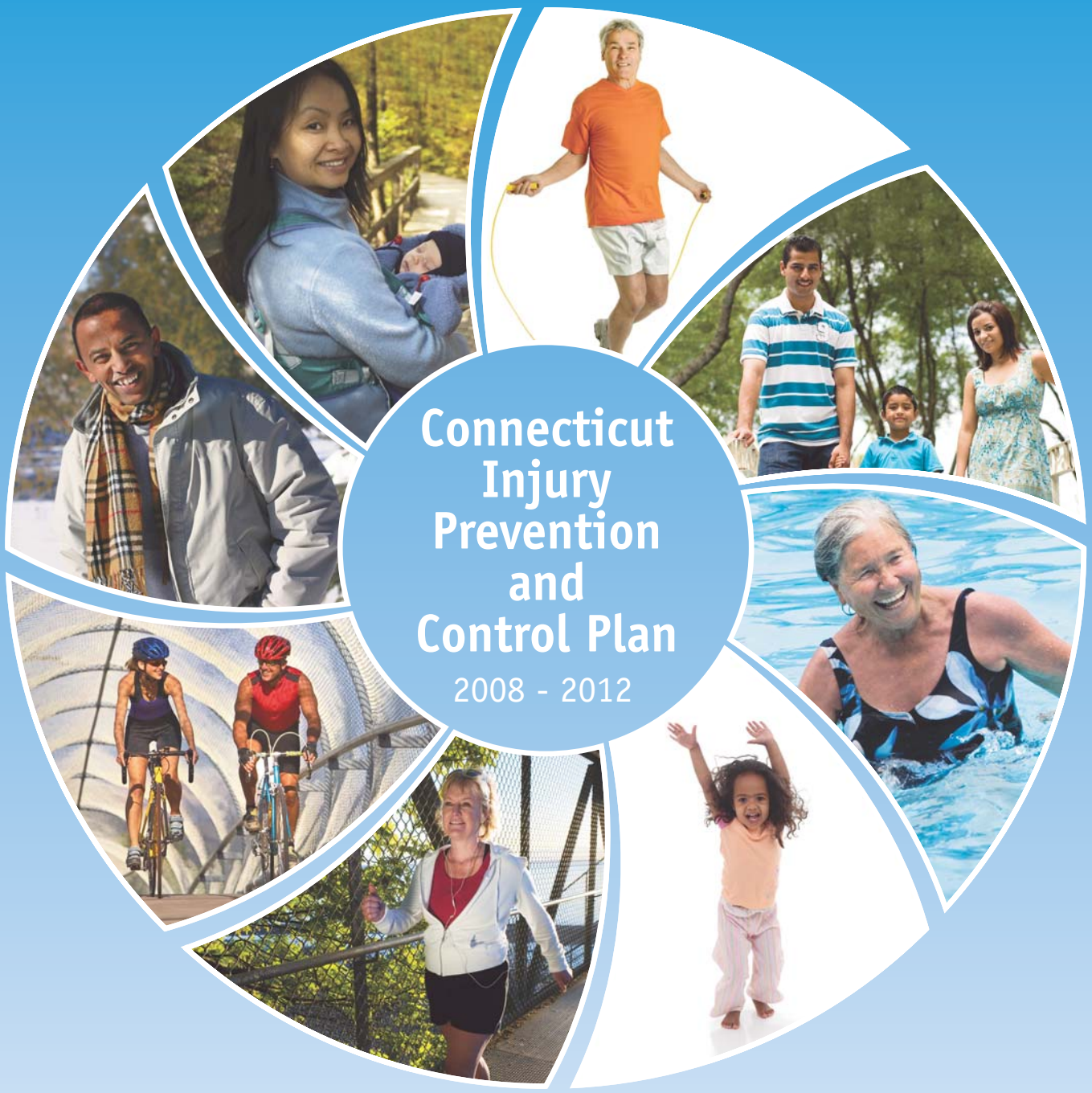


Connecticut Injury Prevention and Control Plan

2008 - 2012

Keeping Connecticut Healthy

DPH

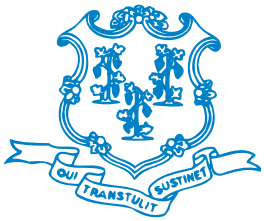
Connecticut Department of Public Health

State of Connecticut Department of Public Health

Injury Prevention and Control Plan - 2008

Injuries Are Preventable

CONNECTICUT INJURY PREVENTION AND CONTROL PLAN 2008



Acknowledgements

J. Robert Galvin, MD, MPH, MBA Commissioner
Connecticut Department of Public Health

Richard Edmonds, MA, Branch Chief
Public Health Initiatives Branch

Renee Coleman-Mitchell, MPH, Section Chief
Health Education, Management and Surveillance Section

Prepared by:

Margie Hudson, RN, BSN, MPH, Injury Prevention Program
Marian Storch, BS, Injury Prevention Program
Mukhtar H. Mohamed, MPH, MA, Injury Prevention Program
Eileen Boulay, RN, BS, Program Supervisor

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Connecticut Department of Public Health
Injury Prevention Program
Public Health Initiatives Branch, Health Education, Management and Surveillance Section
P.O. Box 340308
410 Capitol Ave., MS# 11HLS
Hartford, CT 06134-0308
Phone: (860)509-8251

www.ct.gov/dph

Statewide Injury Community Planning Group

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Judith Andrews	CT Department of Education
Hyacinth Douglas-Bailey	YMCA of Greater Hartford
Dorothy Baker, Ph.D.	Yale University School of Medicine, CT Collaboration for Fall Prevention
Bruce Bernstein, Ph.D.	St. Francis Hospital and Medical Center
Carol E. Bower	CT Department of Public Health, State Health Planning Section
Cate Bourke	CT Assets Network/Safe Schools Advisory Committee
Melanie Bonjour, BS, CHES	Danbury Health Department, School-Based Health Centers
Karen Brock, MPH	Safe Kids Connecticut, CT Children's Medical Center
Elizabeth C. Brown, BA	CT Commission on Children
Valerie Bryan, RN	CT Department of Public Health, Day Care Licensing Section
Louis Campbell, BA, MA	New Haven Public Schools
Constance Catrone, LCSW	Bridgeport Health Department, School-Based Health Centers
Cindy Collins	U.S. Consumer Product Safety Commission
John Chapman, Psy.D.	State of CT Judicial Branch, Court Support Services Division
Joseph T. Cristalli, Jr.	CT Department of Transportation, Transportation Safety Section
Albert Deloreto, MPH	CT Department of Public Health, Occupational Health Section
Linda Degutis, Ph.D.	Yale University School of Medicine
Rev. Paul Echtenkamp	Youth Challenge of CT Inc.
Paul R. Falzer, Ph.D.	Yale University School of Medicine
Karen Foley-Shain, MA, M.Ed, LPC	Children's Trust Fund
Sylvia Gafford-Alexander, MSW	CT Department of Social Services
Sarah Gauger, MPH	CT Department of Social Services, Aging Services Division
Duckworth Grange, BS	CT Department of Children and Families, Hartford Regional Office
Amy Hanoian-Fontana, MA, EMT-B	CT Poison Control Center, University of Connecticut Health Center
Nancy Harnick	CT Department of Developmental Services

Statewide Injury Community Planning Group (cont.)

Stephen Holland, MD	St. Mary's Hospital
Leigh Jones-Bammon, MS	The Governor's Prevention Partnership
Pamela Kilbey-Fox, MPH	CT Department of Public Health, Local Health Administration
Ivan Kuzyk	Independent Consultant for US Attorney's Office
Valerie Lamotte, JD	CT Office of Policy and Management
Garry Lapidus, PA-C, MPH	CT Children's Medical Center, Injury Prevention Center
DeAnna Lia, MA	CT Department of Children and Families Youth Suicide Advisory Board
Stephen P. Livingston	CT Department of Transportation, Transportation Safety Section
Amanda Mangene	CT Department of Social Services/Traumatic Brain Injury
Barbara Nadeau	Brain Injury Association of CT
Scott Newgass, MSW, LCSW	CT State Department of Education
Jay Nowakowski, RN, BA	CT Department of Public Health/ Office of Emergency Medical Services
Patrick Nickoletti, Ph.D.	St. Joseph College
Robert Nakano	CT Department of Consumer Protection
Judy O'Connor, RN	Hospital of St. Raphael, Trauma Program
Regina Owusu, RN, BSN, MPH	CT Department of Public Health
Kate Parker, BSW	CT Sexual Assault Crisis Services Inc.
Julie Peters	Brain Injury Association of CT
Marion Pollack, RN	Western CT Area Agency on Aging
Katherine J. Smith, MSW	St. Francis Hospital and Medical Center, Injury and Violence Prevention Program
Sharon Tarala, RN, JD	CT Department of Public Health, Family Health Section
Faith VosWinkel, MSW	Office of the Child Advocate
Patricia Weel	CT Department of Social Services/Child Maltreatment Domestic Violence Collaborative
LoriBeth W. Young, JD, MHSA	CT Department of Social Services/Interagency Suicide Prevention Network
Joanne Zannoni, MSW, LICSW	CT Sexual Assault Crisis Services, Inc.

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Executive Summary

Injuries are the leading cause of death among Connecticut residents between the ages of one and forty-four years and the fifth leading cause for all ages. Among young persons between the ages of fifteen and twenty-four years, injuries are responsible for over 72% of all deaths. Non-fatal injuries are responsible for approximately 17,000 inpatient hospitalizations and 333,217 emergency department visits each year. The direct charges for inpatient hospitalizations alone, due to injury, totaled $1.6 billion between 2000 and 2004. These charges did not include physician fees, rehabilitation or long-term care costs.

The Connecticut Department of Public Health (DPH) received an Integrated Core Injury Prevention and Control Grant from the Centers for Disease Control and Prevention in 2005. The purpose of this funding was to build injury surveillance capacity, integrate surveillance with program planning and evaluation, and develop a comprehensive state injury prevention and control plan. As part of the CDC Integrated Core Injury Prevention and Control Grant (CDC Grant), the DPH published Injury in Connecticut, a comprehensive compilation of Connecticut data on injury for all ages and injury categories.

The DPH Injury Prevention Program convened an Injury Community Planning Group (ICPG), a critical component of the process and a requirement of the CDC grant. This multi-disciplinary ICPG included new and existing and partners from other state agencies, community-based organizations, state and local injury-related coalitions, academic and health care institutions and other partners.

The ICPG worked with the DPH Injury Prevention Program to 1) review injury surveillance data, 2) identify existing effective state injury prevention programs and policies 3) identify and prioritize state injury problems, 4) provide input to the state injury plan and 5) identify evidence based interventions, potential implementing partners, resources and funding sources.

The Injury Prevention Program incorporated injury-related goals and objectives from the U.S. Department of Health and Human Services Healthy People 2010 into the framework for the Connecticut Injury Prevention and Control Plan. The ICPG and the Injury Prevention Program identified HP2010 objectives and additional partners and developed additional goals, objectives, strategies and action steps for each injury category. During the process, common themes became apparent and the following overarching goals were identified:

- Increase the quality, availability and timeliness of statewide and community specific data for planning, surveillance, and evaluation
- Establish a sustainable infrastructure to coordinate, monitor, and evaluate state plan implementation
- Build community capacity to reduce and prevent injuries to high-risk groups and effectively address injury priorities
- Improve awareness of injury prevention among stakeholders and the general public
- Increase the use of evidence-based interventions
- Build capacity to develop evaluation measures that assess the impact of the state injury plan, and other injury prevention initiatives and interventions
- Strengthen advocacy for public policies that impact injury prevention

The Connecticut Injury Prevention and Control Plan builds on activities underway within the Department of Public Health, among ICPG partners, other state agencies, health care, education and social service organizations; academic institutions, and community-based organizations through existing initiatives, collaborations, and coalitions. The Plan, through partnerships that have expertise in injury prevention and related issues will assist in systems, policy, initiative and other changes necessary to reduce injury.

Executive Summary (cont.)

The Injury Community Planning Group identified four priority injuries:

- older adult falls
- suicides /self-inflicted injuries
- homicides /assault injuries
- motor vehicle crashes

These priorities were chosen because they are leading causes of injury-related mortality and morbidity in Connecticut. In addition, there are organized constituents and coalitions already addressing these issues, and effective or promising interventions are available.

The Connecticut Injury Prevention and Control Plan and the Injury in Connecticut Data Book are the first Connecticut focused, comprehensive injury documents produced by the Department of Public Health's Injury Prevention Program, the Injury Community Planning Group and other partners. The Plan and Data book will assist partners, constituents, policy-makers and others as they work to reduce and eliminate injury-related deaths and disabilities.

Introduction and Background

Injury Prevention Program

The Injury Prevention Program was established in 1993. Section 19a-4i of Connecticut General Statutes established an Office of Injury Prevention within the Department of Public Health "whose purpose shall be to coordinate and expand prevention and control activities related to intentional and unintentional injuries." The duties of the Injury Prevention Program "include but are not limited to, the following: 1) serve as a data coordinator and analysis source of mortality and injury statistics for other state agencies; 2) integrate an injury and violence prevention focus within the Department of Public Health; 3) to develop collaborative relationships with other state agencies and private and community organizations to establish programs promoting injury prevention, awareness and education to reduce automobile, motorcycle and bicycle injuries and interpersonal violence, including homicide, child abuse, youth violence, domestic violence, sexual assault and elderly abuse; 4) to support the development of comprehensive community-based injury and violence prevention initiatives within cities and towns of the state; and 5) to develop sources of funding to establish and continue programs to promote prevention of intentional and unintentional injuries." The Injury Prevention Program is staffed by two Program Coordinators and an Epidemiologist.

Integrated Core Injury Prevention & Control Grant

The State of Connecticut Department of Public Health's Injury Prevention Program received a Centers for Disease Control and Prevention Integrated Core Injury Prevention and Control Grant (ICIPC). The purpose of the five-year grant was to enable DPH to 1) Obtain, analyze and disseminate the most recently available data in a timely manner, 2) Integrate injury surveillance with injury program planning and evaluation through a comprehensive and systematic process, 3) Establish and maintain a multidisciplinary Injury Community Planning Group with broad representation from key partners and injury-related collaborations and 4) Develop a comprehensive state injury prevention and control plan. The ICIPC funds a full-time epidemiologist.

The Planning Process

The Injury Prevention Program (Program) held the first meeting of the Injury Community Planning Group (ICPG) in January 2006. The ICPG includes partners from other state agencies, community-based organizations, state and local injury prevention related coalitions, academic and health care institutions and others. A list of ICPG partners is included on pages 2 and 3. The vision for the ICPG is to reduce fatal and non-fatal injuries in Connecticut. The mission statement is to work collaboratively with the Department of Public Health to increase the focus on and resources devoted to injury prevention and control, provide a collective voice to support needed injury prevention legislation, assist decision makers to make informed decisions, and improve our ability to measure the success of injury prevention initiatives. The ICPG is a partner that collaborates with the Injury Prevention Program with: 1) Review of injury surveillance data; 2) Identification of existing effective state injury-related policies; 3) Identification and prioritization of state injury problems; 4) Provision of input into the development of the state injury prevention and control plan; and 5) Identification of evidence-based intervention strategies, potential implementing partners, resources and funding sources.

Injury-related goals and objectives from Healthy People 2010 Volumes I and II (http://www.healthypeople.gov/Publications/) were used as a framework for development and evaluation of the Injury Prevention and Control Plan. The Plan includes goals from the Injury Prevention and Mental Health chapters of Healthy People 2010 as overall goals for the plan. The Plan includes Connecticut objectives for major injury categories. Evaluation measures include progress towards meeting objections and the extent to which interim and 2010 targets are met. The Program and the Injury Community Planning Group identified specific Healthy People 2010 objectives and developed Connecticut objectives and measures for overall injury and major injury categories. Some Healthy People 2010 objectives are included under specific injury categories and others are not being directly addressed in this document at this time.

The Injury Prevention and Control Plan was developed using data available through the State Department of Public Health (death), the State Department of Public Safety (Crimes Analysis Unit), the State Department of Children and Families (Town Pages), the State Department of Transportation (Fatality Analysis Reporting System and Safety Belt Use Survey), State Department of Labor, Connecticut OSHA, the CT Youth Risk Behavior / CT School Health Survey, the CT Behavior Risk Factor Surveillance System, CT Office of Health Care Access (Hospitalization) expertise of the Injury Prevention Program, Injury Community Planning Group and others. Connecticut targets were or will be established using data, trends and the best available information through the Program, the ICPG and other partners.

Injury Surveillance Data Sources

The two primary data sources used for setting priorities in the state injury prevention plan were mortality and inpatient hospitalization. Additional data sources were utilized for specific injury categories and are noted in relevant sections of the state plan.

Mortality data were obtained from the Connecticut Department of Public Health, Vital Records, death certificates for the calendar years 2000 to 2004. The injury mortality data presented here include all Connecticut residents who died, either in-state or out-of-state, during calendar years 2000 - 2004, with an underlying cause-of-death of injury, based on injury categories as defined in the *External cause-of-injury mortality matrix based on ICD-10* (National Vital Statistics Reports, Vol. 54, No. 10, January 31, 2006, p. 4.). Non-resident deaths are excluded from the analysis.

Inpatient hospitalization data were obtained from the Office of Health Care Access (OHCA) for the calendar years 2000 to 2004. Discharge data from all 31 non-federal, acute-care, inpatient facilities in the state are included in this data set. The injury hospitalization data set includes all Connecticut residents who were hospitalized during calendar years 2000 - 2004, with a principal diagnosis of injury, plus a valid external cause-of-injury code (E-code) as defined in the *STIPDA / CDC Recommended framework of E-code groupings for presenting injury mortality and morbidity data (February 16, 2005)*. Re-admissions, transfers and deaths in the hospital are included; the data are not de-duplicated, in keeping with current CDC recommendations. The data do not include Connecticut residents hospitalized out-of-state, and hospitalizations of non-residents are excluded from the analysis. Numbers of hospitalizations represent number of events, not number of individuals hospitalized. During this 5-year period, of the 86,967 patient records with an injury diagnosis, 95.8% (83,296) included a valid External Cause of Injury Code.

The Connecticut Department of Public Health's Injury Prevention Program has been working collaboratively with state, regional and local partners on injury prevention issues for a number of years. The major need identified by the Injury Community Planning Group is the need for timely, accessible, quality data, data analysis and subsequent dissemination so that it can be used by agencies, providers, constituents and others to increase awareness, plan programs, evaluate initiatives, establish policy and advocate for appropriate legislation. The CDC Integrated Core Injury Prevention and Control Grant has enabled the program to strengthen relationships with existing partners and work with new partners toward the common goal of decreasing injury related incidents, disabilities and deaths, in Connecticut.

Demographics

Connecticut is the southernmost New England state, bordered by Massachusetts to the north, Long Island Sound to the south, Rhode Island to the east, and New York to the west. The state is divided into 8 counties and 169 towns. Much of Connecticut's population lives in larger towns along the coastal plain and in the Connecticut River valley, which bisects the state from north to south.

Connecticut is characterized by high social and economic contrast and racial and ethnic diversity. It is the third smallest state in the U.S. in terms of area, but it has the 29th highest population and is the fourth most densely populated.[1] About 88% of Connecticut's population lives in urban areas. Whether in terms of health status, income, poverty, racial composition, or almost any other factor, statewide averages for Connecticut often are misleading. Striking disparities exist across town lines, among racial and ethnic groups, and between urban and rural populations. These differences have engendered the concept of "two Connecticuts,"[2] one comprising people who live in the wealthiest state in the nation, and the other consisting of those who live in some of the most severe and concentrated pockets of poverty in the U.S. Recently the notion of "five Connecticuts" based on disparate social and economic factors has been proposed.[3] The overall health of Connecticut's people varies dramatically between its wealthiest and poorest communities.

Connecticut's population is changing, and the demographic changes are reflected in both numbers and patterns of injury and evolving needs for health care and support services. Disparities in injury in relation to incidence, mortality, and treatment were fundamental considerations in the development of Connecticut's Injury Prevention Plan.

The Aging of the Population

Connecticut's population is older, on average, compared to the U.S. population as a whole. Older adults are the fastest growing segment of the population. Between 1990 and 2000 the median age of Connecticut residents increased from 34.4 years to 37.4 years, or 2.1 years greater than the national median age.[4] During the same period, the number of people 65 years of age and older grew by more than 24,000 (Table 1).

Table 1

Numbers and Percentages of Selected Population Groups

Connecticut, 1990 and 2000[6]

Population Group	1990 Number	1990 % of Total	2000 Number	2000 % of Total	Change from 1990 to 2000 Number	Change from 1990 to 2000 %
Total Population (all races and ages)	3,287,116	100	3,405,565	100	118,449	3.6
White	2,859,353	87.0	2,780,355	81.6	-78,988	-2.8
African American[a]	274,269	8.3	309,843	9.1	35,574	13.0
Asian American/Pacific Islander	50,698	1.5	83,679	2.5	32,981	65.1
American Indian/Alaskan Native	6,654	0.2	9,639	0.3	2,985	44.9
Hispanic/Latino (any race)	213,116	6.5	320,323	9.4	107,207	50.3
Older adults (65+ years of age)	445,907	13.6	470,183	13.8	24,276	5.4

Source: U.S. Census Bureau, 2000

[a] "African American" refers to African Americans and individuals who consider themselves Black.

Table 2

Selected Social and Economic Characteristics

Connecticut, 1990 and 2000 & United States, 2000

Characteristic	Connecticut 1990[7]	Connecticut 2000[8]	U.S. (2000)[9]
Less than 9th grade education (age 25+)	8.4%	5.8%	7.5%
High school graduates (age 25+)	79.2%	84.0%	80.4%
Bachelor's degree or higher	27.2%	31.4%	24.4%
Speak language other than English	15.2%	18.3%	17.9%
Do not speak English "very well"	6.0%	7.4%	8.1%
Per capita income[7]	$20,198	$28,766	$21,587
Persons living below poverty level[10]	6.6%	7.6%	12.4%

Source: U.S. Census Bureau, 2000

Shifts in Racial and Ethnic Composition

Injury rates and patterns vary across demographic groups, including racial and ethnic groups. From 1990 to 2000, the number and proportion of persons of white race in Connecticut decreased, whereas minority populations increased, in some cases by 50% or more (Table 1). Connecticut's population is predominately white (81.6%) and non-Hispanic (90.6%); however, the racial and ethnic composition is dramatically different in the state's largest towns. Non-whites account for 72% of the population in Hartford, 57% in New Haven, and 55% in Bridgeport, and Hispanics (of any race) represent 41%, 21%, and 32%, respectively, of the population in these three cities.[5] Hispanics are the largest minority group in Connecticut.

Social and Economic Characteristics

Educational Attainment

The educational attainment of Connecticut residents has been increasing, and compared to the U.S. population as a whole, they have higher levels of education (Table 2). In 2000, 84% of Connecticut residents 25 years of age and older were high school graduates or higher, and 31% had completed a bachelor's degree or more, whereas less than 6% had less than a 9th grade education. In contrast to statewide figures, however, in Hartford and Bridgeport only 61% and 65% of residents, respectively, were high school graduates, only about 12% had a bachelor's degree or higher, and 17% and 15%, respectively had less than a 9th grade education.

Language Spoken at Home

The percentages of Connecticut residents who speak a language other than English and who do not speak English well have been increasing. In 2000, nearly one in five Connecticut residents over 5 years of age spoke a language other than English, and more than 7% did not speak English "very well" (Table 2). In Hartford and Bridgeport, more than 40% of the population spoke a language other than English, and more than one in five spoke English less than "very well."

People with a poor ability to read, write and speak English often have a poor understanding of medical information and advice. As a result, they are more likely to engage in risky behaviors, they are less likely to access preventive health services, and they end up with poor health outcomes, compared to people with high English literacy.[11]

Income and Poverty

Connecticut is the wealthiest state in the nation, but a great and growing gap exists between its rich and its poor. Between 1990 and 2000 the per capita income[12] of Connecticut residents rose by 42.5% to $28,766 (Table 7). This figure was more than double the income defined by the federal government as "poverty level" for a family of three ($13,740).[13] During the same period, the poverty rate declined nationally, while the number of people living below the poverty level in Connecticut rose from 217,347 to 259,514 - an increase of nearly 20% - representing 7.6% of the state's population. (Table 2)

No disparities among Connecticut's 169 towns are more glaring than those for income and poverty. In 2000, per capita income ranged from $15,000 in Hartford to nearly $94,000 in New Canaan, and poverty rates ranged from 0.7% in Killingworth to 30.6% in Hartford.[14] Hartford, the capital of the wealthiest state in the nation, had the second highest poverty rate of all U.S. cities.[15]

Connecticut residents of white race had the highest per capita income of any racial or ethnic group ($31,505). Per capita income was 58% lower for Hispanics and 47% lower for African Americans.[16] Connecticut poverty rates were 7% for whites, 28% for African Americans, and 32% for Hispanics in 2002-2003.[17]

The U.S. Census Bureau may be undercounting actual poverty in Connecticut. The cost of living in Connecticut is higher than the national average. Accordingly, although an individual's or family's income may be above the national threshold for poverty, they might still be living in stressed financial conditions by Connecticut standards.[18]

Health Insurance

Connecticut has one of the lowest percentages in the U.S. of people lacking health insurance.[19] In 2004, 5.8% of the Connecticut population had no health insurance at the time they were surveyed, and 9.4% said they had been uninsured at some time during the prior year. Among racial and ethnic groups, 21% of Hispanics, 7% of African Americans, and 3% of whites were uninsured; these disparities were found to be related to low income and lack of permanent, full-time employment. Young adults are least likely to have insurance. By age group, 2% of persons less than 19 years, 16.8% of persons 19-29 years, 9.6% of persons 30-44 years, 4.8% of persons 45-64 years and .4% of persons age 65 and over were uninsured.[20]

Compared to people with health insurance coverage, those without health insurance have more difficulty accessing personal health services, use less medical services, receive less outpatient and inpatient care, and, as a result, tend to have worse health.[21] They often seek care at a later or more advanced stage of disease, leading to higher death rates.[22]

Connecticut Injury Prevention and Control Plan

The Burden of Injury

The Burden of Injury

Injuries are a leading cause of death and disability in the United States and in Connecticut. Injuries are the leading cause of death among Connecticut residents between the ages of 1 and 44 years and the fourth leading cause for all ages. Injuries are responsible for 41% of all deaths for Connecticut residents between the ages of 1 and 44 years, 30% of all deaths for children between the ages of 1 and 14 years and over 72% of all deaths among young people between the ages of 15 to 24 years.

During 2000 through 2003, unintentional injury was the leading cause of death for ages 1 through 44 in both Connecticut and the United States and the fifth leading cause of death overall. Motor vehicle crashes are the leading cause of unintentional injury related death overall, followed by poisoning, falls, suffocation, fire/burns and drowning. Unintentional injuries cause 25% of all deaths among Connecticut children 1 to 14 years of age and approximately half of all deaths among young persons between the ages of 15 to 24 years.

For children ages 1-9, homicide was the 4th leading cause of death in the United States and 5th in Connecticut. For teens aged 10-14, suicide and homicide were the 3rd and 4th leading cause of death respectively, in the United States and 7th and 9th respectively in Connecticut. For children ages 1-14 malignant neoplasms are the 2nd leading cause of death and congenital anomalies the third. Unfortunately in Connecticut, homicide and suicide are ranked 2nd and 3rd among teens ages 15-29 and 3rd and 2nd, respectively among young adults ages 20-24. Homicide is the 2nd and suicide the 3rd leading cause of death among persons ages 15-24 in the U.S. and among teens and young adults ages 15-24, it is the leading cause of death.

In the United States, among persons ages 25-34 suicide is the 2nd leading cause of death and homicide the 3rd. In Connecticut, suicide is also the 2nd leading cause of death with malignant neoplasms in 3rd, heart disease in 4th and homicide is 5th. Among adults 35-44 suicide is

Table 3

10 Leading Causes of Death, United States

2000 - 2004, All Races, Both Sexes

	Age Groups											
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 28,122	Unintentional Injury 8,539	Unintentional Injury 6,072	Unintentional Injury 7,745	Unintentional Injury 34,118	Unintentional Injury 40,539	Unintentional Injury 61,750	Unintentional Injury 81,305	Malignant Neoplasms 246,596	Malignant Neoplasms 465,267	Heart Disease 2,849,430	Heart Disease 3,445,424
2	Short Gestation 22,935	Congenital Anomalies 2,692	Malignant Neoplasms 2,561	Malignant Neoplasms 2,628	Homicide 9,575	Homicide 16,333	Suicide 25,047	Malignant Neoplasms 79,406	Heart Disease 184,737	Heart Disease 318,792	Malignant Neoplasms 1,948,339	Malignant Neoplasms 2,774,920
3	SIDS 11,460	Malignant Neoplasms 2,033	Congenital Anomalies 964	Suicide 1,359	Suicide 7,932	Suicide 12,347	Homicide 22,868	Heart Disease 66,720	Unintentional Injury 73,076	Chronic Low. Respiratory Disease 57,016	Cerebrovascular 704,496	Cerebrovascular 801,634
4	Maternal Pregnancy Comp. 8,036	Homicide 1,947	Homicide 661	Homicide 1,045	Malignant Neoplasms 3,621	Malignant Neoplasms 4,886	Malignant Neoplasms 19,156	Suicide 33,288	Liver Disease 36,091	Diabetes Mellitus 50,289	Chronic Low. Respiratory Disease 535,928	Chronic Low. Respiratory Disease 618,207
5	Placenta Cord Membranes 5,249	Heart Disease 944	Heart Disease 483	Congenital Anomalies 1,003	Heart Disease 1,914	Heart Disease 3,309	Heart Disease 15,696	HIV 27,659	Suicide 31,074	Cerebrovascular 49,373	Alzheimer's Disease 288,654	Unintentional Injury 527,468
6	Unintentional Injury 4,800	Influenza & Pneumonia 607	Influenza & Pneumonia 239	Heart Disease 824	Congenital Anomalies 1,208	Congenital Anomalies 1,164	HIV 9,433	Homicide 16,820	Cerebrovascular 30,284	Unintentional Injury 42,329	Influenza & Pneumonia 283,331	Diabetes Mellitus 361,279
7	Respiratory Distress 4,659	Septicemia 455	Benign Neoplasms 237	Chronic Low. Respiratory Disease 403	Chronic Low. Respiratory Disease 422	HIV 773	Diabetes Mellitus 3,116	Liver Disease 15,680	Diabetes Mellitus 27,018	Liver Disease 30,618	Diabetes Mellitus 269,711	Influenza & Pneumonia 317,855
8	Bacterial Sepsis 3,812	Perinatal Period 356	Chronic Low. Respiratory Disease 214	Influenza & Pneumonia 260	Influenza & Pneumonia 353	Cerebrovascular 653	Cerebrovascular 2,920	Cerebrovascular 12,336	HIV 21,600	Suicide 17,734	Nephritis 169,021	Alzheimer's Disease 291,698
9	Circulatory System Disease 3,136	Benign Neoplasms 275	Septicemia 186	Cerebrovascular 234	Cerebrovascular 345	Influenza & Pneumonia 593	Congenital Anomalies 2,256	Diabetes Mellitus 10,123	Chronic Low. Respiratory Disease 17,098	Nephritis 17,608	Unintentional Injury 166,741	Nephritis 202,638
10	Intrauterine Hypoxia 2,835	Chronic Low. Respiratory Disease 262	Cerebrovascular 159	Benign Neoplasms 219	Septicemia 253	Diabetes Mellitus 560	Liver Disease 1,843	Influenza & Pneumonia 4,905	Viral Hepatitis 10,770	Septicemia 16,766	Septicemia 128,963	Septicemia 164,769

WISQARS™ Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Table 4

10 Leading Causes of Death, Connecticut

2000 - 2004, All Races, Both Sexes

Age Groups												
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Short Gestation 213	Unintentional Injury 49	Unintentional Injury 35	Unintentional Injury 41	Unintentional Injury 273	Unintentional Injury 398	Unintentional Injury 665	Unintentional Injury 1,000	Malignant Neoplasms 2,656	Malignant Neoplasms 5,449	Heart Disease 36,551	Heart Disease 42,647
2	Congenital Anomalies 208	Malignant Neoplasms 19	Malignant Neoplasms 28	Malignant Neoplasms 27	Suicide 64	Homicide 89	Suicide 208	Malignant Neoplasms 890	Heart Disease 1,875	Heart Disease 3,176	Malignant Neoplasms 26,295	Malignant Neoplasms 35,627
3	Maternal Pregnancy Comp. 106	Congenital Anomalies 13	Congenital Anomalies 11	Congenital Anomalies 11	Homicide 56	Suicide 88	Malignant Neoplasms 181	Heart Disease 763	Unintentional Injury 697	Chronic Low. Respiratory Disease 501	Cerebrovascular 8,481	Cerebrovascular 9,338
4	SIDS 102	Homicide 9	Heart Disease 6	Heart Disease 11	Malignant Neoplasms 32	Malignant Neoplasms 46	Heart Disease 168	HIV 401	Liver Disease 364	Diabetes Mellitus 422	Chronic Low. Respiratory Disease 6,606	Chronic Low. Respiratory Disease 7,349
5	Placenta Cord Membranes 72	Heart Disease 8	Cerebrovascular 5	Suicide 11	Heart Disease 22	Heart Disease 39	Homicide 163	Suicide 304	Suicide 338	Cerebrovascular 406	Influenza & Pneumonia 4,038	Unintentional Injury 5,786
6	Respiratory Distress 44	Septicemia 8	Homicide 5	Benign Neoplasms 5	Congenital Anomalies 8	Congenital Anomalies 10	HIV 73	Liver Disease 173	HIV 327	Unintentional Injury 366	Alzheimer's Disease 2,938	Influenza & Pneumonia 4,360
7	Intrauterine Hypoxia 38	Influenza & Pneumonia 7	Chronic Low. Respiratory Disease 3	Chronic Low. Respiratory Disease 5	Cerebrovascular 5	Cerebrovascular 9	Cerebrovascular 24	Cerebrovascular 127	Cerebrovascular 270	Liver Disease 314	Diabetes Mellitus 2,802	Diabetes Mellitus 3,549
8	Circulatory System Disease 33	Perinatal Period 3	Five Tied 2	Homicide 5	HIV 5	Chronic Low. Respiratory Disease 7	Liver Disease 19	Homicide 114	Diabetes Mellitus 217	Septicemia 216	Nephritis 2,452	Alzheimer's Disease 2,965
9	Bacterial Sepsis 27	Three Tied 2	Five Tied 2	Septicemia 5	Chronic Low. Respiratory Disease 4	Four Tied 3	Benign Neoplasms 17	Diabetes Mellitus 87	Septicemia 152	Nephritis 205	Septicemia 2,284	Nephritis 2,834
10	Necrotizing Enterocolitis 23	Three Tied 2	Five Tied 2	Cerebrovascular 4	Four Tied 2	Four Tied 3	Two Tied 15	Septicemia 63	Chronic Low. Respiratory Disease 149	Suicide 186	Unintentional Injury 2,241	Septicemia 2,762

WISQARS™ Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

the 4th leading cause of death in Connecticut and the United States, homicide is 6th in the United States and 8th in Connecticut among those 35 to 44. Malignant neoplasms are 2nd to unintentional injury and heart disease is 3rd. Suicide remains one of the 10 leading causes of death among adults 45-64. Malignant neoplasms and heart disease are the 1st and 2nd leading causes of death in the U.S. and CT in those age groups.

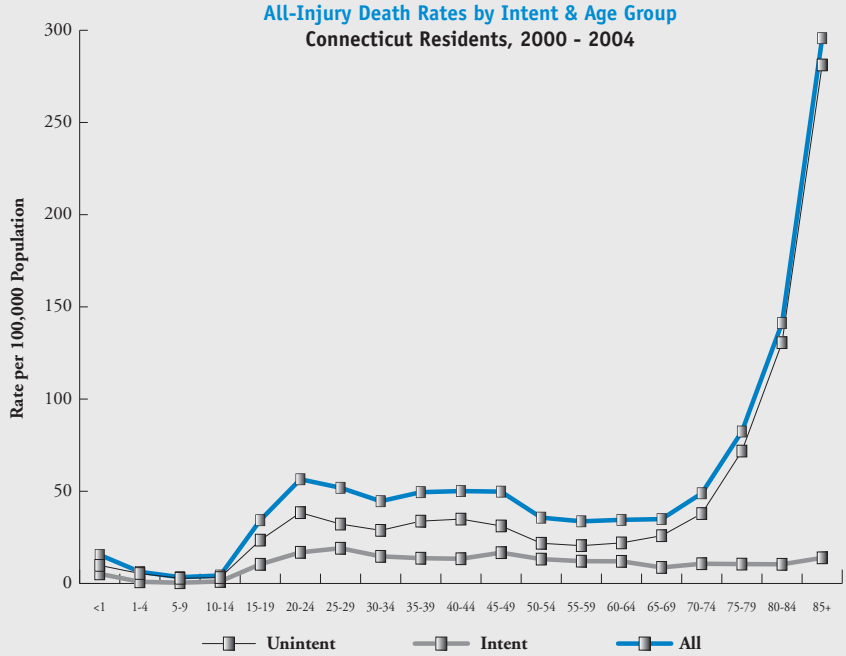
Unintentional injury is the 9th leading cause of death in the United States and 10th in Connecticut among those 65 and older. The leading causes of death in the United States and Connecticut for the 65+ age group are heart disease, malignant neoplasms, cerebrovascular, chronic low respiratory disease and influenza & pneumonia. Falls are the leading cause of injury-related death in this age group. (CDC WISQARS)

During the years 2000-2004 falls were the leading mechanism of injury hospitalization in Connecticut. The rate for all unintentional injury during those years was 421.8/100,000 population. The leading mechanisms of unintentional injury hospitalization during that time were falls with a rate of 245.4, motor vehicle at 70 and poisoning at 19.9. Intentional injury hospitalization rates were lower than those due to falls and motor vehicle crashes. The overall traumatic brain injury hospitalization rate was 65.3/100,000. From 2000-2004, self-inflicted hospitalizations were the leading intentional injury mechanism with a rate of 34.5 while assault injuries had a rate of 18.6 per 100,000. (CT DPH/Office of Health Care Access Hospital Discharge Data) These data reflect hospitalizations across all ages. In almost all injury categories, the characteristics of people who die and are hospitalized differ depending on gender, age, race and/or ethnicity. The Centers for Disease Control and Preventions WISQARS tables and the data included in specific injury sections of the plan provide details and facilitated development of the Comprehensive Injury Prevention and Control Plan.

Overall Injury

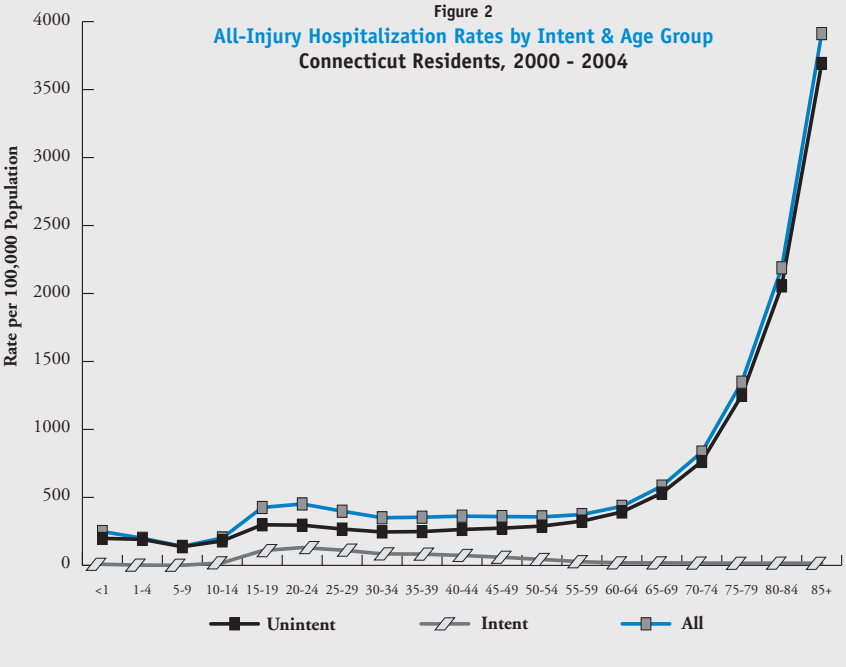
Injury is "damage to tissue caused by the exchange of kinetic, thermal, chemical, electrical or radiation energy at levels intolerable to tissue, or the deprivation of oxygen due to suffocation." Intentional injury is "an injury which is judged to have been purposely inflicted, either by the self or another." Unintentional injury is "an injury which is judged to have occurred without anyone intending that harm be done."[23] Overall in Connecticut between 2000-2004, the unintentional injury death rate was higher than the intentional injury death rate. Death rates from intentional injury were higher among those 20-29 whereas unintentional injury death rates increased with the aging of the population, primarily due to falls. (Figure 1)

Figure 1
All-Injury Death Rates by Intent & Age Group
Connecticut Residents, 2000 - 2004



Connecticut injury hospitalization rates during the same years were also higher for unintentional injury than intentional injury. Intentional injury hospitalization rates increased at ages 15-29 years of age, declining at ages 60-85+ years whereas unintentional injury hospitalizations increased with the aging of the population, again primarily due to falls. (Figure 2)

Figure 2
All-Injury Hospitalization Rates by Intent & Age Group
Connecticut Residents, 2000 - 2004



Overall Injury will be followed by sections addressing Unintentional Injury, Intentional Injury, Traumatic Brain Injury and Occupational Injury. Traumatic brain injury and occupational injury can be caused by either intentional or unintentional injuries, so they are addressed in separate sections. Injury goals, objectives, strategies and action steps are preceded by introductory information and data.

Unintentional Injury

Unintentional Injury

Unintentional injury is the leading cause of death for Connecticut residents between the ages of 1 and 44 years and the fifth leading cause for all ages. Unintentional injuries are defined as those that are not inflicted by deliberate means, i.e., not on purpose. Unintentional injuries are responsible for approximately one-quarter of all deaths among Connecticut children 1 to 14 years of age and half of all deaths among young persons 15 to 24 years of age. Unintentional injuries were responsible for an average 1,137 deaths each year among Connecticut residents between 2000 and 2004. Over one-quarter of unintentional injury deaths were caused by motor vehicle crashes (26.7%). Other leading causes of unintentional injury death were poisoning (23.8%), falls (16.0%), suffocation (10.0%), transport/other (3.3%), fire/burns (2.6%), and drowning (2.3%). (Figure 3)

Unintentional injuries were responsible for approximately 14,578 inpatient hospitalizations each year between 2000 and 2004. The majority of these hospitalizations were caused by falls (58.2%) followed by motor vehicle crashes (16.6%), poisoning (4.7%), struck by/against (2.9%), and overexertion (2.3%). (Figure 4)

For the five-year period of 2000 through 2004, inpatient hospital charges for unintentional injury totaled over 1.2 billion dollars.

Figure 3
Unintentional Injury Deaths by Mechanism
Connecticut Residents, 2000 - 2004

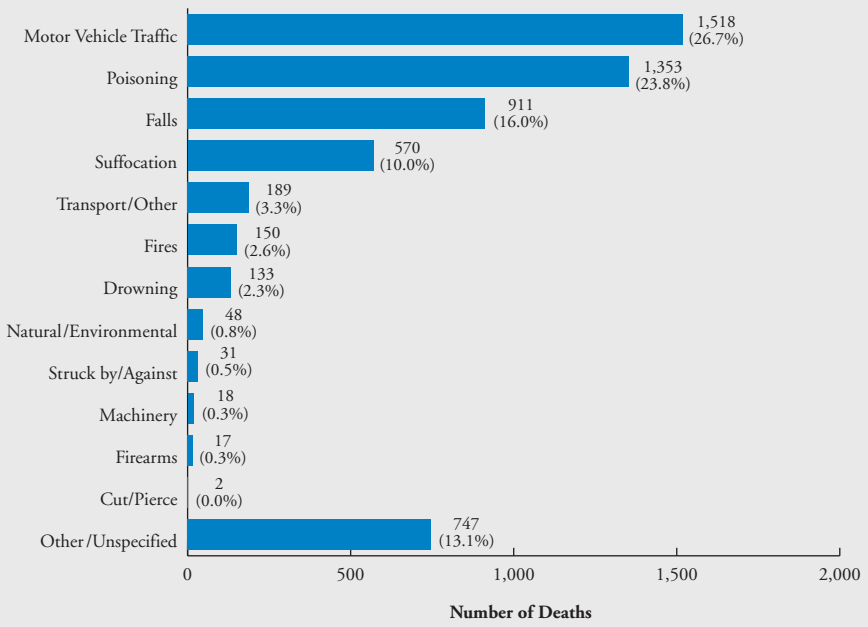
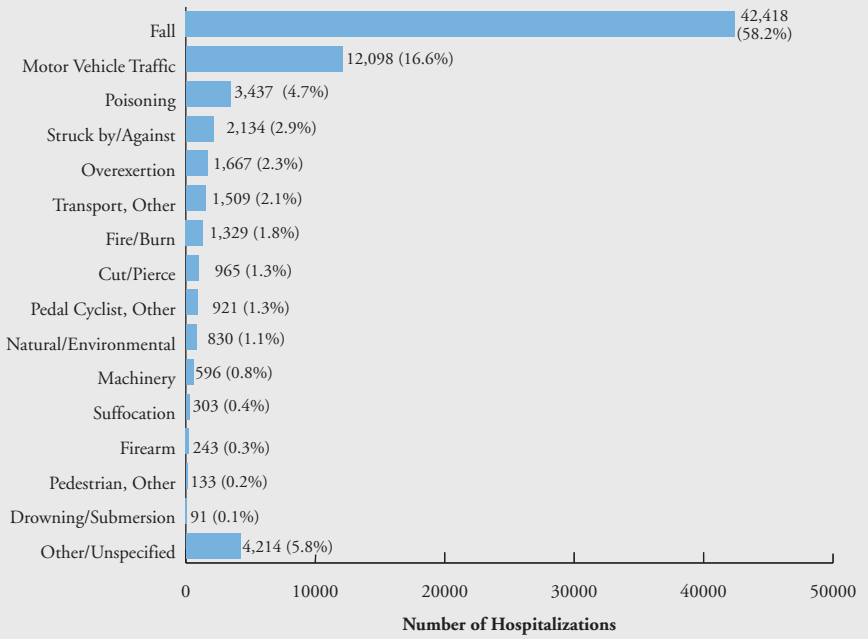


Figure 4
Unintentional Injury Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Population groups at most risk for unintentional injury vary by the injury mechanism and are summarized in each of the following injury-specific sections of the plan.

Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Connecticut Objectives:

By 2010, Reduce deaths caused by unintentional injuries to no more than 33 per 100,000 population.

Baseline CT 2000	34.3 per 100,000 population
Interim CT 2004	35.2 per 100,000 population

(Data Source: CT Department of Public Health Vital Records)

By 2010, Reduce hospitalizations for nonfatal unintentional injuries to no more than 421 per 100,000 population.

Baseline CT 2000	413.1 hospitalizations per 100,000 population
Interim CT 2004	428.7 hospitalizations per 100,000 population

(Data Source: CT Office of Health Care Access Hospital Discharge Data)

Specific unintentional injury-related objectives and action steps are included under each specific injury category.

Motor Vehicle Crashes

Motor vehicle crashes include deaths and injuries to motor vehicle occupants (drivers and passengers), motorcyclists (drivers and passengers), pedal cyclists (bicyclists) injured in a collision with a motor vehicle and pedestrians injured in a collision with a motor vehicle. In all cases the injury occurs on a public roadway.

Motor vehicle crashes are the leading cause of injury related death for Connecticut residents, responsible for approximately 20% of all injury deaths. As recorded on the death certificate, motorcyclists accounted for 14.0% of the deaths, followed by motor vehicle occupants (13.4%) pedestrians (10.4%) and pedal cyclist (1.0%.) However, in over 60% of the deaths the victim was coded as other/unspecified. (Figure 5)

Figure 5
Unintentional Motor Vehicle Traffic Deaths by Person Injured
Connecticut Residents, 2000 - 2004

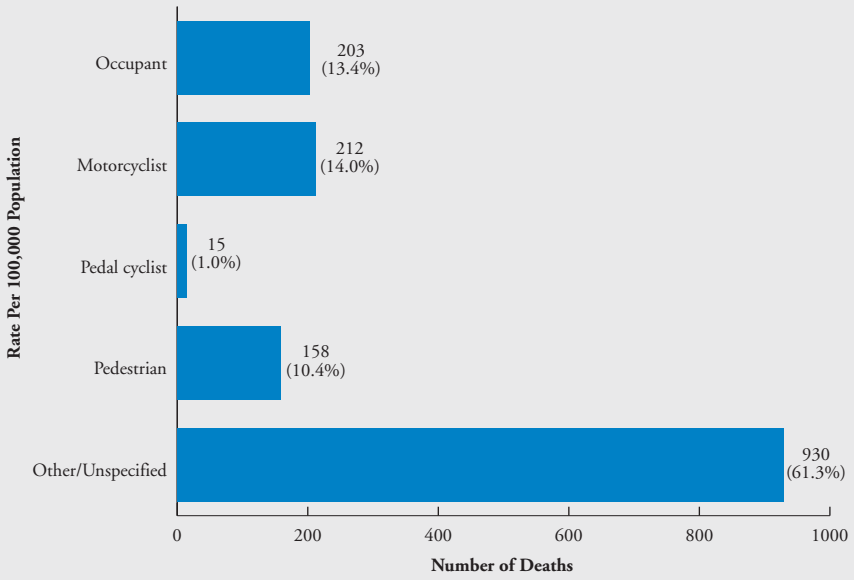
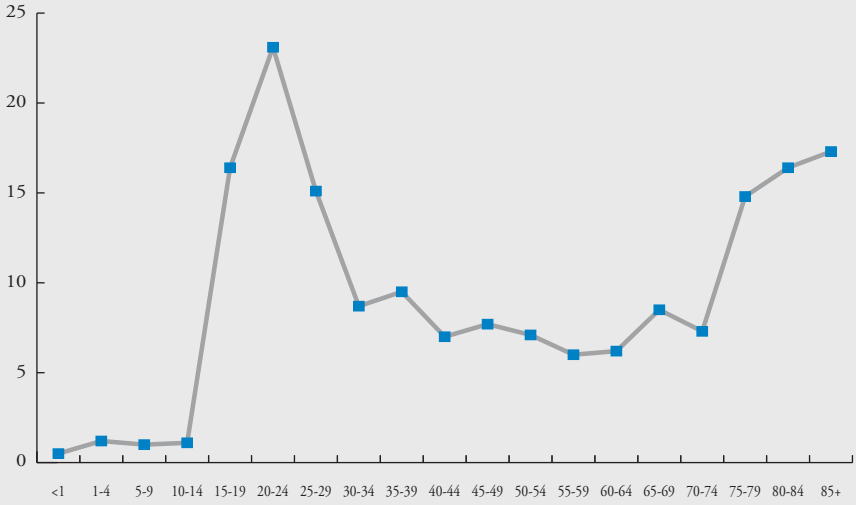


Figure 6
Motor Vehicle Traffic Death Rates by Age Group
Connecticut Residents, 2000 - 2004



Data from the Connecticut Department of Transportation/ National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS) may provide a more accurate picture of who is killed in motor vehicle crashes in Connecticut. FARS data are based on police investigations and reports for all fatal motor vehicle crashes occurring in Connecticut. According to FARS, between 2000 and 2004, approximately 72% of the fatalities in Connecticut motor vehicle crashes were occupants, 14% were motorcyclists, 12% were pedestrians and 1% were bicyclists. During 2004, Connecticut Department of Transportation reported that at least 45.3% of the motor vehicle crash fatalities involved alcohol.

Adolescents, young adults and older adults were most at risk of dying in a motor vehicle crash. Approximately 40% of all motor vehicle deaths occurred to young persons between the ages of 15 and 29 years. The 20 to 24 year old age group had the highest death rate from motor vehicle crashes (23.1/100,000) followed by older adults 85+ years (17.3/100,000), 15 -19 years olds (16.4/100,000) and 80-84 year olds. (Figure 6)

Males have a motor vehicle death rate (12.9/100,000) that is approximately 2.6 times higher than females

Motor Vehicle Crashes (Cont.)

(4.9/100,000). Non-Hispanic Blacks (8.3/100,000) and Hispanics (8.2/100,000) have similar death rates, followed by Whites (7.7/100,000) and Non-Hispanic Other (3.1/100,000).

Motor vehicle crashes were the second leading cause of injury hospitalization in Connecticut, responsible for an average of 2,420 hospitalizations each year between 2000 and 2004. Motor vehicle occupants accounted for 69.1% of these hospitalizations followed by motorcyclists (12.5%), pedestrians (11.3%) and pedal cyclists (2.8%). In 4.2% of the cases the person's involvement was unspecified. (Figure 7)

As with motor vehicle deaths, adolescents, young adults and older adults were most at risk of hospitalization from a crash-related injury. Approximately one third of all hospitalizations were among the 15 to 29 year olds. The 20 to 24 year old age group had the highest rate of hospitalization (150.6/100,000) followed by 15 to 19 year olds (131.5/100,000) and 25 to 29 year olds (114.5/100,000). Hospitalization rates generally decreased with age however, rates began to increase with the 60 to 64 age group and reached a high of 92.6/100,000 among 80 to 84 year olds. (Figure 8)

Males had a higher hospitalization rate (99.3/100,000) than females (53.3/100,000); however, the difference was not as pronounced as the difference in death rates. The highest hospitalization rates were among Non-Hispanic Other Races (120.3/100,000), followed by Non-Hispanic Blacks (89.2/100,000), Hispanics (86.6/100,000) and Whites (63.4/100/000.)

Figure 7
Unintentional Motor Vehicle Traffic Hospitalizations by Person Injured
Connecticut Residents, 2000 - 2004

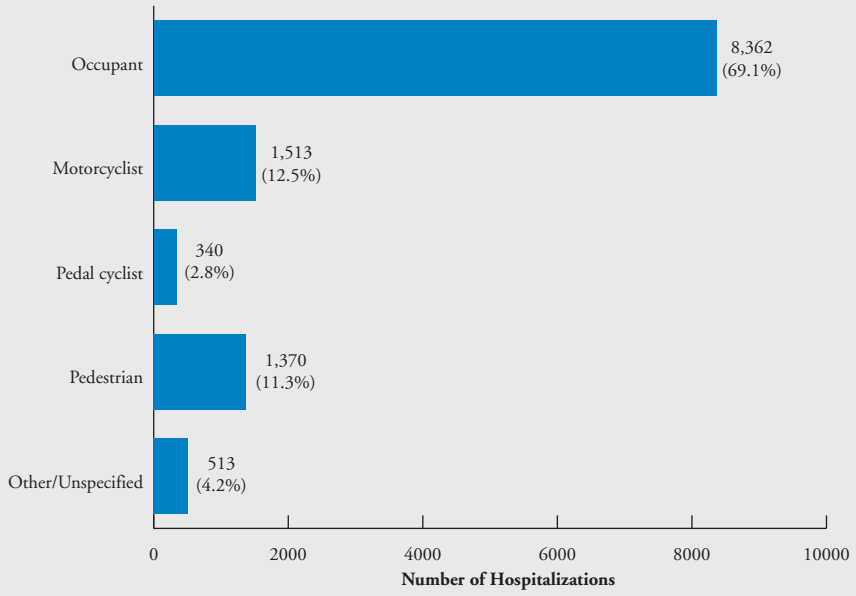
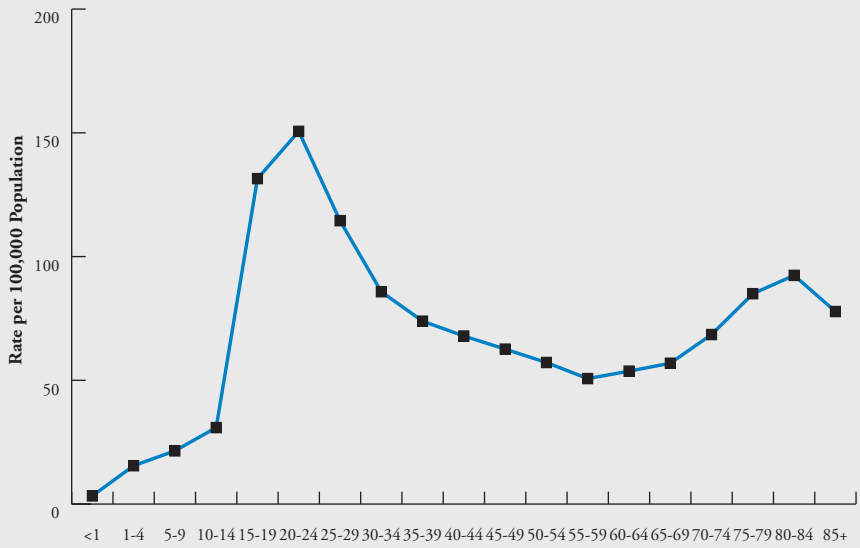


Figure 8
Motor Vehicle Traffic Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004



For the five-year period from 2000 to 2004, inpatient hospital charges for motor vehicle crashes totaled over $277 million, with an average charge of $12,946 per hospital stay.

Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Motor Vehicle Crashes

Connecticut Objectives:

By 2010, Reduce deaths caused by motor vehicle crashes to no more than 8.5 per 100,000 population.

Baseline CT 2000	8.9 per 100,000 population
Interim CT 2004	9.1 per 100,000 population

(Data Source: CT Department of Public Health, Vital Records)

By 2010, Reduce hospitalizations caused by motor vehicle crashes to no more than 65.0 per 100,000 population.

Baseline CT 2004	75.6 hospitalizations per 100,000 population
Interim CT 2004	65.6 hospitalizations per 100,000 population

(Data Source: CT Office of Health Care Access, Hospital Discharge Data)

By 2010, Reduce pedestrian deaths on public roads to no more than -TBD per CDC, Healthy People 2010

Baseline CT 2000	Developmental
Interim CT 2004	Developmental

(Data Source: CT Department of Public Health, Vital Records)

By 2010, Reduce nonfatal pedestrian injuries to no more than -TBD per CDC, Healthy People 2010

Baseline CT 2000	Developmental
Interim CT 2004	Developmental

(Data Source: CT Office of Health Care Access, Hospital Discharge Data)

By 2010, Increase use of safety belts to 86%.

Baseline CT 2000	76% usage rate
Interim CT 2004	83% usage rate

(Data Source: CT Department of Transportation, Observational Survey)

Unintentional Injury

Motor Vehicle Crashes

Connecticut Objectives *(continued)*

By 2010, Reduce the percentage of motor vehicle fatalities that are alcohol-related to 41.0 %.

Baseline CT 2000	42.7%
Interim CT 2003	45.3%

(Source: CT Department of Transportation, Fatality Analysis Reporting System)

By 2010, Reduce the proportion of adolescents who report that they rode with a driver who had been drinking alcohol to no more than 26.5%.

Baseline CT 2003	26.8% of high school students
Interim CT 2005	29.7% of high school students

(Data Source: CT School Health Survey, Youth Risk Behavioral Survey)

Data, Surveillance and Evaluation

Strategies:

- Improve the collection, accessibility, and quality of motor vehicle injury data sets.
- Increase the number of data sets used for motor vehicle injury surveillance.
- Increase the use of motor vehicle injury surveillance data for planning and evaluation of programs and policies.
- Increase the availability of data to seek additional funding sources.

Action Steps:

- Collaborate with partners to support implementation of the CT Traffic Records Coordinating Committee's 2006 Strategic Plan for Traffic Records, especially recommendations relating to improving quality, timeliness, completeness of motor vehicle-related data systems.
- Analyze and dissimate motor vehicle crash and injury data in formats designed to meet state and community-based user needs.
- Use the linked Crash Outcome Date Evaluation System (CODES) data, in planning and evaluating motor vehicle injury prevention programs and policies.
- Facilitate use of CODES data by state and community based users.
- Collaborate with partners to include additional data sets such as the CT Trauma Registry and Emergency Medical Service Run data in CODES data linkages.

Unintentional Injury

Motor Vehicle Crashes

Action Steps (continued):

- Promote research to identify state or community specific motor vehicle injury problems, develop interventions and evaluate existing programs and laws.
- Promote inclusion of (or keeping) questions on motor vehicle safety behaviors such as safety belt and child restraint use, helmet use, and impaired driving on CT Behavioral Risk Factor Surveillance System and CT School Health Surveys (YRBS).
- Provide data on medical costs associated with motor vehicle injuries.

Legislation and Policy

Strategy - Strengthen Connecticut's motor vehicle safety laws and policies.

Action Steps:

- Review existing state motor vehicle safety-related laws and policies and identify gaps in coverage.
- Research model motor vehicle safety related legislation including national models and other states' legislation.
- Build support for legislative initiatives through provision of data and public awareness campaigns on the effectiveness of specific motor vehicle safety measures and community education programs.
- Collaborate with partners to support new legislative initiatives and changes to current legislation that will reduce the incidence of motor vehicle crashes, injuries and deaths.
- Collaborate with partners to promote roadway modification and engineering strategies.

Public Awareness, Education, and Enforcement

Strategies:

- Increase public awareness of leading causes of motor vehicle crashes, injuries and fatalities including impaired driving, non-use of occupant protection, protective gear and helmets, distracted driving, and speeding.
- Increase public awareness of the most effective prevention measures for motor vehicle crashes, injuries and fatalities.
- Increase public awareness of and promote enforcement of motor vehicle safety laws.

Unintentional Injury

Motor Vehicle Crashes

Public Awareness, Education, and Enforcement *(continued):*

Action Steps:

- Collaborate with partners to support implementation of the CT Department of Transportation's Highway Safety Plan. (http://www.ct.gov/dot)
- Collaborate with partners to develop or identify effective public awareness and education materials.
- Collaborate with partners to support media campaigns and/or public awareness messages on motor vehicle safety related laws.
- Collaborate with partners on the dissemination of public awareness and education materials through media outlets, and state and community networks.

Occupant Protection

Strategies:

- Increase correct use of child restraint systems.
- Increase correct use of safety belts.
- Increase awareness of the importance of booster seat use for appropriate aged children.
- Improve the capacity of health care, child care and community service agencies to address passenger safety issues.

Action Steps:

- Analyze and disseminate CODES data for vehicle occupants including the use of occupant protection and impact on motor vehicle crash related injuries.
- Collaborate with partners to promote awareness of and support enforcement of Connecticut's safety belt and child restraint laws.
- Identify gaps and potential components that will strengthen Connecticut's existing laws and policies.
- Collaborate with partners to support initiatives to strengthen existing laws.
- Provide education to parents and caregivers on the correct use and installation of child restraints.
- Provide child passenger safety training to health care, child care and other family and community service providers.
- Identify or develop public awareness and educational materials, including materials for non English speaking and low literacy populations.
- Collaborate with partners to identify and seek additional sources of funding.

Unintentional Injury

Motor Vehicle Crashes

Motorcycles

Strategies:

- Expand motorcycle safety skills training.
- Increase awareness of the importance of motorcycle helmet use.
- Increase awareness of motor vehicle operators on "sharing the rode" safely with motorcyclists.

Action Steps:

- Analyze CODES and other relevant data sets to describe injuries and health care costs related to motorcycle crashes.
- Promote motorcycle operator safety skills training programs.
- Explore feasibility of requiring safety training as a prerequisite for the motorcycle operator's license.
- Promote the importance of motorcycle helmet and protective gear use.
- Promote campaigns targeting other vehicle operators on "sharing the road safely" with motorcyclists.
- Explore and identify strategies for promoting implementation of motorcycle helmet legislation.
- Collaborate with partners to identify and seek additional sources of funding.

Teen Drivers and Passengers

Strategies:

- Increase awareness among parents and teens of the major risk factors associated with crashes involving teen drivers.
- Increase awareness among parents and teens of effective prevention measures.
- Increase compliance with Connecticut's Graduated Driver License System and other laws related to teen motor vehicle occupants.

Action Steps:

- Analyze CODES and other motor vehicle data sets to better describe the injuries and risk factors associated with young teens and young adults in motor vehicle crashes.
- Collaborate with partners to educate parents and teens on Connecticut's Graduated Driver Licensing and other laws related to young drivers and passengers.

Unintentional Injury

Motor Vehicle Crashes

Teen Drivers and Passengers

Action Steps *(continued):*

- Review state legislation and policies to identify gaps and potential changes that would strengthen Connecticut's laws pertaining to young drivers and passengers.
- Collaborate with partners to support efforts to strengthen Connecticut's laws and policies related to young drivers and passengers.
- Support community based initiatives, policies and enforcement activities targeting underage drinking and youth access to alcohol.
- Collaborate with partners to identify and seek additional sources of funding.

Alcohol and Drug Related Motor Vehicle Injuries and Deaths

Strategies:

- Increase awareness of the impact of alcohol and drug use and abuse on motor vehicle injuries, deaths and disability.
- Increase awareness of the ages and genders of impaired drivers most likely to be involved in motor vehicle crashes.

Action Steps:

- Analyze and disseminate CODES data and other appropriate data sets to better describe injuries and costs associated with alcohol related crashes.
- Collaborate with partners to support high visibility enforcement campaigns for impaired driving and other alcohol related laws.
- Collaborate with partners to support public awareness campaigns on impaired driving including those tied to enforcement initiatives.
- Review existing alcohol and impaired driving laws to identify gaps and potential components that would strengthen laws.
- Support initiatives to strengthen existing alcohol-related laws.
- Support community based initiatives, policies and enforcement activities targeting underage drinking and youth access to alcohol.
- Collaborate with partners to identify and seek additional sources of funding.

Unintentional Injury

Motor Vehicle Crashes

Pedestrians

Strategies:

- Increase the focus on developing safe walkable communities through a combination of engineering, enforcement, education and policy strategies.
- Increase the awareness of pedestrian safety among pedestrians and motor vehicle operators.
- Expand bicycle safety education programs.

Action Steps

- Analyze CODES and other appropriate data sets to better describe pedestrian injuries, identify state and community specific pedestrian safety problems, and set Connecticut baseline and Healthy People 2010 objective levels.
- Work with partners to support implementation of the CT Department of Transportation's State Bicycle-Pedestrian Safety Plan. (http://www.ct.gov/dot)
- Work with partners to promote pedestrian safety education and awareness campaigns for pedestrian and motor vehicle operators.
- Collaborate on bikeable/walkable community initiatives such as Safe Routes to School.
- Work with partners to identify or develop materials designed for specific target audiences including materials in languages other than English and low literacy materials.

Bicyclists

Strategies:

- Increase use of bicycle helmets.
- Expand bicycle safety education.
- Increase awareness of bicycle safety among bicyclists and motor vehicle operators.
- Increase the focus on developing safe bikeable communities through a combination of engineering, enforcement, education and policy strategies.

Action Steps:

- Analyze CODES and other appropriate data sets to better describe bicycle injuries, identify state and community-specific bicycle problems, and set Connecticut baseline and Healthy People 2010 objective levels.
- Collaborate with partners to support implementation of the CT Department of Transportation's State Bicycle-Pedestrian Safety Plan (http://www.ct.gov/dot)
- Support public awareness campaigns on bicycle helmet use and other bike safety measures.
- Educate drivers on "sharing the road" with bicyclists.

Unintentional Injury

Motor Vehicle Crashes

Bicyclists

Action Steps *(continued):*

- Collaborate on bikeable/walkable community initiatives such as Safe Routes to School.
- Identify or develop materials designed for specific target audiences including languages other than English and low literacy materials.
- Promote community- based bicycle safety activities that promote bike helmet use and provide bicycle skills training.
- Collaborate with partners to identify and seek additional sources of funding.

Motor Vehicle Partners: ICPG members, Department of Transportation, CT and local Safe Kids Coalitions, CT Department of Public Health, State and Local Police, Brain Injury Association of CT, CT-based Transportation Safety Researchers, local health departments, National Highway Traffic Safety Administration and other Federal Agencies, CODES Advisory Board members, CT Traffic Records Coordinating Committee Members, Regional Planning Organizations, Bicycle coalitions. Child care organizations, State Department of Education, schools, Connecticut Trauma Committee and Trauma System, Office of the Child Advocate, MADD, Judicial Department, CT Department of Motor Vehicles, Commission on Children, Governors Prevention Partnership, CT Coalition on Underage Drinking.

Falls

Fall-related injuries are received when a person descends abruptly as a result of gravity and strikes a surface at the same or lower level. Falls are the fourth leading cause of injury- related death in Connecticut, leading to 12% of all injury deaths. Older adults were most at risk of dying from a fall related injury. Over 85% of fall deaths occur in persons age 60 years and older. The fall death rate for adults age 65 and older (31.4/100,000) is 6 times that of Connecticut residents over all (5.3/100,000). (Figure 9)

Males have fall death rate (5.9/100,000) which is 26% higher than females (4.7/100,000.) Non-Hispanic Whites have the highest fall death rate (6.1/100,000), followed by Non-Hispanic Blacks (2.3/100,000), and Hispanics (1.2/100,000). In 73% of the fall-related deaths, the circumstance of death were coded as "other/unspecified fall" on the death certificate. Where the circumstances were specified, approximately 13% involved stairs or steps, 4% involved bed, chair or other furniture, 3% involved falls from ladder, building or other structures and 3% involved slipping, tripping or stumbling. (Figure 10)

Figure 9
Unintentional Fall Death Rates by Age Group
Connecticut Residents, 2000 - 2004

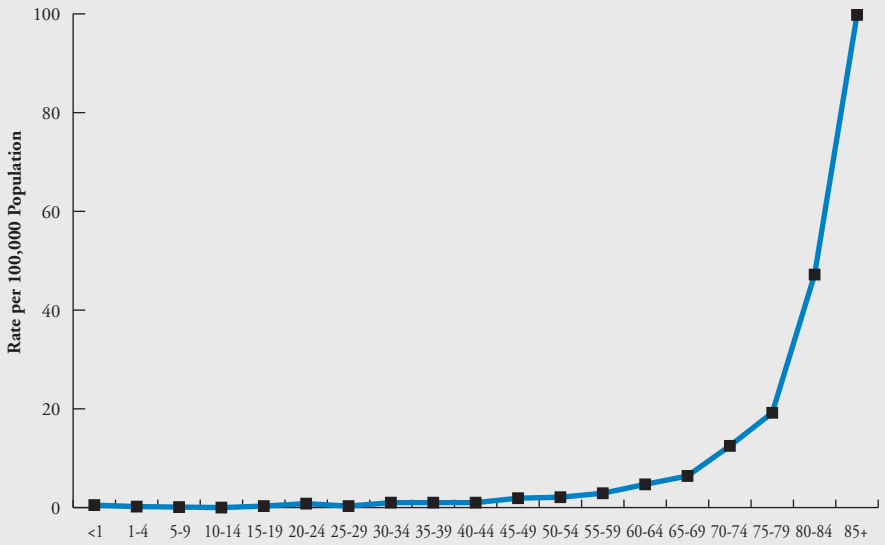
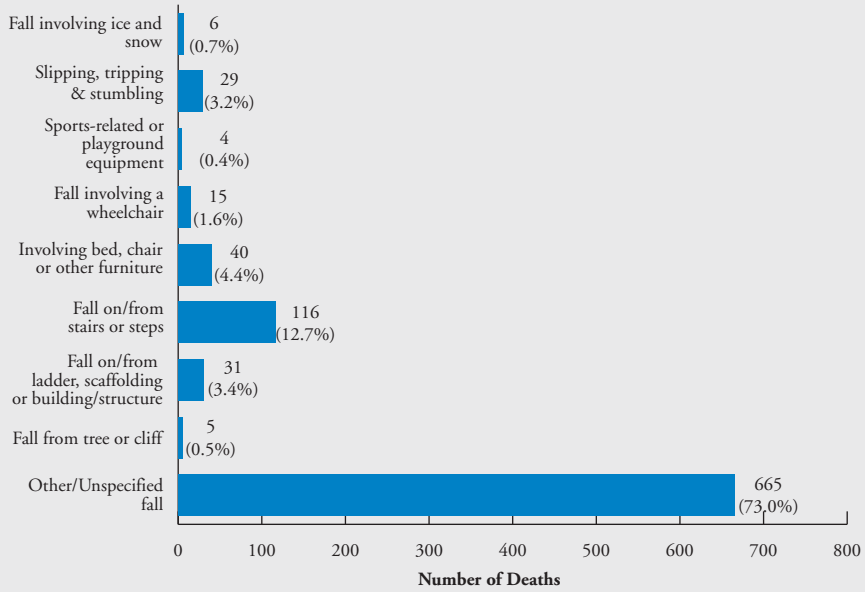


Figure 10
Fall Deaths by Mechanism
Connecticut Residents, 2000 - 2004



Falls

Falls were the leading cause of injury related hospitalizations in Connecticut, responsible for approximately one half of all injury related hospitalizations. On average, there were 8,484 fall- related hospitalizations per year between 2000 and 2004. Falls were the leading causes of injury - related hospitalization for infants less than 1 year of age to children 14 years old and for adults from 35 through + years of age. (Figure 11)

Persons age 65 and older accounted for 68% of fall-related hospitalizations. In contrast to fall deaths, females had a 69% higher hospitalization rate (305.9/100,000) than males (181.2/100,000). Males had a higher hospitalization rate up to the age of 54; the rate for females was higher across the rest of the life span. Non-Hispanic Whites had the highest fall hospitalization rate (248.6/100/000) followed by Non-Hispanic other race (193.4) Non-Hispanic Black(107.3/100,000) and Hispanics 88.4/100/000.) Slipping, tripping or stumbling was coded as the cause of 37.3% fall hospitalizations, almost equal percentage (36.7) were coded as other/unspecified falls. (Figure 12)

For the five-year period 2000-2004, inpatient hospital charges for falls were over $697 million with an average charge of $12,705 per stay. During this time period, inpatient hospital charges for persons age 65 and older totaled almost $500 million, or approximately $100 million per year. Over half of fall hospitalizations were discharged to a skilled nursing facility. Medicare covered the costs of over two thirds of fall hospitalizations.

Figure 11
Unintentional Fall Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004

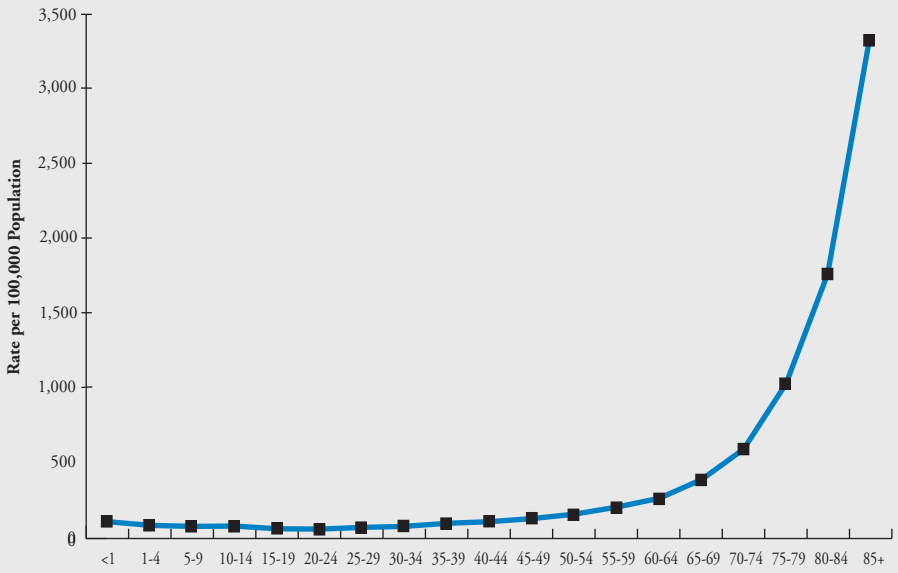
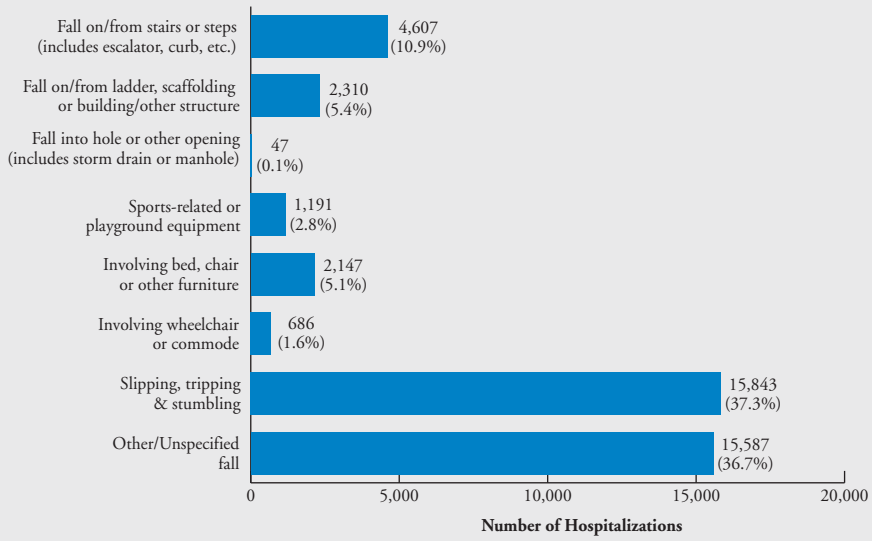


Figure 12
Fall Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Falls

By 2010, Reduce deaths from falls to no more than 5.3 per 100,000 population.

Baseline CT 2000	4.6 per 100,000 population
Interim CT 2004	6.3 per 100,000 population

(Source: *CT Department of Public Health, Vital Records)*

By 2010, Reduce hospitalizations due to falls to no more than 245.0 per 100,000 population.

Baseline CT 2000	240.2 per 100,000 population
Interim CT 2004	249.6 per 100,000 population

(Source: CT Office of Health Care Access, Hospital Discharge Data)

By 2010, Maintain the rate of hip fractures among adults age 65 and older at no more than 681 per 100,000 population.

Baseline CT 2000	726.2 hospitalizations per 100,000 population
Interim CT 2004	681.5 hospitalizations per 100,000 population

(Source: CT Office of Health Care Access, Hospital Discharge Data)

Fall-Related Deaths and Injuries Among Older Adults

Strategies:

- Improve fall injury surveillance.
- Increase public awareness that falls are preventable.
- Increase public awareness of proven prevention strategies.
- Build the statewide capacity of health care providers, aging service providers and other providers to conduct fall risk assessment, management, referral and prevention through professional development and training.
- Increase statewide availability and accessibility of fall prevention services for older adults.
- Increase the availability of data to seek fall prevention funding.

Unintentional Injury

Falls

Fall-Related Deaths and Injuries Among Older Adults

Action Steps:

- Develop procedures for improving the coding of data on causes and locations of falls.
- Identify and access additional sources of data on falls.
- Promote implementation of evidence-based multi-faceted programs for community dwelling older adults that integrate fall risk reduction strategies including physical activity, exercise, medication review and management; vision and foot care; and home modification strategies.
- Work with partners to determine venues, content and methods for promoting widespread dissemination of proven effective fall prevention strategies.
- Facilitate connections with home care and other providers on ways to implement fall risk assessment as a routine part of health care visits and other services for older adults.
- Provide education and awareness programs on fall risks and effective prevention measures for older adults, family members and other caregivers.
- Support policy and legislative changes that will incorporate fall risk assessment, management and prevention into programs and services for older adults.
- Develop, implement and evaluate effective approaches to reducing falls in long term care and assisted living facilities.
- Identify barriers to the implementation of effective fall prevention interventions and strategies to address those barriers.
- Analyze and review the impact of falls on health care costs, the potential for reducing falls and most effective strategies for reducing health care costs associated with falls.
- Provide ongoing evaluation of the implementation and impact of fall prevention interventions.
- Partner with regulators and other partners to identify and implement environmental and regulatory changes that reduce the risk of falling.
- Collaborate with partners to identify and seek additional sources of funding for fall prevention.

Partners: ICPG members, CT Collaboration for Fall Prevention, CT Department of Social Services, CT Commission on Aging, CT Department of Public Health, Area Agencies on Aging, Aging Service Providers, Brain Injury Association of CT., CT Long Term Care Commission, Connecticut Commission on Aging, Connecticut Trauma Committee, Connecticut Trauma System, health care providers including nurses, physicians, physical therapists, pharmacists, emergency medical services, hospitals, home care agencies, rehabilitation facilities, local health departments, community volunteer groups, and others.

Unintentional Injury

Falls

Fall-Related Deaths and Injuries among Children and Youth

Strategies:

- Improve fall injury surveillance.
- Increase public awareness of causes and prevention measures for falls.
- Increase use of appropriate safety equipment for sports and recreational activities.
- Expand environmental and regulatory measures that reduce the risk of falls.

Action Steps:

- Identify, access and analyze potential alternative sources of data on causes and locations of falls for specific age groups including home, recreational and sports related falls.
- Develop procedures for improving the coding of data on causes of falls.
- Facilitate development of a comprehensive home safety program for families and caregivers focusing on leading injury risks for children.
- Provide education for health, childcare and other providers on fall prevention.
- Develop partnerships with sports, athletic and recreational associations and organizations.
- Collaborate with partners, schools, sports and recreation stakeholders on strategies, policies and training to facilitate increased use of appropriate protective equipment for sports and recreational activities.
- Collaborate with regulators and other partners to promote development and maintenance of playgrounds that meet the US Consumer Product Safety Commission's Guidelines for Public Playground Safety.
- Collaborate with regulators and other partners to identify and implement environmental and regulatory changes that reduce the risk of falling.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG, Connecticut and local Safe Kids coalitions, CT Department of Education, CT Department of Public Health, CT Department of Consumer Protection, US Consumer Product Safety Commission, schools, child care providers and consultants, early childhood education professionals, coaches and athletic associations; municipal parks and recreation departments; state and local building inspector; local health departments, CT Recreation and Parks Association; Office of the Child Advocate, CT Commission on Children and others.

Unintentional Injury

Falls

Fall-Related Injuries among Adults

Strategies:

- Improve fall injury surveillance.
- Increase public awareness of causes and prevention measures for falls.
- Increase use of appropriate safety equipment for sports and recreational activities.
- Increase compliance with work site safety laws.
- Expand environmental and regulatory measures that reduce the risk of falls.

Action Steps:

- Identify, access and analyze potential alternative sources of data on causes and locations of falls for specific age groups including home, recreational, sports-related, and occupational related falls.
- Develop procedures for improving the coding of data on causes and locations of falls.
- Develop partnerships with sports, athletic and recreational associations, and organizations.
- Collaborate with partners and sports and recreation stakeholders to develop strategies, policies and training to increase the use of appropriate protective equipment for sports and recreational activities.
- Collaborate with ICPG, receptive employers, DPH Occupational Health Unit and others to facilitate the provision of research-based occupational fall prevention training and programs.
- Collaborate with regulators and other partners to identify and implement environmental and regulatory changes that reduce the risk of falling.
- Support compliance with State and federal occupational safety laws, i.e. Fall Protection Standard.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG, CT Department of Labor, US Department of Labor, CT Department of Public Health, Employers and Industry Associations, unions, coaches and athletic trainer associations, municipal parks and recreation departments, CT Collaboration for Fall Prevention, CT Recreation and Parks Association, CT Department of Consumer Protection, US Consumer Product Safety Commission, local health departments, state and local building inspectors and others.

Fire/Burn-Related

Fire and burn-related injuries result from exposure to flames, heat or chemicals, or smoke inhalation. Fire and burn-related injuries were responsible for an average of 30 deaths per year between 2000 and 2004. Older adults aged 65 and over had the highest rates for fire related death. (Figure 13)

Males (0.9/100,000) and females (0.8/100,000) have similar death rates. Non-Hispanic Blacks had the highest fire and burn death rates (1.0/100,000) followed by Non-Hispanic Whites (0.8/100,000), Hispanics (0.6/100,000) and Non-Hispanic Other (0.4/100,000). The majority of fire-related deaths (79.3%) were caused by uncontrolled fires in a building or other structure. (Figure 14)

Infants less than one year and young children ages 1 to 4 years have the highest rates for fire and burn hospitalizations (29.0/100,000 and 23.9/100,000 respectively). (Figure 15)

The rate for the population overall is 7.7/100,000. The majority of fire-and burn-related hospitalizations (61.6%) were caused by exposure to hot, caustic, or corrosive substances or steam. Ninety-five percent of the fire and burn hospitalizations among children less than 5 years were due to burns from hot, caustic or corrosive substances. (Figure 16)

Males had twice the hospitalization rate for fire and burns (10.3/100,000) compared to females (5.2/100,000.) Non-Hispanic Blacks had the highest rate for fire and burn hospitalizations (13. 9/100,000) followed by Hispanics (12.7/100,000), Non-Hispanic Other (12.0/100,000), and Non-Hispanic Whites (6.1/100,000). From 2000 through 2004, total inpatient hospitalization charges for fire and burns was over $25 million, with an average charge of $7,983 per hospital stay.

Figure 13
Unintentional Fire/Burn Death Rates by Age Group
Connecticut Residents, 2000 - 2004

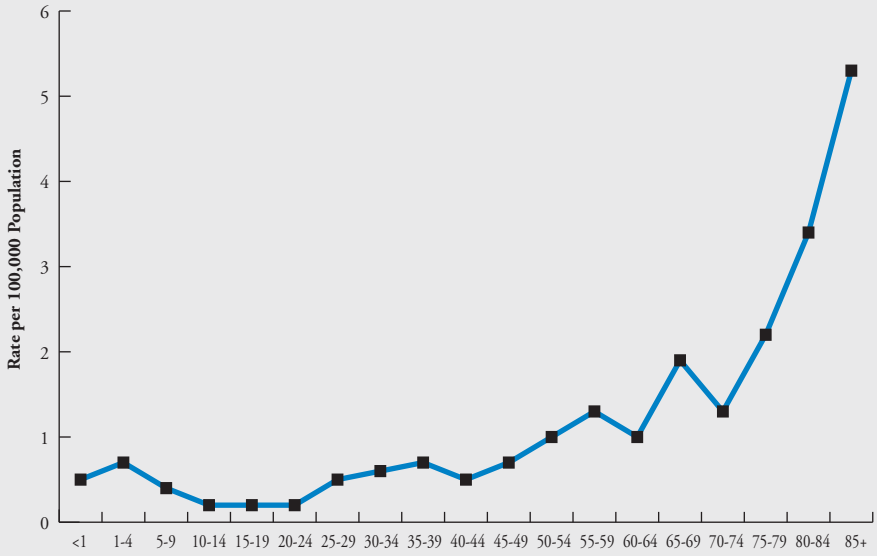
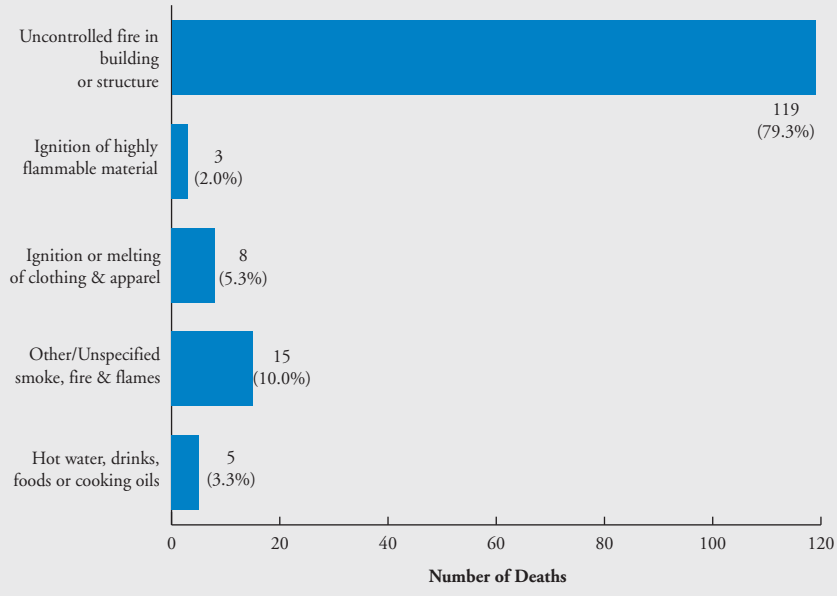


Figure 14
Fire/Burn Deaths by Mechanism
Connecticut Residents, 2000 - 2004



Fire/Burn-Related

Figure 15
Unintentional Fire/Burn Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004

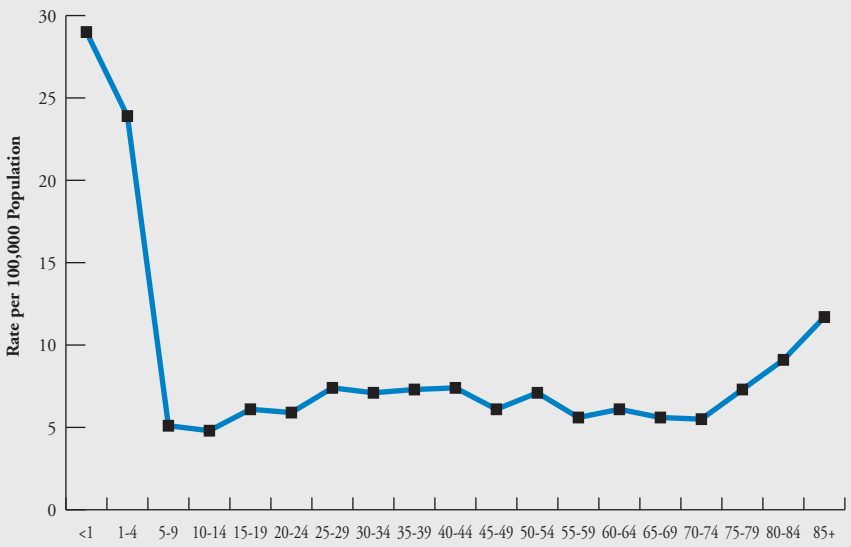
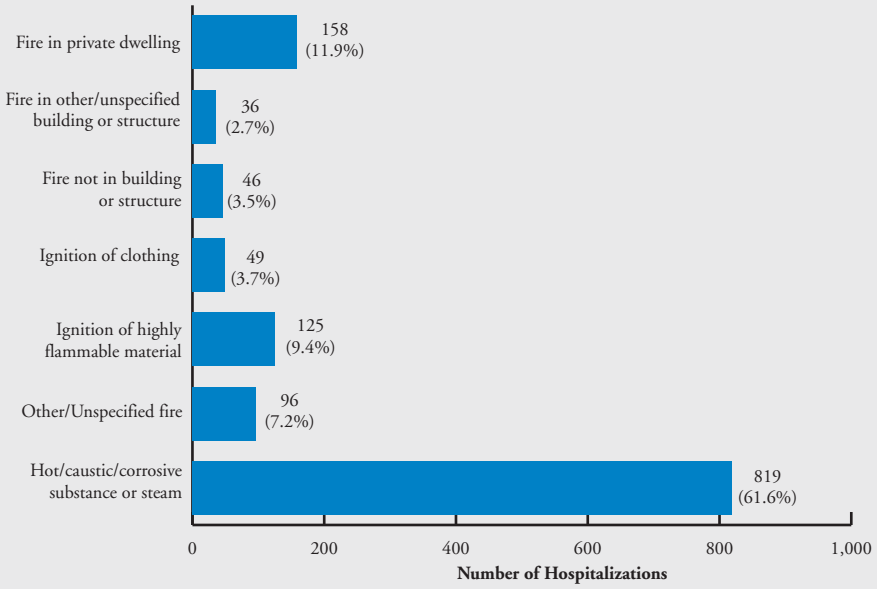


Figure 16
Fire/Burn Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Fire/Burn-Related

Connecticut Objectives:

By 2010, Reduce fire-and burn-related deaths to no more than 0.7 per 100,000 population.

Baseline CT 2000	0.7 per 100,000 population
Interim CT 2004	0.9 per 100,000 population

(Data Source: CT Department of Public Health, Vital Records)

By 2010, Reduce hospitalizations caused by fires and burns to no more that 7.3 per 100,000 population.

Baseline CT 2000	7.3 hospitalizations per 100,000 population
Interim CT 2004	7.7 hospitalizations per 100,000 population

(Data Source: CT Office of Health Care Access, Hospital Discharge Data)

Strategies:

- Expand partnerships with fire safety and burn prevention organizations and agencies.
- Increase the number of households with functioning residential smoke alarms.
- Increase public awareness of the causes and prevention of fire and burn related deaths and injuries.
- Strengthen fire and burn prevention related regulations.

Action Steps:

- Contact additional fire and burn prevention partners and invite to participate in ICPG.
- Review data to determine population groups at highest risk for fire and burn related injury and death.
- Identify or develop educational materials on fire and burn prevention for high-risk populations.
- Review existing legislation and support legislative and code changes related to fire and burn safety.
- Support community-based fire and burn safety programs including smoke alarm testing and installation programs.
- Support community-based carbon monoxide detector installation and testing.
- Support public education and awareness campaigns on fire and burn prevention including importance of developing home emergency escape plans.

Unintentional Injury

Fire/Burn-Related

Action Steps: *(continued):*

- Facilitate development of a comprehensive home safety program for families and caregivers focusing on leading injury risks for children.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG members, Connecticut and local Safe Kids Coalitions, local fire departments, CT Commission on Fire Prevention and Control, State and local fire marshals and building inspectors, local health departments, CT Department of Consumer Protection, US Consumer Product Safety Commission, CT State Department of Education, schools and child care organizations, CT Department of Public Health, CT Department of Consumer Protection, US Consumer Product Safety Commission, CT Commission on Children, Office of the Child Advocate.

Poisoning

Poisoning includes ingestion, inhalation, absorption through the skin or injection of so much of a drug, toxin (biological or non-biological) or other chemical that a harmful effect results (e.g. drug overdoses). Adverse reactions to therapeutic drugs administered during a normal course of treatment, and bacterial illness such as food poisoning, are not included in this category.

Poisoning was the third leading cause of injury-related death, responsible for on average 271 deaths per year. Drugs were responsible for approximately 94% of poisoning deaths with over 60% due to narcotic and psychodysleptic drugs alone. In 29.3% of the cases the drug was coded as other/unspecified. (Figure 17)

The highest rates of poisoning occurred between the ages of 20 to 49 years of age with the highest rate among 40 to 44 year olds. (Figure 18)

Males had a death rate that was 3 times higher than females (12.0/100,000 compared to 3.9/100,000). Hispanics had the highest death rate from poisoning (8.0/100,000), followed by Non-Hispanic Blacks (8.3/100,000) and Non-Hispanic Whites (7.6/100,000).

Poisonings were the 4th leading cause of hospitalization among Connecticut residents (an average of 687 hospitalizations each year between 2000 and 2004). Poisoning hospitalization rates were highest among adults 85 and older (44.9/100,00) followed by adults 80-84 years old (40.5/100,000), and children 1-4 years old (38.8/100,000.) (Figure 19)

Figure 17
Unintentional Poisoning Deaths by Mechanism
Connecticut Residents, 2000 - 2004

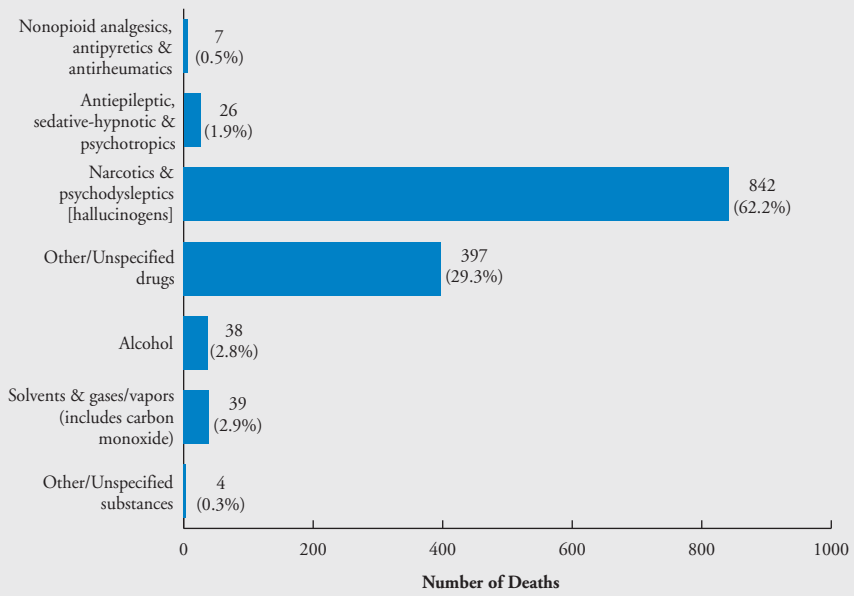
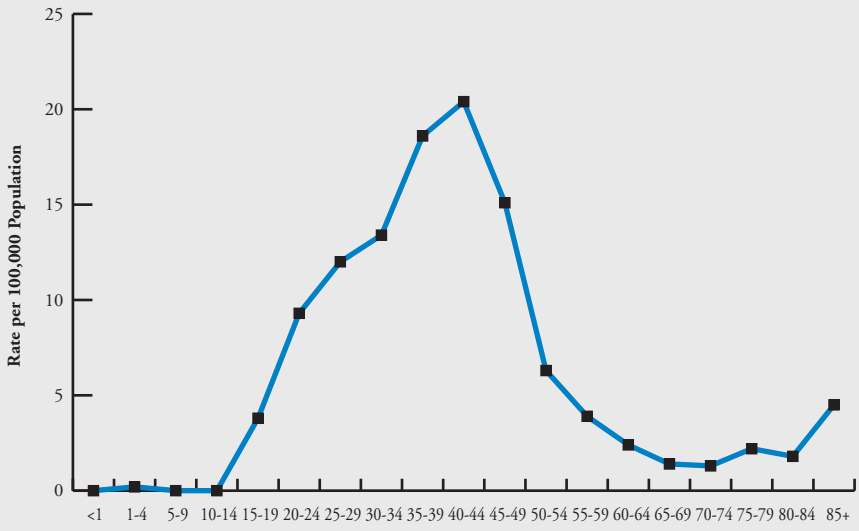


Figure 18
Poisoning Death Rates by Age Group
Connecticut Residents, 2000 - 2004



Poisoning (Cont.)

Males had higher rates of poisoning across the life span compared to females (22.1/100,000 vs. 17.8/100,000).

Approximately 85% of the poisoning hospitalizations were due to drugs. Antiepileptic, sedative-hypnotic and psychotropic drugs were responsible for 35.6% of poisoning hospitalizations and narcotic and psychodysleptic drugs were responsible for an additional 18.2%. In 21.5% of the cases the poison was coded as other/unspecified drug. (Figure 20)

Non-Hispanic Blacks had the highest poisoning hospitalization rate (29.3/100,000) followed by Non-Hispanic Other (22.8/100,000), Hispanic (21.6/100,000) and Non-Hispanic White (18.4/100,000.)

For the five-year period 2000-2004, inpatient hospital charges for poisoning totaled almost $37 million with an average cost of $6,733 per stay. Unintentional poisonings can also occur in the workplace. Occupations such as exterminators, farmers and pesticide applicators are at risk for work-related poisonings. In 2000 there were 35 work-related pesticide poisonings reported in Connecticut (Connecticut Poison Control Center).

Figure 19
Unintentional Poisoning Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004

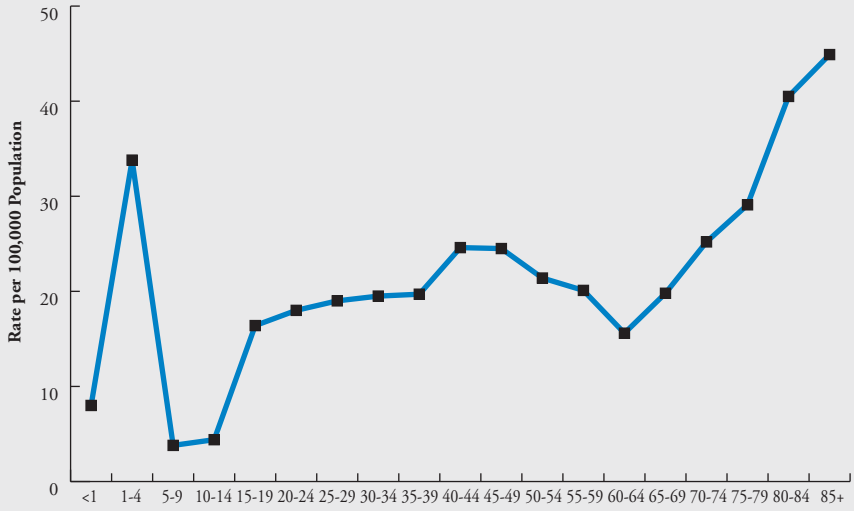
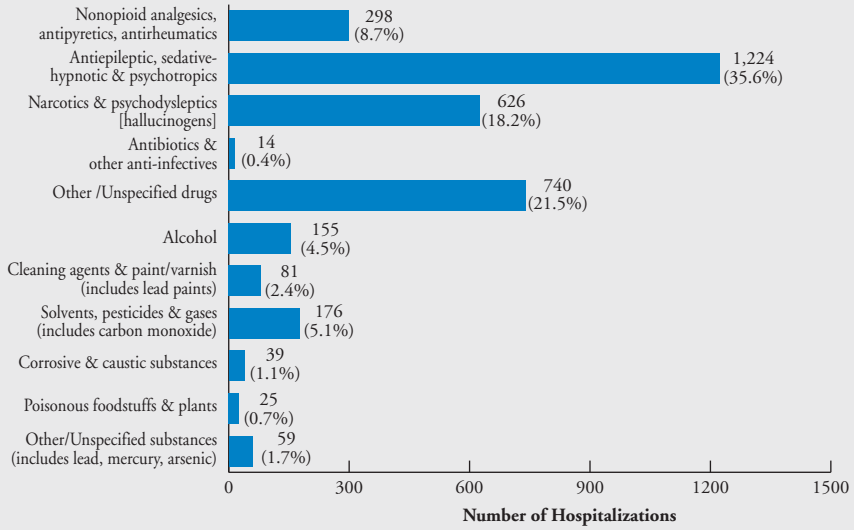


Figure 20
Poisoning Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Poisoning

Connecticut Objectives:

By 2010, Reduce deaths caused by unintentional poisonings to no more than 7.8 per 100,000.

Baseline CT 2000	7.7 per 100,000 population
Interim CT 2004	8.3 per 100,000 population

(Source: CT Department of Public Health, Vital Records)

By 2010, Decrease the hospitalization rate from non-fatal poisonings to no more than 19.9 per 100,000.

Baseline CT 2000	17.7 hospitalizations per 100,000
Interim CT 2004	23.9 hospitalizations per 100,000

(Source: CT Office of Health Care Access, Hospital Discharge Data)

Strategies:

- Expand collaborations, including ICPG participation, to include the CT Department of Mental Health and Addiction Services and other appropriate partners in the substance abuse prevention and control and poison prevention fields.
- Improve surveillance on causes of poisoning-related injuries and deaths.
- Increase public awareness of the causes and prevention of poisonings.
- Expand the role of health care and other service providers in providing poison prevention education.
- Increase awareness and usage of CT Poison Control Center services to reduce unnecessary hospital and emergency department visits.

Action Steps:

- Contact additional poison prevention partners and invite to participate in the ICPG.
- Identify and access additional data sources to provide a more complete picture of poison - related issues in Connecticut.
- Review and analyze data from multiple sources (i.e. Toxic Exposure Surveillance System, hospital and ED, mortality) and provide more detailed information on causes of poisoning for specific population groups.
- Promote increased public and provider awareness and use of CT Poison Control Center Services and resources.
- Work with CT Poison Control Center to expand audiences reached by Center's public awareness and community education programs on poison prevention.

Unintentional Injury

Poisoning

Action Steps *(continued):*

- Promote health literacy education for health care providers.
- Provide training on medication safety issues to health care and other providers serving older adults.
- Provide education and training for families, childcare, health care and other family service providers on poison prevention.
- Facilitate development of a comprehensive home safety program for families and caregivers focusing on leading injury risks for children.
- Partner with the DPH Occupational Health Unit, Connecticut Poison Control Center and others to promote awareness and provide resources to workers at risk for occupational poisoning.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG members, CT Poison Control Center, CT Department of Mental Health and Addiction Services, CT Department of Public Health, State and local substance abuse prevention services providers, Connecticut and local safe kids coalitions, CT Department of Social Services, Aging Service Providers, Area Agencies on Aging, CT Collaboration for Fall Prevention, local health departments, Office of the Child Advocate, CT Commission on Children, CT Department of Consumer Protection, US Consumer Product Safety Commission, health care providers including hospitals and emergency medical services, and others.

Drowning

Drowning results from submersion in water or other liquid. Mechanisms for drowning include natural bodies of water, pools, and bathtubs. Between 2000 and 2004 there were an average of 27 drowning deaths per year. There were 1.5 times more drowning-related deaths (133) during this time period than hospitalizations (91), demonstrating the lethality of drowning-related injuries. The highest rates of drowning occurred among infants (2.7/100,000) and children between the ages of 1 to 4 years (2.0/100,000) and older adults 80 to 85 years (2.8/100,000) and 85+ years (3.8/100,000). (Figure 21)

The death rate for drowning was three times higher among males (1.2/100,00) than females (0.4/100,000). Non-Hispanic Blacks had the highest rate for drowning (1.2/100,000) followed by Hispanics (0.9/100,000). Non-Hispanic Whites had a rate of 0.6/100,000. Over half (56.4%) of drowning deaths were coded as other/unspecified drowning. Where the circumstances were identified on the death certificate, 25.6% of drownings occurred in natural bodies of water, 11.3% in swimming pools and 6.8% in bathtubs. (Figure 22)

Figure 21
Unintentional Drowning Death Rates by Age Group
Connecticut Residents, 2000 - 2004

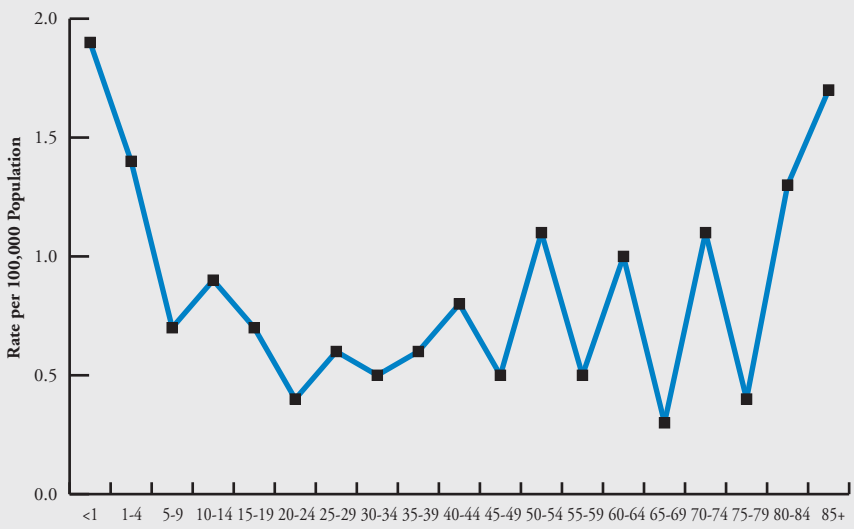
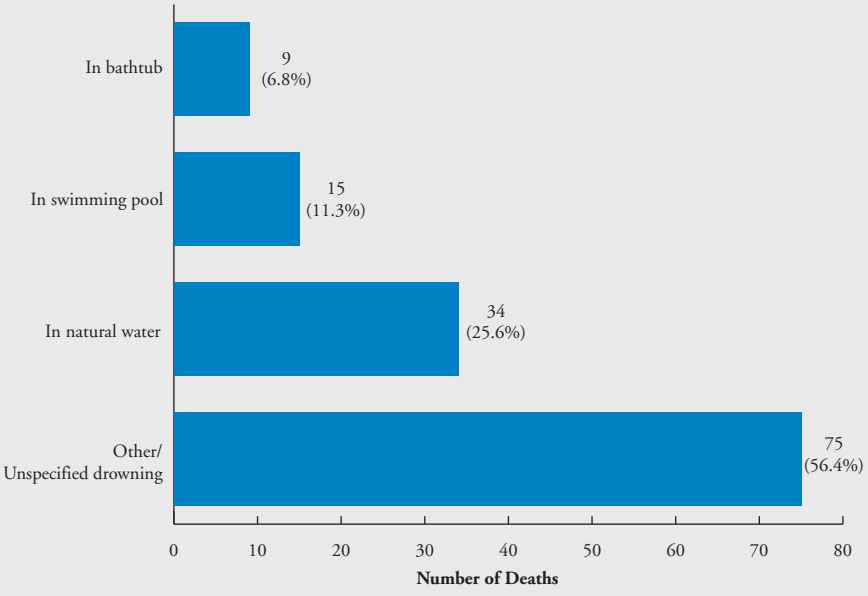


Figure 22
Drowning Deaths by Mechanism
Connecticut Residents, 2000 - 2004



Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Drowning

Connecticut Objectives:

By 2010, Reduce deaths caused by drowning to no more than 0.6 per 100,000 population.

Baseline CT 2000	0.7 per 100,000 population
Interim CT 2004	0.8 per 100,000 population

(Source: CT Department of Public Health, Vital Records)

Strategies:

- Expand collaborations to include water safety, sports and recreation related organizations.
- Increase public awareness of drowning risks and prevention measures.

Action Steps:

- Collaborate with partners to identify or develop public education materials on water safety and drowning prevention especially for high-risk populations.
- Support public awareness campaigns in partnership with recreation organizations and recreation-related businesses.
- Provide support for legislative and/or code changes that would decrease drowning risks.
- Collaborate with partners to develop or enhance public awareness of high-risk water safety activities and environments and to support enforcement of existing water safety laws.
- Promote use of Personal Flotation Devices (PFDs).
- Promote safety training for watercraft operators.
- Promote increased access to swimming lessons.
- Facilitate development of a comprehensive home safety program for families and caregivers focusing on leading injury risks for children.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG members, Connecticut and local Safe Kids Coalitions, CT Department Environmental Protection, YMCA, US Coast Guard, municipal parks and recreation departments, CT Recreation and Parks Association, local health departments, law enforcement agencies, state and local building officials, boating associations, Office of the Child Advocate and others.

Suffocation

Suffocation is defined as 1) inhalation, aspiration, or ingestion of food or other object that blocks the airway, 2) unintentional mechanical suffocation caused by hanging or strangulation (i.e. clothing drawstrings, crib slats), or 3) lack of air in a closed place, plastic bags, bedding or falling earth. Suffocation was the fifth leading cause of injury-related death in Connecticut.

There were nearly twice as many suffocation deaths (570) from 2000 to 2004 as hospitalizations, indicating the high lethality of suffocation-related injuries. The inhalation or ingestion of food or other objects accounted for approximately 80% of suffocation deaths. (Figure 23)

The highest rates of suffocation deaths were found among older adults; 75% of all suffocation deaths occurred among persons 70 and older. (Figure 24)

Ninety-nine percent of choking deaths among older adults were caused by inhalation or ingestion of food or other objects, possibly medications. For infants less than one year of age, the predominant cause of suffocation was mechanical suffocation, i.e. bedding, plastic bags, or unintentional hanging or strangulation. Males had slightly higher rates of choking across the life span (3.5/100,000) compared to females (3.1/100,000); however the rates were significantly higher among older adults for males. Non-Hispanic Whites had the highest rate of death (3.7/100,000) followed by Non-Hispanic Blacks (2.3/100,000), and Hispanics (1.0/100,000). Approximately 30% of all suffocation deaths occurred in nursing homes.

Figure 23
Unintentional Suffocation Deaths by Mechanism
Connecticut Residents, 2000 - 2004

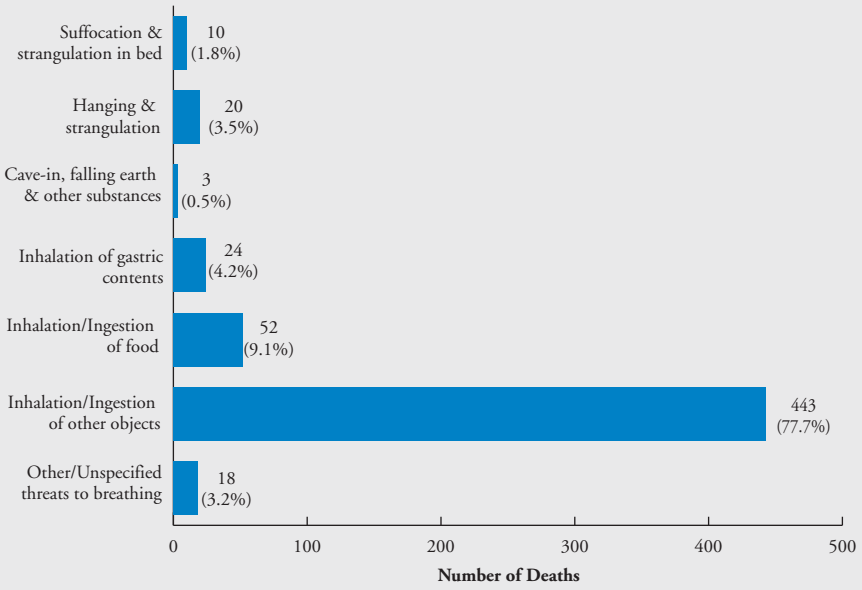
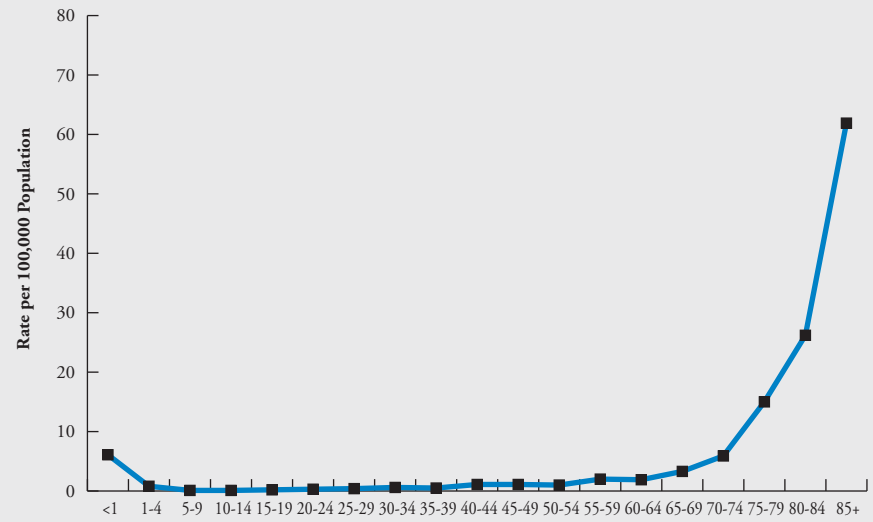


Figure 24
Suffocation Death Rates by Age Group
Connecticut Residents, 2000 - 2004



Unintentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.**

Suffocation

Connecticut Objectives:

By 2010, Reduce deaths caused by suffocation to no more than 3.3 per 100,000 population.

Baseline CT 2000	3.8 per 100,000 population
Interim CT 2004	3.6 per 100,000 population

(Source: CT Department of Public Health, Vital Records)

Strategies:

- Improve surveillance on causes of suffocation-related deaths.
- Increase public awareness on causes and prevention of suffocation-related deaths.

Action Steps:

- Review and analyze existing data to provide more detailed information on causes of suffocation, i.e. inhalation and ingestion of food; inhalation and ingestion of other object and strangulation, for specific age groups.
- Identify and access potential additional data sources to provide more complete information on causes and circumstances of suffocation-related deaths and the types of settings where these deaths occur.
- Facilitate development of a comprehensive home safety program for families and caregivers focusing on leading injury risks for children.
- Identify and promote effective choking prevention strategies.
- Incorporate choking prevention measures into medication safety and other services and programs for older adults.
- Promote training on first aid for choking.
- Collaborate with partners to identify and seek additional sources of funding.

Partners: ICPG members, Connecticut and local Safe Kids Coalitions, CT Department of Public Health, CT Department of Social Services, Health care providers and facilities, Aging Service Providers, CT Department of Consumer Protection, US Consumer Product Safety Commission, Office of the Child Advocate, American Red Cross, EMS and first aid instructors.

Intentional Injury

All Intentional Injury

Interpersonal violence is defined by Krug et. al. as "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."[24] Violence-related deaths and injuries are described as intentional. They include deaths and injuries due to homicides, assault, fighting, suicide, suicide attempts, domestic violence, child abuse and sexual violence.

In Connecticut, deaths due to suicide outnumbered deaths due to homicide. From 2000-2004, Connecticut intentional injury death rates for persons dying by homicide and suicide were fairly similar across ages until ages 25-29 at which point rates for suicide increased and homicide decreased relative to total intentional injury. (Figure 25)

Males died more frequently due to homicide and suicide. Black and Hispanic males died more frequently than Caucasian males due to homicide, however Caucasian males died more frequently due to suicide.

Rates for intentional injury hospitalization followed a slightly different pattern, from 2000-2004, with self-inflicted injury increasing beginning at ages 10-14, peaking at ages 15-19, slowly declining through age 34, leveling through age 44 and declining through age 55 to remain almost level through age 85 and above. Total intentional injury assaults rose steeply from age 15-24, declining through the third through fifth decades to very low levels through age 85 and above.

Figure 25
Intentional Injury Death Rates by Mechanism & Age Group
Connecticut Residents, 2000 - 2004

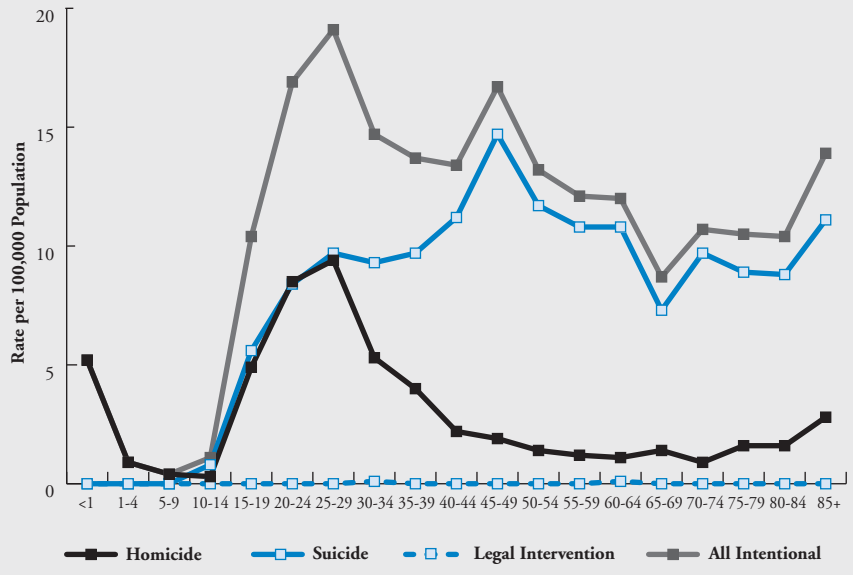
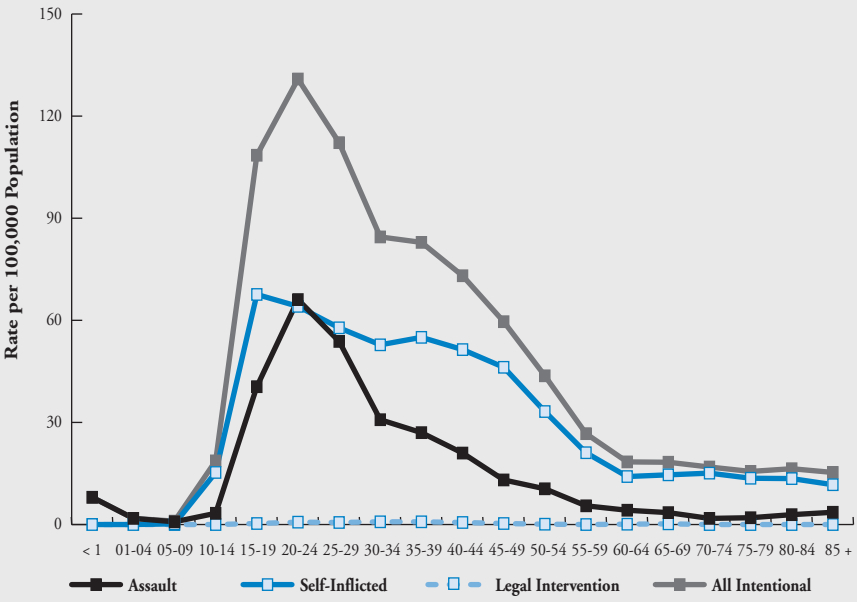


Figure 26
Intentional Injury Hospitalization Rates by Mechanism & Age Group
Connecticut Residents, 2000 - 2004



(Sources: CT DPH / Office of Health Care Access Hospital Discharge Data, CT DPH Vital Records.) (Figure 26)

The Intentional Injury section of the Plan includes additional information and Goals, Objectives, Strategies, and Action Steps for intentional injury and specific intentional injury-related categories.

All Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Connecticut Objectives:

By 2010, Reduce Intentional Injury Deaths to no more than 10.8 per 100,000 Total Population.

Baseline CT 2000	11.6 per 100,000	Total Population
Interim CT 2004	11.2 per 100,000	Total Population

(Data Source: CT Department of Public Health, Vital Records)

By 2010, Reduce Intentional Injury Hospitalizations to no more than 50.5 per 100,000 Total Population.

Baseline 2000	52.5 per 100,000	Total Population
Interim 2004	53.7 per 100,000	Total Population

(Data Source: CT Office of Health Care Access, Hospital Discharge Data)

Strategies:

- Identify and intervene early to address risk factors that contribute to violent behavior among children and families.
- Expand prevention and intervention strategies.
- Identify, explore and address factors that increase anger and disconnection.
- Increase rewards for prosocial behavior rather than focusing the majority of resources and rewards on those with risky behaviors.
- Reduce risk factors and enhance protective factors related to traumatic victimization and child/youth witnesses to violence.
- Identify and utilize trauma assessment tools as part of assessment and provision of trauma related services.
- Increase the number of adults who incorporate and role model pro-social behaviors in their interaction with children and youth.
- Enhance the ability of adults to motivate, provide positive messages and build in incentives and rewards for accomplishment.
- Identify, explore and address unacceptable behaviors of adults through schools and agencies that deal with children and youth.

Action Steps:

- Facilitate collaborations and connections that increase access and quality of services and supports that address mental health issues.
- Outreach to, involve and work with families proactively, before problems arise.
- Facilitate increased positive parental involvement with school communities.
- Collaborate with partners to increase geographic, cultural and operational accessibility of services and programs.

All Intentional Injury

Connecticut Objectives:

By 2010, Reduce firearm related deaths to no more than 4.4 per 100,000 total population.

Baseline CT 2000	5.2 per 100,000	Total population
Interim CT 2004	4.9 per 100,000	Total population

(Data Source: CT Department of Public Health, Vital Records)

By 2010, Reduce firearm related injuries to no more than 5.4 per 100,000 total population.

Baseline CT 2000	6.3 per 100,000	Total population
Interim CT 2004	5.9 per 100,000	Total population

(Data Source: CT Office of Health Care Access, Hospital Discharge Data)

Strategies:

- Develop and implement a social marketing campaign focused on gun violence reduction.
- Enhance enforcement of existing laws and regulations regarding firearms.

Action Steps:

- Collaborate with partners and law enforcement to support enforcement of existing firearm legislation and ordinances.
- Collaborate with partners to support enforcement of penalties for illegal firearm carrying and selling.
- Collaborate with partners to support enforcement of domestic violence and mental health related firearm ordinances.
- Collaborate with parents, caregivers and community partners to diminish the "gun mentality" among some youth and adults.
- Collaborate with schools to support enforcement of penalties for students who bring firearms onto school property.
- Collaborate with community and law enforcement to investigate the viability of advocating for legislation that provides for higher penalties for persons who sell firearms to children and youth.
- Collaborate with police departments to obtain buy-in and facilitate capturing "shots fired" reports data in addition to firearm injuries and deaths.

All Intentional Injury

Connecticut Objective:

Improve intentional injury-related data access, quality and use.

Strategies:

- Identify relevant data sources, identify gaps and collect relevant data.
- Develop and implement resources to compile, analyze and disseminate data.
- Obtain and analyze more local community level data.

Action Steps:

- Identify and prioritize data needs.
- Collaborate with partners to obtain access to data not currently available.
- Facilitate the compiling of violence related data, analysis and dissemination.
- Evaluate differences in homicide and assault data and use to facilitate more effective prevention and intervention strategies.
- Include additional descriptive data as a part of analysis such as race/ethnicity, age, gender, socioeconomic status, population density and geography.

Connecticut Objective:

Enhance evaluation of intentional injury-related programs and services.

Strategy:

- Whenever feasible, require and include funding for evaluation as part of new and renewal contracts.

Action Steps:

- Collaborate with contractors to increase capacity to conduct realistic process, outcome and impact evaluation.
- Gather information about what is working in CT and other states and integrate as appropriate.
- Collaborate with partners to develop dissemination products that include pertinent and salient evaluation findings.

All Intentional Injury

Connecticut Objective:

Develop, implement, facilitate more comprehensive prevention and early interventions for children and youth.

Strategies:

- Improve educational activities focused on reducing violence and its' precursors.
- Improve prevention and intervention activities and services focused on very young children.
- Develop and promote more effective prevention programs in schools and after-school venues including conflict resolution and peer mediation.
- Develop and use strategies, programming and resources that increase protective factors and foster youth of character.
- Promote early intervention strategies when problems arise to decrease the frequency of arrest being the only option available for "minor" offenses.
- Develop and use more effective intervention and treatment programs and services for children and youth.
- Support expansion of mental health clinicians in School-Based Health Centers and similar facilities.
- Promote early intervention strategies and services that improve the mental health of children and youth.

Action Steps:

- Collaborate with partners to facilitate an increased focus on prevention.
- Collaborate with partners to identify resources and strategies to increase availability of and access to affordable, quality day care.
- Collaborate with education, administrators and others to facilitate training and continuing education that improves the ability of teachers, day care providers and other adults to appropriately intervene with and refer children with disruptive behavior.
- Collaborate with partners to identify and minimize knowledge, skill-building and resource gaps between and within programs.
- Collaborate with systems, schools, providers and communities to improve school to community provider referrals.
- Collaborate with partners, parents, caregivers and communities to identify and address antecedents to the despairing attitude among some children and youth and incorporate meaningful, effective interactions that build hope and raise expectations.
- Use resources that describe behavioral, risk and protective factor differences in gender and use the information to facilitate improvements in prevention programs and strategies.
- Encourage providers to include assessment for traumatic brain injury in care of children and youth suspected of being neglected and/or abused.

All Intentional Injury

Connecticut Objectives:

Develop. implement and facilitate more comprehensive prevention and early interventions focused on adults and elders.

Strategies:

- Increase awareness of and initiatives that address risk and protective factors associated with intentional injury among adults and elders.
- Establish and improve screening for traumatic brain injury among persons who are homeless, veterans and others at potentially higher risk.
- Increase awareness of the potential connection of depression, including post-partum depression, to suicide, assault and homicide.

Action Steps:

- When working with adults in unsafe circumstances and environments who are victims of domestic violence, assault, sexual violence and other intentional injury related issues and work with partners to develop policies, strategies and interventions to address risk factors, protective factors and needed resources.
- Increase the focus on environmental strategies that could decrease violence.
- Encourage providers to include assessment for traumatic brain injury in care of female victims of domestic violence.
- Facilitate increased awareness and prevention strategies focused on the connection of violence and traumatic brain injury.
- Examine data to enhance planning, programs and strategies.
- Collaborate with partners to design and implement more awareness, prevention and intervention for young adults ages 18-24.
- Set up task a force to review, plan and develop initiatives for the 18-24 age group.

Partners: ICPG, State Departments of Public Health, Education, Children and Families, Social Services, Mental Health and Addiction Services, Judicial, Labor, Corrections, Protection and Advocacy, Policy and Management, Higher Education; local education, health and mental health providers, survivors, community-based agencies, state and local collaboratives, Youth Challenge International, Young Mens' Christian Association, Boys and Girls' Clubs, Girl Scouts, Cub Scouts, Boy Scouts, Mi Casa, CT Poison Control Center, state and local law enforcement, emergency medical responders, Commission on Children, youth serving organizations, child care providers, health care providers, CT Coalition Against Domestic Violence, CT Sexual Assault Crisis Services Inc., grassroots organizations, senior/elder organizations, faith-based institutions, health care institutions and organizations, criminal justice, businesses and others.

Homicide/Assault

From 2000 to 2004, there were 11 homicides of children less than one year of age. The known mechanisms were firearms and stabbing (cut/pierce). There was a significant increase in deaths due to homicide at ages 15-19 with the highest rate of homicide occurring among those ages 25-29, most of them male. Homicide death rates declined from ages 30 through 59, remaining fairly level through age 85 and above. (Figure 27, 28)

Death rates were significantly higher for males than females except at the end of life; the rate for females was higher than males at age 85 and older. (Injury in Connecticut)

Teens and young adults have the highest rates of assault hospitalizations. The most frequent mechanisms for those ages, 15-24, include struck by/against (fighting), cut/pierce (stabbing) and firearms. There is a decrease of assault hospitalizations through the third and fourth decades with a larger decrease at ages 55-59. (Figures 29, 30)

Female assault hospitalization rates are very low across all ages, exceeded by males at all ages, except in those under age one through age nine and age 75 and older. For the five-year period, total hospitalization charges for assault were $51,794,775 with an average of $10,106 per hospital stay. (Sources: CT DPH/Office of Health Care Access Hospital Discharge Data, CT DPH Vital Records.)

Figure 27
Homicide Death Rates by Age Group
Connecticut Residents, 2000 - 2004

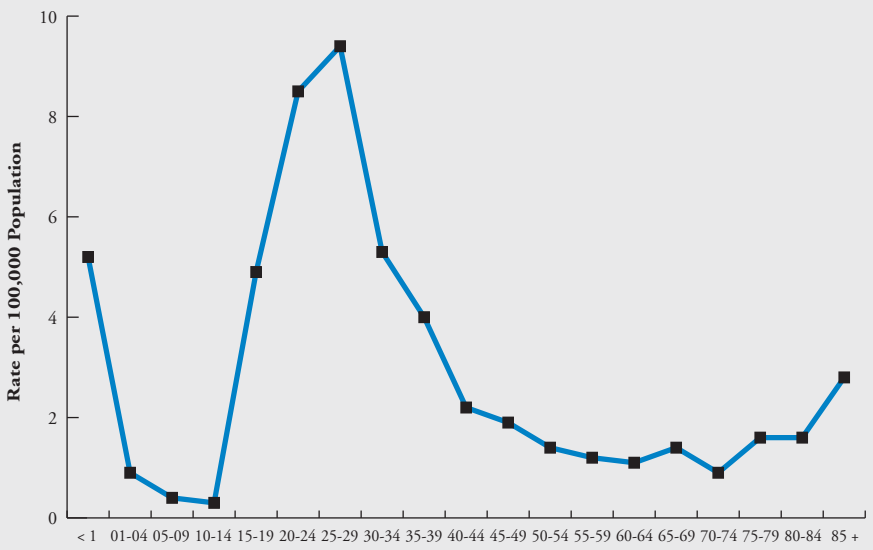
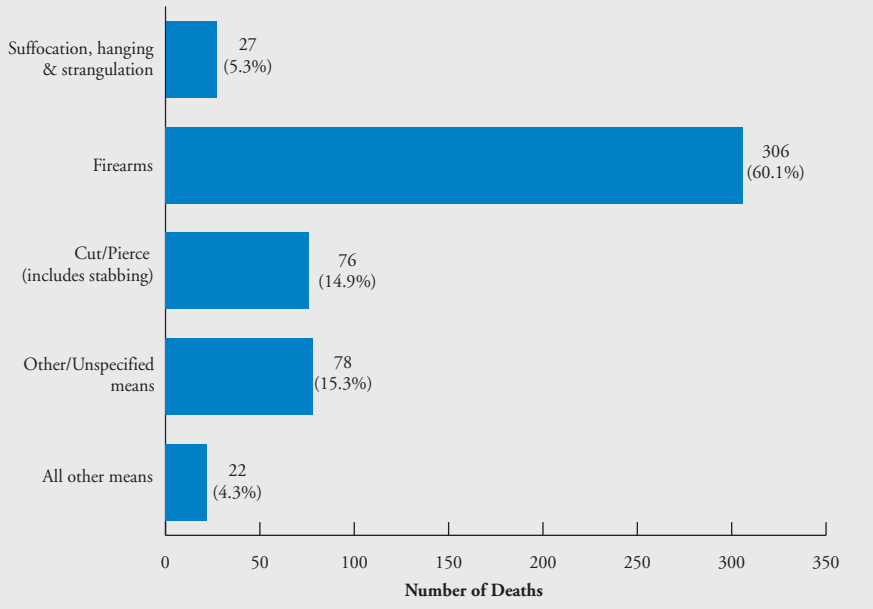


Figure 28
Homicide Deaths by Mechanism
Connecticut Residents, 2000 - 2004



Homicide/Assault

Figure 29
Assault Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004

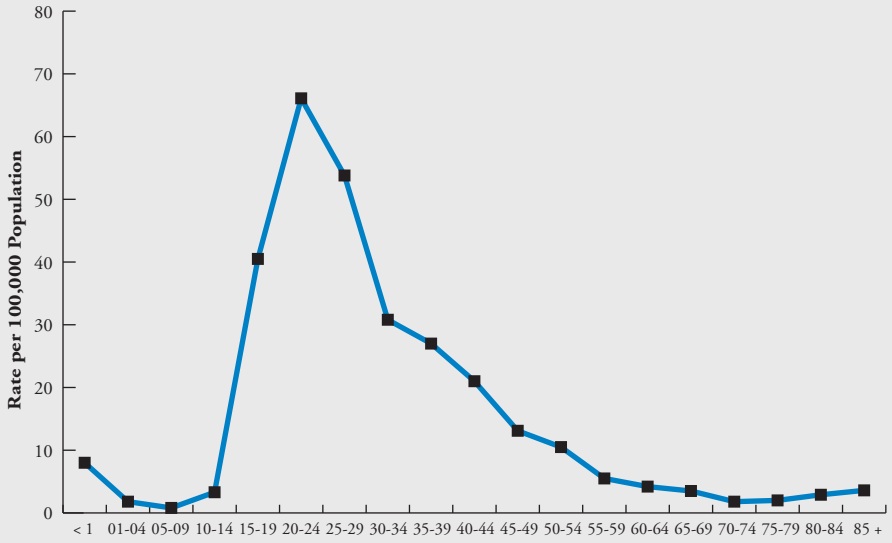
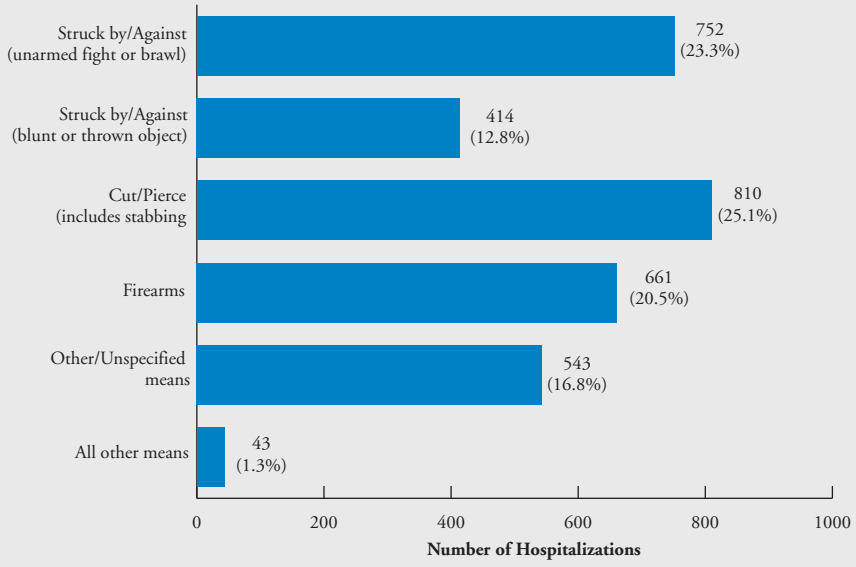


Figure 30
Assault Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Homicide/Assault

Connecticut Objective:

By 2010, Reduce homicides to no more than 2.8 per 100,000 population.

Baseline CT 2000	2.7 per 100,000 population
Interim CT 2004	3.0 per 100,000 population

(Data Source: CT Department of Public Health, Vital Records)

Strategies:

- Reduce risk factors associated with homicides.
- Increase collaboration and communication among criminal justice, community-based, faith-based, and prevention-oriented systems.
- Use environmental strategies to facilitate change in social norms in the communities with increased homicide rates.
- Implement comprehensive methodologies that include many layers and diverse strategies.
- Recognize and implement violence reduction strategies that address differences based on location, gender, race, age, ethnicity and class.
- Reward and promote non-violent behaviors and positive activities conducted by children and youth.

Action Steps:

- Partner with local police and local education to address the issue of arrests for minor assaults within schools.
- Facilitate programs, strategies and resources that decrease anger and disconnection.
- Partner with criminal justice agencies to educate and work with inmates who are incarcerated because of firearm charges.
- Partner with criminal justice agencies and others on transition of inmates to community upon release from prison or jail.
- Review restorative justice programming and work with partners to increase their use including requiring that individuals give back to the community.
- Collaborate with partners to identify and address barriers to successful completion of high school and attainment of viable employment among risk populations in localities with increased homicide rates.
- Collaborate with state and local partners to increase awareness of the impact of homicide and assaults on communities.

Intentional Injury

Homicide/Assault

Connecticut Objective:

By 2010, Reduce assault injuries to no more than 15 per 100,000 population.

Baseline CT 2000	18.5 per 100,000 population
Interim CT 2004	19.3 per 100,000 population

(Source: CT Department of Public Health Vital Records)

By 2010, Reduce the incidence of physical fighting among high school youth to no more than 28% of high school students being in a physical fight.

Baseline CT 1997	33.8% of high school students reported being in a physical fight.
Interim CT 2005	32.7% of high school students reported being in a physical fight.

(Source: CT School Health Survey - Youth Risk Behavior Survey)

Strategies:

- Address the socioeconomic, unemployment and poverty connection to violence.
- Reward and promote non-violent mentalities i.e. children and youth who are doing positive things.
- Implement improved interventions to reduce fighting among children and youth including parental education and awareness.
- Decrease truancy and drop-out rates, especially among disparate populations.
- Investigate and address risk and protective factors associated with truancy.
- Expand and improve school-based alternatives to suspension and expulsion.
- Increase adherence to anti-bullying legislation, policies and other safe school initiatives.
- Increase the effectiveness of school-based bullying prevention programs.
- Strengthen anti-bullying legislation.
- Increase support for out of school programming for children and youth.

Action Steps:

- Collaborate with existing persons working on improvements to anti-bullying legislation.
- Work with partners to use more effective bullying prevention programs.
- Develop more effective policies within schools that do not make police the first option for difficult children with minor offenses.

Intentional Injury

Homicide/Assault

Action Steps *(continued):*

- Collaborate with existing persons working on improvements to anti-bullying legislation.
- Collaborate with partners to use more effective bullying prevention programs.
- Develop more effective policies within schools that do not make police the first option for difficult children with minor offenses.
- Develop new policies.
- Use alternatives to suspensions and expulsions.
- Collaborate with partners to revise "Zero Tolerance" policies to reduce unintended consequences of those policies.
- Facilitate environmental and social strategies to increase a sense of community, such as creating small communities.
- Collaborate with education and partners to facilitate appropriate responses to children and youth with behavioral health problems.
- Collaborate with education and partners to diminish marginalization of children and youth with behavioral health problems.
- Collaborate with young, disengaged fathers ages 19 to 39 on appropriately enhancing relationships with their child/children.

Partners: ICPG, State Departments of Public Health, Education, Children and Families, Social Services, Mental Health and Addiction Services, Judicial, Labor, Corrections, Policy and Management; law enforcement, Safe Schools and Communities Coalition, local education, community-based agencies, local collaboratives, Youth Challenge International, Young Mens' Christian Association, Boys and Girls' Clubs, Girl Scouts, Cub Scouts, Boy Scouts, Mi Casa and others.

Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Child Maltreatment

Connecticut Objective:

By 2010, Reduce child maltreatment to no more than 21,671 (rate of 25.7 per 1,000 children) Abuse/Neglect/Uncared for substantiated allegations.

Baseline CT 2000	24,871 (29.5/1,000 Children) Abuse/Neglect/Uncared for substantiated allegations
Interim CT 2004	24,017 (28.6/1,000) Abuse/Neglect/Uncared for substantiated allegations

(Source: State of Connecticut Department of Children and Families Town Pages)
(Source: CT Department of Public Health calculated the rates)

Strategies:

- Intervene early, including increasing emphasis on providing services and information to mothers and prospective mothers.
- Implement effective, family-centered systems of care that facilitate child and family-centered prevention and intervention services.
- Develop or bring to CT a broader model of the National Curriculum and make it more applicable for all early childhood partners.
- Increase provider awareness in assessing mental delays related to traumatic brain injury that may be linked to child maltreatment.
- Increase awareness of potential connection of child maltreatment to domestic violence.

Action Steps:

- Continue, research and facilitate initiatives that have been evaluated and demonstrated to be effective with CT children such as the Children's Trust Fund Nurturing Families initiative.
- Collaborate with the Office of the Child Advocate to investigate the feasibility of a more comprehensive review of CT child fatalities.
- Collaborate with the Department of Children and Families and others to facilitate policies and practices that provide a more comprehensive, differential response for families and children with needs who fall between child protection mandates.

Intentional Injury

Child Maltreatment

Action Steps:

- Reactivate "train-the-trainer" collaborative model to continue implementation of the National Curriculum for Head Start on Domestic Violence.
- Facilitate improved treatment of and programs for children with problem sexual behaviors.
- Facilitate improved treatment of and programs for child witnesses of violence including domestic violence.
- Facilitate programs that appropriately meet child protection mandates without penalizing domestic violence victims.
- Facilitate improved programs for parents of children with sexual behavior problems.
- Implement middle school programs that provide knowledge and skill-building that facilitate healthy relationships.

Partners: ICPG, CT Departments of Children and Families, Health, Education, Mental Retardation, Social Services, Mental Health and Addiction Services; Office of the Child Advocate, Children's Trust Fund, Domestic Violence/ Child Maltreatment Collaborative, Commission on Children, community-based agencies, youth serving organizations, child care providers, health care providers, Birth to Three, Court System, Early Childhood Consultation Project, Children's Advocacy Centers, Family Resource Centers, CT Coalition of Parent Educators, American Pediatric Association and others.

Dating/Domestic/Intimate Partner Violence

"Intimate partner violence is the threatened or actual use of physical force against an intimate partner that either results in or has the potential to result in death, injury, or harm. Intimate partner violence includes physical and sexual violence, both of which are often accompanied by psychological or emotional abuse. Some common terms used to describe intimate partner violence include domestic abuse, spouse abuse, domestic violence, courtship violence, battering, marital rape, and date rape."[25] Sexual violence is addressed in a separate section of the Plan Data is taken from the CT Uniform Crimes compiled by the CT Department of Public Safety. Data sources include Uniform Crime Reports (UCR) and service data from the CT Coalition Against Domestic Violence.

Family violence data compiled by the CT Department of Public Safety include "persons who are both victims and offenders and in dating relationships". A family violence offense classification is defined in the Uniform Crime Reports (UCR) as an incident in which "there must be either injury or present danger with the likelihood that physical violence will occur, and the relationship between parties conforms to the definition of family or household members". Family household members as defined by C.G.S.46b-38a-2 in the UCR, include "spouses, former spouses, parents and their children, persons eighteen years of age or older related by blood or marriage, persons sixteen years of age or older who are presently residing together or who have resided together in the past, and persons who share a child in common regardless of their marital status or living arrangement, and persons in or have been in a dating relationship."[26]

UCR reported 21,328 family violence offenses in 2002; 20,428 in 2003 and 20,320 in 2004 involving 18,898; 18,069 and 18,084 victims respectively in the same years. Approximately 75% of the victims were female in those years. Children were involved in almost 20% of the incidents and were present in the household in more than 20% of the incidents. There was a slight decrease in children involved or present from 2002-2004.

Of the 18,084 victims in 2004: 3,226 were spouses; 384 former spouses; 6,204 live-ins; 6,074 relatives residing and not residing in the home and 2, 197 were boyfriend/girlfriend. Persons arrested used physical force in the majority of the incidents each year - 13,673 and 67% of the incidents in 2004. Guns were used in only 284 (1%), knives in 778 (4%) and other dangerous weapons in 1,377 (7%) of incidents during the same year. There were two family violence offenders identified as ages six to nine in 2003, otherwise most offenders (62% in 2004) were between the ages of 21 and forty-four.

There were 21 family violence homicides in 2002, 29 in 2003 and 27 in 2004. During each year some of the offenders completed suicide; three in 2002, six in 2003 and six in 2004. The Family Violence Report states that "These murder-suicides generally resulted from an estranged love relationship in which the husband/boyfriend was the offender." Guns were the primary weapon used in murder-suicides.

(Source: www.ct.gov/dps - Connecticut State Police/Uniform Crime Reports)

Citation : Osattin A, Short LM. Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1998.

Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Dating/Domestic/Intimate Partner Violence

Connecticut Objective:

By 2010, Reduce the number of family violence victims who are spouses, former spouses, live-ins, boyfriend, girlfriend to no more than 16,000 victims. (469.3 per 100,000 population)

Baseline CT 2000	17,035 victims (499.6 per 100,000 population)
Interim CT 2004	18,084 victims (516.2 per 100,0000 population)

(Source: Uniform Crime Reports, CT Department of Public Safety, Crimes Analysis Unit)
(Source: CT Department of Public Health calculated rates)

Data, Surveillance, Evaluation

Strategies:

- Improve access, analysis and use of sources of dating and domestic violence data.
- Identify additional data sources and determine ways to improve the quality of intimate partner data.
- Improve and /or develop systems that analyze and use available data sources to improve program planning and evaluation.

Action Steps:

- Partner with the CT Coalition Against Domestic Violence and others to determine data needs and to improve access to and quality of data.
- Continue use of Uniform Crime Reports data.
- Collaborate with partners to develop and legislate for data sources to determine rates of mortality and morbidity related to physical assault by current or former intimate partners.

Prevention, Intervention, Policy

Strategies:

- Increase the focus on promoting healthy relationships as a means of reducing dating violence among middle and high school-aged youth.
- Develop and implement prevention strategies that are diverse and inclusive, facilitating and incorporating healthy behaviors and appropriate ways to deal with common, everyday issues.

Dating/Domestic/Intimate Partner Violence

Strategies *(continued):*

- Develop, implement and facilitate prevention and intervention strategies that are comprehensive and address issues of social capital, housing, increased recreational activities, employment opportunities, substance abuse and mental health issues for families experiencing domestic violence and for the abuser.
- Facilitate provision of sufficient resources to clinicians for intimate partner violence training, continuing education and to expand services for those affected by domestic violence.
- Facilitate system enhancements, policies and strategies that hold the batterer accountable and provide for victim safety and protection.

Action Steps:

- Involve the community, including funding community-based organizations for all aspects of activities addressing violence against women's issues including developing and implementing prevention, intervention and evaluation.
- Collaborate with partners to develop messages that facilitate a change in social norms and attitudes about violence against women and male victimization.
- Focus prevention messages on peers and adults in the lives of children and youth so that they facilitate changes in attitudes and behavior among potential victims, increasing the potential for them not to tolerate abuse, and for potential abusers to behaviorally incorporate the message that abuse and controlling behavior are unacceptable.
- Involve young people in developing messages and leading prevention activities that promote healthy relationships and reduce dating violence.
- Domestic violence and sexual assault organizations, agencies and others involved in assisting victims involved in the courts and other aspects of the criminal justice system assure that the victim/survivor receives competent, caring assistance and reliable information from the time she enters the system until the time resolution occurs.
- Include trauma informed models in prevention and intervention programming.
- Collaborate with judicial to increase the consistency of judges' responses to violations of protective orders.
- Collaborate with criminal justice and police to increase consistency in response across police stations.
- Collaborate with partners to increase suspected victims and general awareness of dangers of leaving an abusive relationship among victims and the general population.
- Collaborate with partners to initiate an immediate response system and database tied into local police departments.

Partners: ICPG, CT Coalition Against Domestic Violence, Domestic Violence/ Child Maltreatment Collaborative, Office of Public Safety, local domestic violence collaboratives, community-based organizations, grassroots organizations, faith-based institutions, health care institutions and organizations, law enforcement, criminal justice, businesses, state agencies-public health, protection and advocacy, mental retardation, social services, children and families, education, higher education, mental health and addiction services and others.

Intentional Injury

Sexual Violence

Sexual violence includes rape, sexual assault and other sexual offenses. Sexual violence is underreported. Data sources include CT Uniform Crime Reports and service data from CT Sexual Assault Crisis Services Inc.

Under "Defining Rape" in Crime in Connecticut 2004 (Uniform Crime Reports) the following information is provided - "In 1930, the FBI's definition of rape was focused on nonconsensual intercourse involving a male perpetrator and female victim. This definition has been retained in UCR to ensure comparability of rape statistics over the years. More recently, the FBI has adopted a definition of rape that recognizes male victims, female perpetrators, and non-intercourse forms of rape."[27]

In 2000, 668 rape offenses were reported in Connecticut. The overall rate in 2000 was 19.62/100,000 persons and 38.01/ 100,000 females. The number of reported offenses decreased to 640 in 2001, but subsequently increased to 734, 701 and 778 in 2002,2003,2004 respectively. The rate of rape offenses in 2004 was 22.21/100,0000 persons and 43.03/100,000 females including 702 completed and 76 attempted rapes. There were 61 arrestees between the ages of 15 and 19; 24 younger than 15 with most of the remaining arrestees between the ages of 20 and 44. In 2004, four females and 302 males were arrested.

(Source: www.ct.gov/dps - Connecticut State Policy Uniform Crime Reports)

Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Sexual Violence

Connecticut Objective:

Reduce sexual violence:
By 2010, Reduce the annual rate of rape to no more than 20.1 per 100,000 persons.

Baseline CT 2000	19.62 per 100,000 persons
Interim CT 2004	22.21 per 100,000 persons

(Source: CT Uniform Crime Reports , Department of Public Safety, Crimes Analysis Unit)

By 2010, Reduce the annual rate of rape to no more than - 40.3 per 100,000 females.

Baseline CT 2000	38.01 per 100,000 females
Interim CT 2004	43.03 per 100,000 females

(Source: CT Uniform Crime Reports , Department of Public Safety, Crimes Analysis Unit)

By 2010, Reduce forcible rape offenses to no more than 276 arrests/offenses (rate of 8.1 per 100,000 person).

Baseline CT 2000	306 arrests/offenses (9.0 per 100,000 person)
Interim CT 2004	306 arrests/offenses (8.7 per 100,000 person)

(Source: CT Uniform Crime Reports, CT Department of Public Safety, Crimes Analysis Unit)
(Source: CT Department of Public Health calculated the rates)

By 2010, Reduce sex offenses to no more than 750 arrests/offenses (rate of 22.0 per 100,000 person).

Baseline CT 2000	799 arrests/offenses (23.4 per 100,000 person)
Interim CT 2004	781 arrests/offenses (22.3 per 100,000 person)

(Source: CT Uniform Crime Reports, CT Department of Public Safety, Crimes Analysis Unit)

Intentional Injury

Data, Surveillance, Evaluation

Strategies:

- Improve access, analysis and use of sources of sexual violence data.
- Identify additional data sources, methods of access and determine ways to improve quality of sexual violence data.
- Improve initial clinical assessment and documentation.
- Develop a system that analyzes and uses available data sources to improve program planning and evaluation.

Action Steps:

- Partner with the CT Sexual Assault Crisis Services and others to determine data needs and to improve access to and quality of data.
- Investigate the possibility of obtaining summary data from child sexual abuse clinics and state Multi-Disciplinary Teams.
- Continue use of Uniform Crime Reports data.
- Use State Department of Children and Families sexual abuse data.
- Track evidence collection kits using billing and diagnosis codes.
- Partner with the CT Hospital Association to standardize and accurately identify sexual assault codes.
- Incorporate evaluation into sexual violence initiatives to facilitate effectiveness.
- Improve evaluation of sexual violence programming, training, strategies and initiatives.
- Incorporate as appropriate results of research when planning initiatives to improve program effectiveness.
- Use applicable research-based programs and strategies.
- Evaluate knowledge, attitudes and behavior change as part of programs and training.

Prevention, Intervention, Policy

Strategies:

- Develop and use effective prevention and intervention programs geared towards abusers and sexual offenders.
- Consider self-defense training such as RADD training as part of a comprehensive prevention strategy.
- Develop and facilitate policies and change attitudes about the acceptability of sexual violence including skill-building to interrupt behaviors that promote a climate that condones sexual harassment and sexual violence.
- Develop and enhance effective training for physicians and obstetrical gynecology practitioners regarding taking a sexual violence history.

Sexual Violence

Strategies *(continued):*

- Develop and expand treatment programs for children with problem sexual behaviors.
- Improve initial clinical assessment and documentation.
- Develop and promote multiple session skill-building programs that teach and promote skill-building related to healthy relationships, healthy sexuality and equitable relationships.

Action Steps:

- Partner with media, constituents and stakeholders to change social norms and attitudes about male victimization.
- Promote education about definition and role of consent starting in teen years through adulthood.
- Promote awareness that use of alcohol and other substances by the victim and/or the abuser is frequently associated with sexual assault.
- Expand programs and services for adult victims of sexual violence.
- Develop and incorporate messages, professional education and training that facilitates an increase in general awareness of the increased risk of sexual violence for disabled individuals and that facilitates increased provider assessment of disabled individuals for sexual violence.
- Institute training, policies and practices that prevent sexual assault and rape in institutional and criminal justice settings.
- Implement environmental safety measures such as adequate lighting, identified safe businesses and emergency call boxes.
- Facilitate media literacy about messages, information, attitudes and behaviors that support sexual violence.
- Address the special needs of male victims of sexual violence.
- Promote an increase in Sexual Assault Nurse Examiner programs.
- Promote an increase in the use of forensic interviews and exams in suspected child sexual abuse cases.
- Facilitate multiple session skill-building programs that address sexual violence prevention and intervention.

Intentional Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Violence**
- **Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services**
- **Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All**

Child Sexual Abuse

Connecticut Objective:

Reduce child sexual abuse to no more than 660 (rate of 0.78 per 1,000) cases of substantiated child sexual abuse allegations per year.

Baseline CT 2000	669 cases (0.79 per 1,000) of substantiated child sexual abuse allegations
Interim CT 2004	745 cases (0.89 per 1,000) of substantiated child sexual abuse allegations

(Source: State of Connecticut Department of Children and Families Town Pages)
(Source: Rates calculated by CT Department of Public Health)

Strategies:

- Develop more effective intervention and treatment programs for children and youth.
- Provide services, educational programming to non-offending parents/caregivers of suspected victims of child sexual abuse.
- Develop and provide effective prevention and intervention programs geared towards abusers and sexual offenders.
- Consider expansion of initiatives that focus on the adult role in the prevention of child sexual abuse such as the Child Sexual Abuse initiative under East Hartford Child Plan.

Action Steps:

- Facilitate access to programs for underage victims who are suspected victims of child sexual abuse but there is no proof that sexual abuse occurred.
- Facilitate access to more effective prevention, intervention and treatment programs for child sexual abuse victims, siblings and nonoffending parents/caregivers.
- Promote programs which provide awareness and education in the prevention, location, recovery and reunification of missing and abducted children.

Partners - ICPG, CT Sexual Assault Crisis Services, Child Sexual Abuse Prevention Collaborative, Children's Trust Fund, community-based organizations, grassroots organizations, faith-based institutions, health care institutions and organizations, law enforcement, criminal justice, businesses, state agencies - public health, protection and advocacy, mental retardation, social services, children and families, education, higher education, mental health and addiction services and others.

Suicide/Suicide Attempts

In Connecticut from 2000 to 2004, people ages 85 and older had the highest rates of suicide completion (30.2/100,000) followed by people ages 45-49 (22.6/100,000). Teens ages 15-19 had a rate of 8.3/100,000. From age 20 through age 79, suicide completion rates were 14.0/100,000 to 19.5/100,000. The most frequent methods of suicide completion among teens ages 10-19 is suffocation/hanging. Methods used by young adults ages 20-49 are primarily firearms and hanging/suffocation in almost equal measure. The primary method for adults age 50 through elders 85 and older is firearms. (Figures 31, 32)

Across all ages, males have significantly higher suicide completion rates than females and Caucasian males have the highest rates of suicide completion.

Figure 31
Suicide Death Rates by Age Group
Connecticut Residents, 2000 - 2004

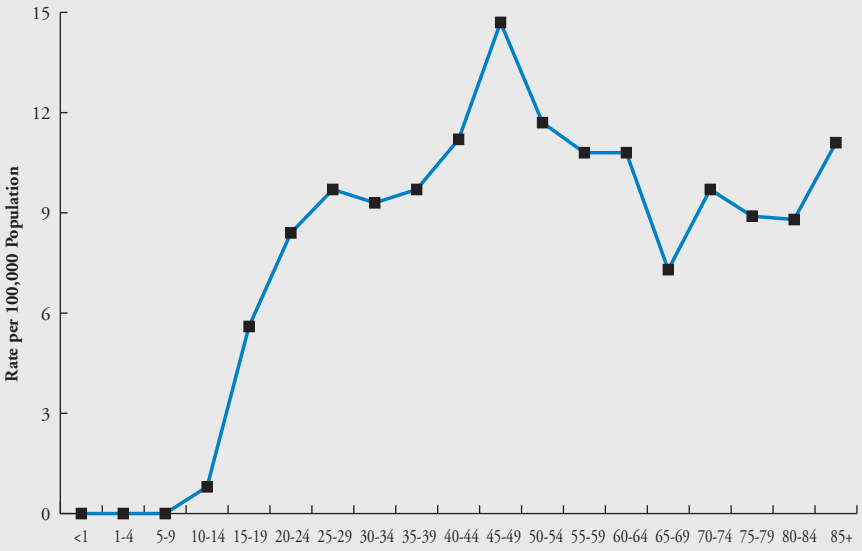
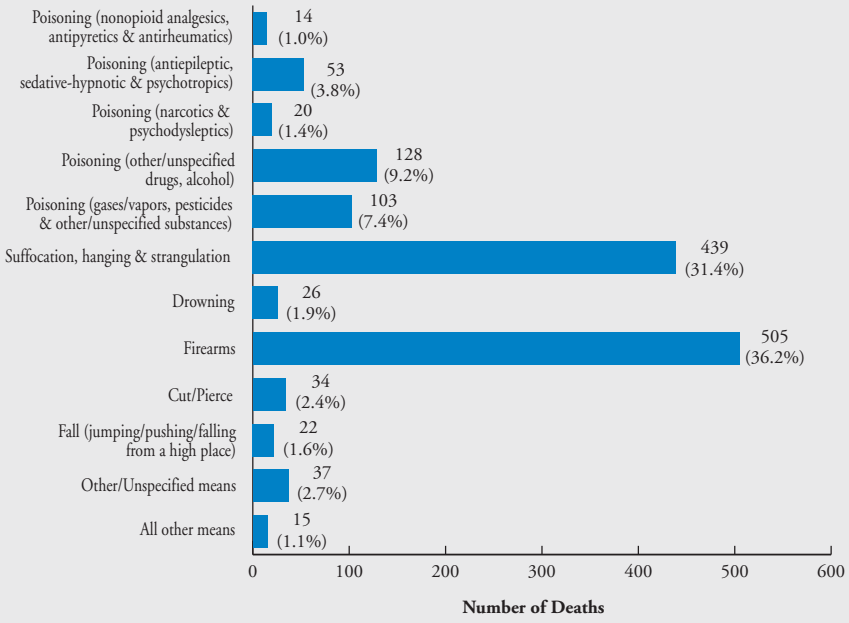


Figure 32
Suicide Deaths by Mechanism
Connecticut Residents, 2000 - 2004



Intentional Injury

Suicide/Suicide Attempts

Self-inflicted injury data is used as a source for nonlethal suicide behaviors or "suicide attempts". There is a "lack of consensus about what actually constitutes suicidal behavior" and if "self-injurious behavior in which there is no intent to die (can) be classified as suicidal behavior".[28] Self-inflicted injury data is the best nonlethal suicide behavior data source available at this time.

Across all ages, males have significantly higher suicide completion rates than females and Caucasian males have the highest rates of suicide completion.

In Connecticut historically, females have been reported to attempt suicide more frequently than males, although the gap between male and female Connecticut teens is narrowing. In CT, most people who attempt suicide use drugs. From 2000-2004, the highest self-inflicted injury hospitalization rates were among persons ages 15-19 (67.6/100,000), with rates among females in that age group about twice the rate for males. Self-inflicted injury hospitalization rates between ages 20 and 50 were 46.2 /100,000 to 64.1/100,000, decreasing to 13.5/100,000 at ages 80-84. Rates in the 85 and older age group were 6 or less. (Figures 33, 34)

For the five-year period, the total hospitalization charges for self-inflicted injury were $63,700,991, with an average of $6,657 per hospital stay.

Figure 33
Self-Inflicted Injury Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004

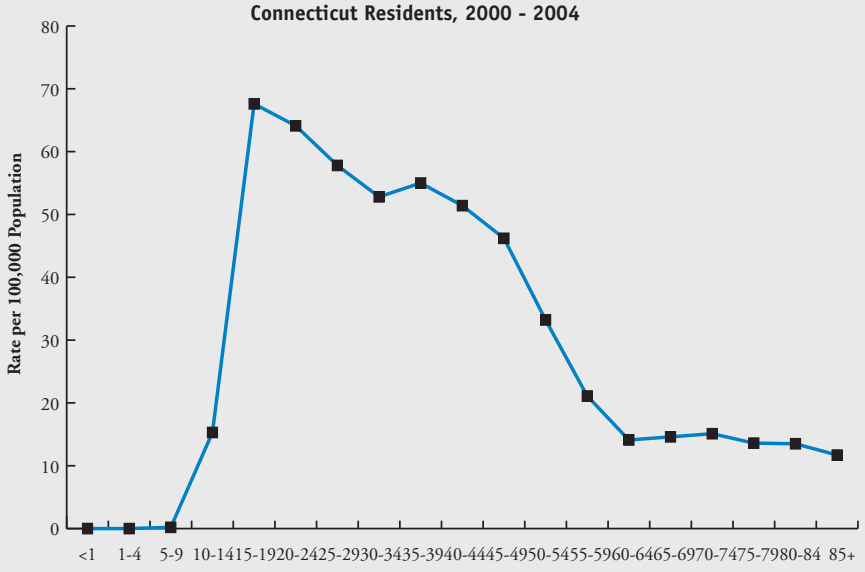
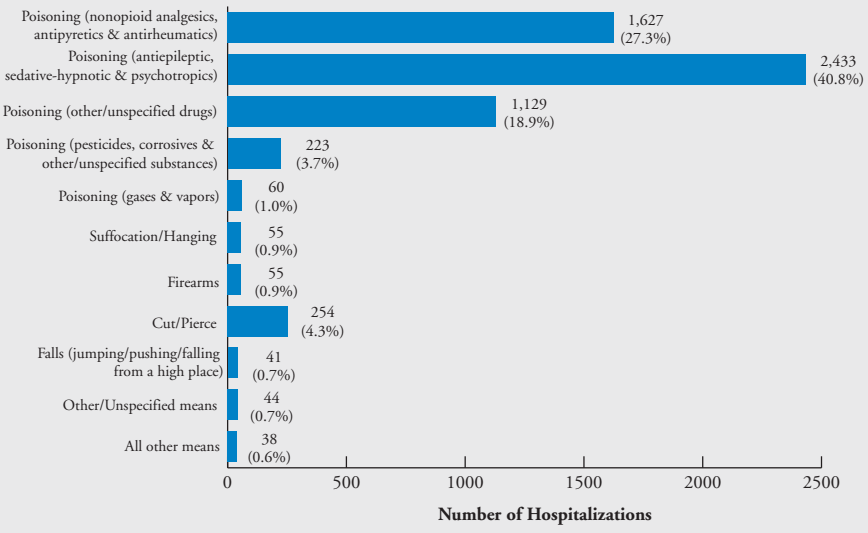


Figure 34
Self-Inflicted Injury Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004



Source: National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

Intentional Injury

Suicide/Self-Inflicted Injury/Suicide Attempts

Connecticut Objectives:

By 2010, Reduce the suicide rate to no more than 8.0 per 100,000 total population.

Baseline CT 2000	8.9 per 100,000 total population
Interim CT 2004	8.2 per 100,000 total population

(Source: CT Department of Public Health, Vital Records)

By 2010, Reduce suicide self-inflicted injuries to no more than 32.0 per 100,000 total population.

Baseline CT 2000	33.7 per 100,000 total population
Interim CT 2004	34.1 per 100,000 total population

(Source: CT Office of Health Care Access)

By 2010, Reduce suicide attempts among adolescents to no more than 8% reported suicide attempts - high school students.

Baseline CT 1997	9.1% reported suicide attempts - high school students
Interim CT 2005	12.1 % reported suicide attempts- high school students

(Source: Youth Risk Behavior Survey (YRBS), 2005 CT School Health Survey)

Strategies and Action Steps in this section are taken or adapted in part from the CT Comprehensive Suicide Prevention Plan (http://wwwct.gov/dph - Publications - Suicide Prevention Plan).

Implementing Partners include the Interagency Suicide Prevention Network, the Youth Suicide Advisory Board, the Injury Community Planning Group and others identified at the end of this section.

Intentional Injury

Reduce Suicide/Self-Inflicted Injury/Suicide Attempts - All Ages

Strategies:

- Improve data collection, analysis and surveillance related to suicide completions, attempts and related risk and protective factors.
- Improve collaboration among the State Departments of Public Health, Children and Families, Mental Health and Addiction Services, Office of the Child Advocate and others who collect data.
- Establish and implement clean and concise policies related to suicide prevention.
- Promote mental healthy parity.
- Decrease, eliminate and treat signs and symptoms of suicide-related behaviors.
- Improve identification of the particular needs of high-risk populations and situations.
- Improve collaboration with the CT Poison Control Center.

Action Steps:

- Identify suicide-related priorities and facilitate implementation of selected recommendations from the Comprehensive Suicide Prevention Plan.
- Support local and state efforts that increase access to treatment resources.
- Address continuity of care issues including access, treatment and follow-up.
- Facilitate policies and practices that increase and ensure access to mental health care.
- Encourage development of critical incident response teams.
- Promote policy changes that facilitate increased access and payment for treatment.
- Encourage safe medical management of addictions.
- Partner with insurers and policy-makers to increase awareness of cost benefits of early, effective, clinically sound and evidence-based treatment.
- Assess existing and facilitate development of new standards for cultural competency plans that include communication styles, cultural issues, competence and subject matter , adherence to confidentiality issues, literacy, and resource materials.
- Promote appropriate screening and assessment of persons for suicide risk, depression and other mental health issues.
- Partner with clinicians to promote practice standards and adherence to practice standards that recommend that medical, social service and mental health professionals include assessment of suicide risk, substance use and addictions in routine exams.
- Educate and encourage clients and families to seek and/or change to providers who might be more able to meet their needs.
- Provide information about referral systems and/or referral resources to facilitate appropriate referral of clients by providers.
- Encourage partners, including first responders and law enforcement to include the CT Poison Control Center on conference training agendas and/or as an exhibitor.

Intentional Injury

Reduce Suicide/Self-Inflicted Injury/Suicide Attempts - Among Elders Ages 65+

Strategies:

- Develop, implement and disseminate awareness messages that dispel the myth that "it is to be expected at that age."
- Enhance public education to encourage appropriate precautions to improve safety and prevent injuries.

Action Steps:

- Facilitate elder programs and settings that maintain and promote social engagement e.g. peer to peer, intergenerational and cooperative housing.
- Develop appropriate ways to market to elders.
- Promote awareness of the potential impact of chronic illnesses and debilitating injuries on mental health.
- Collaborate with partners to improve agency support for policies, information and/or training that would assist lay personnel and home service workers to identify obvious signs of potential problems and take appropriate action.
- Facilitate increased screening for depression and appropriate treatment for elders.
- Provide training that addresses specific needs of elders including elder suicide risk factors, potential behaviors that might indicate a mental health issue and the use by professionals of scientifically validated screening instruments.

Intentional Injury

Reduce Suicide/Self-Inflicted Injury/Suicide Attempts - Among Adults Ages 20-64

Strategies:

- Increase awareness of the potential adverse impact of interpersonal violence, including domestic violence, sexual abuse and assault.
- Increase awareness of the potential impact of the challenge of transition, especially in early adulthood.
- Increase awareness of resources including support groups.
- Develop, improve and/or facilitate locally initiated and implemented strategies, resources and activities that encourage people to stay connected to the community.

Action Steps:

- Facilitate policies and strategies that increase access to behavioral health services without adverse consequences.
- Facilitate policies and strategies that reduce and eliminate real or perceived stigma associated with accessing mental health services.
- Seek assistance from and work with faith-based and other community organizations.
- Identify and promote awareness of resources that address financial, parenting, educational issues and relationship breakups including divorce.

Reduce Suicide/Suicide Attempts and Depression in Women During the Post-Partum Period

Strategies:

- Promote awareness of the potential connection of depression, including post-partum depression, to suicide, assault and homicide.

Action Steps:

- Identify screening tools for postpartum depression
- Partner with women's health providers, mental health providers and others to develop, improve and assess efficacy of post partum screening assessment and treatment.
- Partner with providers including obstetricians, pediatricians, midwives and other women's health providers to increase routine screening for depression and referral to appropriate services in the postpartum period.
- Partner with providers, families and others in the community to increase support for depressed women in the postpartum period and awareness of the potential for harm to the mother, to children and others if the issue is not recognized and/or appropriately treated.

Reduce Suicide/Self-Inflicted Injury/Suicide Attempts - Among Children and Youth

Strategies:

- Develop, improve and/or facilitate training for children, youth, parents, caregivers and professionals on child development, substance abuse, coping skills, mental health issues, conflict resolution, competition and stress relieving strategies.
- Increase community-based services that effectively address needs identified above.

Action Steps:

- Promote a public awareness campaign that promotes the adult role in facilitating the mental health of children and youth.
- Promote awareness of issues specific to children and youth who may be victimized by their peers because they are perceived to be not acceptable.
- Facilitate more early mental health prevention and intervention such as early childhood services and specialized nursery schools.
- Conduct rapid assessment and planning of care for children, youth and their caregivers.
- Collaborate with partners on system changes and resource allocation that will facilitate improved access of adolescents to behavioral health care.

Intentional Injury

Law Enforcement/First Responders

Strategies:

- Improve awareness and the response of law enforcement, emergency service providers and other first responders.
- Increase focus on awareness and appropriate response to persons with traumatic brain injury and mental health issues.
- Develop, improve and/or facilitate more police academy and police continuing education seminars and courses that facilitate an increase in the police officer's knowledge of mental illness, suicidal thinking and related issues.
- Improve crisis response and encourage development of specialized police units to deal with behavioral emergencies.

Action Steps:

- Collaborate with partners to facilitate increased collaboration of police, mental health providers and agencies.
- Partner with emergency service providers and other first responders to encourage or enhance collaboration with local hospitals, training organizations and mental health providers to enhance knowledge of and appropriate response to persons with mental illness and suicidal behaviors.
- Collaborate with partners to review existing and encourage availability of critical incident services to police and emergency personnel impacted by suicide.

Criminal Justice System

Strategies:

- Improve knowledge of suicide issues, policies, procedures and national standards within the criminal justice system.
- Increase knowledge of national standards for suicide prevention.
- Establish and implement concise and clear policies related to suicide prevention.

Action Steps:

- Facilitate adherence to national standards regarding the screening of all inmates.
- Provide proper access to mental health care.
- Conduct administrative review of serious suicide attempts and suicides.
- Provide critical incident support to corrections staff following serious suicide attempts or suicides.
- Review each facility for environmental safety risks and take corrective action where possible.

Partners: ICPG, Interagency Suicide Prevention Network, Youth Suicide Advisory Board, health and mental health agencies, providers, survivors, community-based agencies, criminal justice, corrections, law enforcement, emergency medical responders, State Departments of Public Health, Mental Health and Addiction Services, Children and Families, Education, Judicial, Aging, Mental Retardation, Office of the Child Advocate, Office of Protection and Advocacy, CT Poison Control Center, Commission on Aging and others.

Traumatic Brain Injury

Traumatic Brain Injury

A traumatic brain injury (TBI) is caused by a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. The severity of a TBI may range from "mild," i.e. a brief change in mental status or consciousness to "severe," i.e. an extended period of unconsciousness or amnesia after the injury. A concussion is a form of brain injury. TBIs can result in short or long-term problems with independent function.

Unintentional, intentional and occupational injuries can cause TBI. On average, there were 386 TBI-related deaths and 2,256 hospitalizations each year in Connecticut. The leading causes of TBI-related death were falls (25%) suicide (23.6%) and motor vehicle crashes (23.1%). Among children through the age of 14 years, and young adults 15 to 34 years motor vehicle crashes were the leading cause of TBI related death. For adults aged 36 to 64 years suicide was the leading cause of TBI related death. Falls were the most common cause of TBI death for adults age 65 years and older. Adults age 75 and over had the highest death rates from TBI. (Figures 35, 36)

Males had a TBI death rate (17.0/100,000) that was 3 times higher than females (5.7/100,000).

Non-Hispanic Whites (11.1/100,000) and Non-Hispanic Blacks (10.9/100,000) had similar death rates, followed by Hispanics (8.1/100,000).[29]

Figure 35
Traumatic Brain Injury Deaths by Mechanism
Connecticut Residents, 2000 - 2004

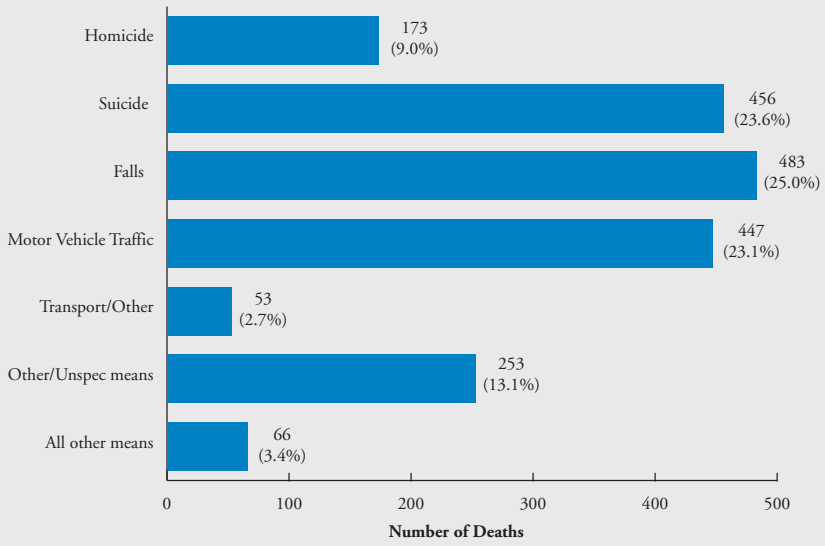
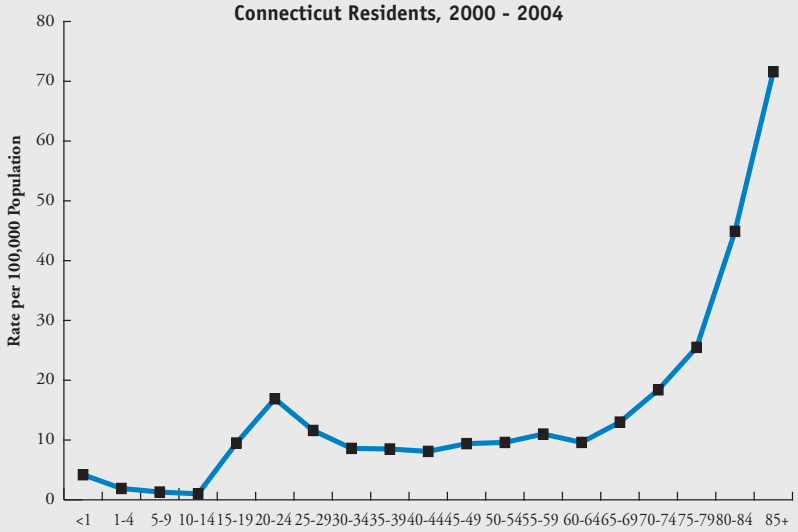


Figure 36
TBI Death Rates by Age Group
Connecticut Residents, 2000 - 2004



Traumatic Brain Injury

The leading causes of TBI-related hospitalization were falls (41.4%), motor vehicle traffic (33.6%) and assault (5.9%). Adults aged 75 and older had the highest rates of TBI related hospitalizations followed by infants less than one year of age. Falls were the leading cause of TBI hospitalization among children through the age of 14 years. Motor vehicle crashes were the leading cause of TBI hospitalization for teens through adults aged 15 to 34 years and adults between the ages of 35 and 64 years. Among adults aged 65 and older falls were the leading cause of TBI hospitalization. (Figures 37, 38)

Males had approximately twice the hospitalization rate (85.3/100,000 as females (46.4/100,000.) Non-Hispanic Others had the highest hospitalization rates (95.7/100,000) followed by Hispanics (69.2/100,000.) Non-Hispanic Blacks and Non-Hispanic Whites had similar rates (64.2/100,000 and 63.6/100,000 respectively.) (Figures 37,38) For the five-year period 2000-2004, the direct inpatient hospital charges for TBI were over $312 million, with an average charge of $12,482 per stay.[30]

Figure 37
Traumatic Brain Injury Hospitalizations by Mechanism
Connecticut Residents, 2000 - 2004

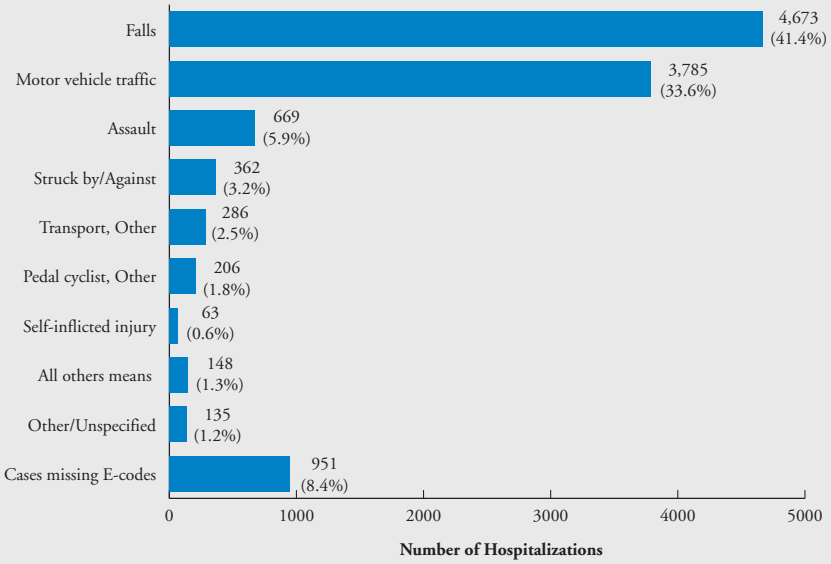
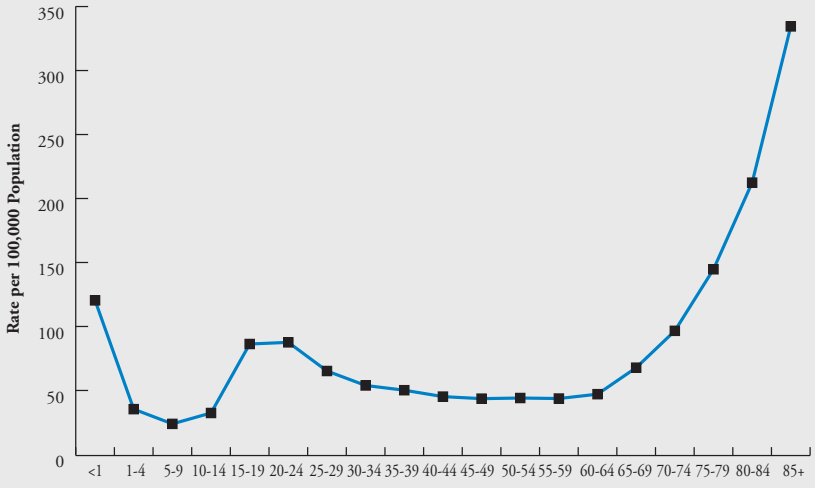


Figure 38
TBI Hospitalization Rates by Age Group
Connecticut Residents, 2000 - 2004



Traumatic Brain Injury

Connecticut Goal

- **Reduce Injuries, Disabilities and Deaths due to Unintentional Injury and Violence.**

Connecticut Objectives:

By 2010, Reduce deaths due to traumatic brain injuries to no more than 11.0 per 100,000 population.

Baseline CT 2000	12.5 deaths per 100,000 population
Interim CT 2004	10.8 deaths per 100,000 population

(Source: CT Department of Public Health, Vital Records)

By 2010, Reduce hospitalizations for traumatic brain injuries to no more than 65.0 hospitalizations per 100,000 population.

Baseline CT 2000	66.7 hospitalizations 100,000 population
Interim CT 2004	67.5 hospitalizations per 100,000 population

(Source:CT Office of Health Care Access, Hospital Discharge Data)

Strategies:

- Increase public and provider awareness of leading causes of and prevention measures for traumatic brain injury (TBI) including falls, motor vehicle crashes, suicide attempts, shaken baby syndrome and domestic violence.
- Increase public and provider awareness of the effects of TBI including the long-term effects associated with head injury.
- Increase awareness among the public and providers that concussions are brain injuries and the signs, symptoms, and appropriate treatment for concussions.
- Improve screening of persons with TBI.
- Increase reporting of head injuries.
- Expand partnerships with community agencies serving underserved populations and persons with TBI.
- Increase worker and employer awareness of mechanisms responsible for TBI in the work site and effective prevention methods.

Action Steps:

- Promote implementation of the CT Department of Social Services Connecticut Statewide TBI Action Plan. (http://www.ct.gov/dss)
- Analyze data sets - mortality, hospital, emergency department, Trauma Registry, and CODES to provide additional information on causes and factors associated with TBI.
- Incorporate information on TBI into awareness and educational materials designed for relevant injury categories.

Traumatic Brain Injury

Action Steps *(continued):*

- Collaborate with partners to promote the implementation of key prevention strategies for the leading causes of TBI-motor vehicle crashes, falls, homicide, assault injuries, suicide and self-inflicted injuries. (Specific action steps are included under related injury sections of the plan.)
- Partner with coaches, educators, athletic and recreational groups to promote use of appropriate head protection for wheeled sports, other sports and recreational activities.
- Provide education to coaches, educators, school officials, parents and athletes on recognition and treatment of concussions.
- Develop procedures to increase documentation of head injury.

Strategies:

- Improve care and services for persons post traumatic brain injury.
- Increase awareness that persons with TBI may be more at risk for re-injury.
- Increase awareness of key prevention strategies.

Action Steps:

- Collaborate with partners to improve training and education about the acute and chronic cognitive and behavioral limitations of many persons with TBI.
- Collaborate with partners to improve continuity of care for TBI clients from acute care through rehabilitation into community-based settings and/or extended care facilities.
- Incorporate best practice standards and strategies into the care continuum for TBI clients.
- Increase awareness that persons with TBI may be more at risk for re-injury and of key strategies for prevention.

Partners: ICPG members, CT Department of Social Services, TBI Advisory Committee, Brain Injury Association of CT, CT Department of Children and Families, Office of the Child Advocate, CT Commission on Children, health care providers, TBI Service Providers, CT State Department of Education, schools, CT Department of Public Health, State Trauma Committee. Additional partners are included under specific injuries that are leading causes of TBI - motor vehicle crashes, falls, homicide/assault injuries and suicide/self-inflicted injuries.

Occupational Injury
(Work – Related)

Occupational Injury

Occupational injuries, more commonly referred to as "work-related injuries", include any injuries that occur to an individual while he or she is on the job. Work-related injuries occur in many different types of work environments each workday. As with other injuries, occupational injuries can either be intentional, as in the case of workplace violence, or unintentional, such as a fall from a ladder. Both are equally important, but need to be addressed in very different ways.

In Connecticut, there are over 1.7 million workers, and every year many of these workers are injured or killed as a result of their job. In addition to the impact on the workers and their families, workplace injuries carry an economic impact; in 2003, over $753 million was paid out in Workers' Compensation benefits in Connecticut.

In 2004, the State of Connecticut Department of Labor, Occupational Safety and Health Division (CONN-OSHA) received 63,600 work-related injury reports, which included only those injuries severe enough to require care beyond first aid. With such large numbers of work-related injuries in Connecticut each year there is an ongoing need for injury prevention activities in our state. A much larger number of less severe work-related injuries occur in Connecticut workplaces, however these do not require reporting.

Work-related fatalities are also problematic; in Connecticut, from 2000-2004 there were 225 work-related fatalities. In 2004, the work-related fatality rate was 3.2 deaths per 100,000 workers. The leading causes of workplace death that year were transportation incidents accounting for approximately 40 percent, followed by violence/assaults, and falls at 18 percent each; and contact with an object or equipment at 14 percent.

Certain industries have disproportionate rates of workplace injury. Examples of these industries include agriculture, manufacturing, and construction. Many laws have helped to make workplaces safer in Connecticut, but each day many injuries still occur. Promoting safer work environments, changing attitudes toward worker safety, and educating workers who experience disproportionate rates of injury are some steps that can be taken to prevent occupational injuries.

Occupational (Work-Related) Injury

Connecticut Goals

- **Reduce Injuries, Disabilities and Deaths Due to Unintentional Injury and Violence.**

Connecticut Objectives:

By 2010, Reduce deaths from work-related injuries to no more than 2.0 per 100,000 workers.

Baseline CT 2000	3.2 per 100,000 workers
Interim CT 2004	3.2 per 100,000 workers.

(Source: CT Department of Labor CONN OSHA)

By 2010, Reduce hospitalizations (or emergency room visits) due to work-related injuries to no more than -TBD.

Baseline CT 2000	Developmental
Interim CT 2004	Developmental

(Source: CT Office of Health Care Access/CT Hospital Association-CHIME)

By 2010, Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity to no more than - TBD.

Baseline CT 2000	Developmental
Interim CT 2004	Developmental

(Source: CT Department of Labor CONN-OSHA)

Strategies:

- Improve the health and safety of workers through prevention and early intervention.
- Increase and improve reporting of work-related injury cases.
- Expand partnerships around work-related injury.

Action Steps:

- Access, analyze and disseminate data on work-related injuries.
- Support initiatives to improve the reporting of workplace injury.
- Collaborate with partners to increase awareness of major work-related hazards.
- Support initiatives to strengthen occupational health and safety and labor laws.
- Support enforcement of occupational health and safety labor laws.
- Identify or develop worker safety educational materials including low literacy, targeting specific occupations, targeting job-related injuries and translated into languages other than English.

Occupational (Work-Related) Injury

Action Steps *(Continued)*:

- Promote employer education and training programs for reducing risks associated with work-related injury.
- Support implementation of workplace policies and procedures that reduce injury risks including violence-related injury.
- Collaborate on the development and implementation of the DPH Occupational Health Unit's workplace violence initiatives.
- Evaluate trends in occupational injury data to measure changes in injury rates.

Strategy: Young Workers

- Improve the health and safety of adolescents in the work environment through prevention and early intervention.

Action Steps:

- Access, analyze and disseminate data on work-related injuries among teens.
- Explore methods to improve surveillance of injuries to young workers.
- Collaborate with partners to raise awareness of increased risks that young workers face.
- Collaborate with partners to support efforts to strengthen child labor laws.
- Collaborate with partners to support enforcement of CT and Federal child labor laws.
- Promote awareness of the requirements of CT and Federal child labor laws among employers, parents, teens, and educators.
- Identify or develop educational materials targeting teens, parents, employers and for specific worksites and jobs that commonly employ teens.
- Collaborate with partners to provide training about young worker safety (CT Curriculum) to educators, and others who work with teens.
- Work towards institutionalization of safety training for youth as part of work-based learning programs, youth employment programs and other programs that prepare youth for the workforce.
- Work towards incorporating work safety training into the educational system for all students.

Partners: ICPG, CT Department of Labor, US Department of Labor, Department of Public Health (Occupational Health Unit, Injury Prevention Program, Family Health Section), State Department of Education, Workforce Investment Boards, employers and employer associations, school systems, educational associations, local health departments, health care providers, unions, youth serving organizations and others. Additional partners are included under specific injuries that are leading causes of workplace injuries and deaths, including motor vehicles, falls, and homicide/assaults.

Appendices

Technical Notes

Data Sources [31]

Data were obtained from Connecticut Department of Public Health, Vital Records, death certificate data from calendar years 2000 - 2004.

The injury mortality data set here presented includes all Connecticut residents who died in state or out of state during calendar years 2000 - 2004, with an underlying cause-of-death of injury, based on injury categories as defined in the *External cause-of-injury mortality matrix based on ICD-10* (*National Vital Statistics Reports*, Vol. 54, No. 10, January 31, 2006, p. 4.). Non-resident deaths are excluded from the analysis.

Inpatient Hospitalization Data were obtained from the Connecticut Office of Health Care Access (OHCA), hospital discharge data from all 31 non-federal, acute-care, inpatient facilities in the state, for calendar years 2000 - 2004.

The injury hospitalization data set includes all Connecticut residents who were hospitalized during calendar years 2000 - 2004, with a principal diagnosis of injury, plus a valid external cause-of-injury code (E-code) as defined in the STIPDA / CDC *Recommended framework of E-code groupings for presenting injury mortality and morbidity data (February 16, 2005)*. Re-admissions, transfers and deaths in the hospital are included; the data are not de-duplicated, in keeping with current CDC recommendations. The data do not include Connecticut residents hospitalized out of state, and hospitalizations of non-residents are excluded from the analysis. Numbers of hospitalizations represent number of events, not number of individuals hospitalized. During this 5-year period, of the 86,967 patient records with an injury diagnosis, 95.8% (83,296) included a valid E-code.

Motor Vehicle Crash-Related Fatalities Data[32] were obtained from the Connecticut Department of Transportation (CT DOT), Bureau of Policy and Planning, police crash report data from calendar years 2000-2004.

The CT DOT receives crash investigation reports from state and local police for all fatal crashes occurring on Connecticut roads. Connecticut residents and non-residents killed in Connecticut are included in this data set. Connecticut residents killed in crashes occurring out of state are not included.

Child Maltreatment & Child sexual Violence Data were obtained from the Connecticut Department of Children & Families' Town pages.[33]

Dating Violence/Domestic Violence/Intimate Partner Violence & Sexual Violence (Rape & Sexual Offenses) were obtained from the Connecticut Department of Public Safety, Uniform Crime Reports.[34] The crime data collection has 100% participation from 100 police departments, and the State ensures quality control and uniformity of the crime reports submitted. Uniform Crime Reports collect data on all crime categories except traffic violation, and include data on age, sex and race. Limitations include "variability of the degree of crime reported from area to area; a considerable volume of crime is not reported to law enforcement agencies because the victims consider the offenses against them to be of very little consequences or that the likelihood of apprehending the suspect is small; and fear of retaliation." The Uniform Crime Reports provide the best network of actual state and national crime figures currently available.[35]

Occupational Fatalities and Injuries Data[36] were received from the Connecticut Department of Public Health, Division of Occupational Safety and Health (CONN-OSHA), Safety and Health Statistics Unit.

The fatality data were based on reports of work-related deaths occurring in Connecticut. All employers are required to report to Federal OHSA, all work fatalities, which include any death occurring in the workplace or while an employee is "on duty". In addition to employer reports, information may be collected from media coverage, police reports and death certificates. Nonfatal injury data is obtained from the annual CONN-OSHA survey of approximately 4,500 private and public employers in Connecticut. Employers are required to maintain logs of injuries that resulted in either lost work time, medical treatment other than first aid, loss of consciousness, restriction of work or motion, or transfer to another job. Data sets include CT residents and non-residents who are killed or injured on the job in Connecticut.

Injury Mortality

Injury death: An injury death is defined as "any death with an ICD-10 code of U01-U03 or V01-Y89 registered as the underlying cause of death on a death certificate".

Cause of death:[37] Death certificates differentiate between the *immediate cause of death* ("the final disease, injury or complication directly causing death") and the *underlying cause of death* ("the disease or injury that initiated the chain of events that led directly and inevitably to death"). Death certificates also allow for recording *other significant diseases, conditions or injuries* that "contributed to death, but which did not result in the underlying cause of death". Injury diagnostic categories are based on the underlying cause of death.

Certification of death: Connecticut death certificates instruct that all deaths "shall be certified by the attending physician or attending Advanced Practice Registered Nurse (APRN)". In the absence of these medical professionals, or with their approval, "medical certification may be completed and signed by an associate physician, a physician assistant, registered nurse, the chief medical officer of the institution in which the death occurred, or the pathologist who performed an autopsy. Medical certification by a registered nurse or physician assistant is limited to cases in which death was anticipated and such registered nurse or physician assistant made the pronouncement of death". The cause-of-death information should be the certifying professional's "best medical opinion". Note: A condition can be listed as "probable" even if it has not been definitely diagnosed.

Classification of injury deaths:[38] The classification of injury deaths presented in the external cause-of-injury mortality matrix is based on the underlying cause of death, which is defined by the International Classification of Diseases (ICD) as "(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury". For injury deaths, the external cause rather than the injury diagnosis is always selected as the underlying cause because public health efforts are generally directed at preventing the incident that led to the death (e.g. motor vehicle traffic crash), rather than toward the injury diagnosis (e.g. skull fracture) that could result from a variety of external causes.

Injury Hospitalizations

Injury hospitalization:[39] An injury hospitalization is defined as "a patient record that lists the principal reason for admission to a non-federal, acute-care, inpatient facility as an injury, including the late effects of injury. Readmissions, transfers and deaths in the hospital are included in this definition. Excluded from the definition are adverse effects of the therapeutic use of drugs, of medical/surgical care, and the late effects of those adverse effects". Note: numbers of hospital discharges represent number of events, not number of individuals hospitalized.

This case definition is based on the single diagnostic field for which there is a generally accepted coding rule: the principal diagnosis field, which is reserved for the code corresponding to *the reason for which, after study by the attending physician or nurse, the patient was admitted*. There are no national standards for the order in which codes are assigned in the additional diagnostic fields. Therefore, the presence of an injury diagnosis code in subsequent fields does not necessarily reflect an injury of sufficient severity that it would have led to hospitalization on its own.

Classification of injury morbidity data:[40] Injury hospital discharge records are included for analysis based on the creation of a subset of all hospital discharge records for a given calendar year(s), selected to meet the following two criteria (ICD-9-CM codes): Have an injury diagnosis (nature-of-injury codes 800.0-994.9, 995.5-995.59, or 995.80-995.85, excluding 909.3 and 909.5) listed in the principal diagnosis field; plus, A valid external cause-of-injury code (E-codes E800-E999, excluding codes E849, E967, E869.4, E870-E879 and E930-E949) listed in any one of the additional diagnosis fields.

If more than one external cause code is listed for a given patient record, only the first valid E-code listed in the diagnostic code fields is reported. [Connecticut hospital discharge records currently include 10 diagnostic code fields; unlike many other states, Connecticut does not include a dedicated E-code field.] If the first E-code is invalid, or is E849, E869.4, E870-E879, E930-E949 or E967, the next valid E-code listed in the diagnostic code fields is used.

Technical Notes *(continued)*

LOS (Length of Hospital Stay): Length of stay in a hospital measured in days for an injury

Total Hospital Charges: The sum of total charges incurred during hospitalization for an injury. Hospitalization "charges refer to the amount associated with a patient's entire hospitalization, including, but not limited to, treatment associated with the primary reason for admission, and reflecting charges by the hospital only. Physician fees are not included. Charges are not the same as the actual cost of the treatment or the actual payment received by the hospital".[41]

Average Hospital Charges: The median of charges incurred during hospitalization for an injury. For explanation on charges, see the above statement regarding hospitalization charges.

Child Maltreatment & Child Sexual Violence

Abuse/Neglect/Uncared Substantiated Allegation: represents the number of unique(unduplicated) children that were the victims of substantiated Abuse and/or Neglect during the State Fiscal Year.[42]

Sexual Violence (Rape & Sexual Offenses)

Rape: "Carnal knowledge of a female forcibly and against her will" mainly focusing upon nonconsensual intercourse involving a male perpetrator and female victim. This definition has been retained in Uniform Crime Reports to ensure compatability of rape statistics. Recently, the FBI adopted a definition of rape that recognizes male victims, female perpetrators, and nonintercourse forms of rape.[43]

Calculation of Rates

Rates per 100,000 population are calculated by dividing the number of events in a particular population by the total number of people in that population, then multiplying that ratio by 100,000. For example, to determine the death rate for a specific age group, the age specific death rate is calculated, as follows:

$$\text{Age-specific death rate} = \frac{\text{Number of deaths in a specific age group}}{\text{Total population in that specific age group}} \times 100{,}000 \text{ population}$$

The number of deaths in a specific age group, per 100,000 population in the same age group.

Abuse/Neglect/Uncared Substantiated Rates are calculated by dividing the number of unique/unduplicated children that were victims of substantiated Abuse/Neglect/Uncared during a given State Fiscal Year by the child population[44] and multiplying by 1,000. Rates for Child Sexual violence rates are calculated by the same method as above.

Race & Ethnicity

Ethnicity: A decedent's ethnicity is recorded on Connecticut death certificates "as given by the informant". "Hispanic" is not a race, but rather refers to people whose origins are from Spain, Mexico and the Spanish-speaking countries of Central America, South America, and the Caribbean islands; individuals of Hispanic origin can be of any race. ("Origin" includes ancestry, nationality and lineage.)

Race: Race is defined[45] as "a population of individuals who identify themselves from a common history, nationality, or geographical place". A decedent's race is recorded on Connecticut death certificates according to the following categories: White, Black or African American, Asian Indian, American Indian or Alaska Native, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, or Other.

Technical Notes *(continued)*

Definition of ICD Terms & Categories[46]

Mechanism and intent of injury:

Mechanism and injury: the mechanism or cause, of injury is the way in which the person sustained the injury, how the person was injured, or the process by which the injury occurred.

Intent of injury: the intent, or manner of injury is whether an injury was caused by an act carried out on purpose by oneself (self-harm or suicide), or by another person(s) (assault or homicide), with the goal of injuring or killing.

Injury categories by mechanism or cause:

Cut/pierce/stab: injury resulting from an incision, slash, perforation, or puncture by a pointed or sharp instrument, weapon or object. This category does not include injury from being struck by or against a blunt object or bite wounds; these injuries fall in the category "struck by/against".

Drowning/near drowning/submersion: suffocation (asphyxia) resulting from submersion in water or another liquid.

Fall: injury received when a person descends abruptly due to the force of gravity and strikes a surface at the same or lower level.

Fire/burn/smoke inhalation: severe exposure to flames, heat or chemicals that leads to tissue damage in the skin or places deeper in the body; injury from smoke inhalation to the upper airway, lower airway or lungs.

Firearm gunshot: a penetrating force injury resulting from a bullet or other projectile shot from a powder-charge gun. This category includes gunshot wounds from powder-charged handguns, shotguns and rifles. This category does not include injury caused by a compressed air-powered paint gun or a nail gun, which falls in the "other specified" category.

Inhalation/ingestion/suffocation: inhalation, aspiration or ingestion of food or other object that blocks the airway or causes suffocation; intentional or accidental mechanical suffocation due to hanging, strangulation, lack of air in a closed place, plastic bag or falling earth. This category does not include injury resulting from a foreign body that does not block the airway.

Machinery: injury that involves operating machinery, such as drill presses, fork lifts, large power-saws, jack hammers, and commercial meat slicers. This category does not include injury involving machines not in operation, falls from escalators or moving sidewalks, or injuries from powered lawn mowers or other powered hand tools or home appliances.

Natural/Environmental: injury resulting from exposure to adverse natural and environmental conditions, such as severe heat, severe cold, lightning, sunstroke, large storms, and natural disasters, as well as lack of food or water.

Other specified causes: injury associated with any other specified cause that does not fit another category. Some examples include causes such as electric current, electrocution, explosive blast, fireworks, overexposure to radiation, welding flash burn, or animal scratch.

Overexertion: working the body or a body part too hard, causing damage to muscle, tendon, ligament, cartilage, joint or peripheral nerve (e.g. common cause of strains, sprains and twisted ankles). This category includes overexertion from lifting, pushing or pulling, or from excessive force.

Poisoning: ingestion, inhalation, absorption through the skin, or injection of so much of a drug, toxin (biologic or non-biologic), or other chemical, that a harmful effect results, such as drug overdoses. This category does not include harmful effects from normal therapeutic drugs (i.e. unexpected adverse effects to a drug administered correctly to treat a condition) or bacterial illnesses.

Technical Notes *(continued)*

Struck by/against or crushed: injury resulting from being struck by (hit) or crushed by a human, animal or inanimate object or force other than a vehicle or machinery; injury caused by striking (hitting) against a human, animal or inanimate object or force other than a vehicle or machinery.

Transportation-related causes: injury involving modes of transportation, such as cars, motorcycles, bicycles and trains. This category is divided into four subcategories according to the person injured: motor vehicle occupant, motorcyclist, pedal cyclist, pedestrian and other transport. This category also involves another factor: whether the injury occurred in traffic (i.e. on a public road or highway).

Unknown / unspecified cause: injury for which the emergency department [hospital or other] report does not provide enough information to describe the cause of injury.

Intentional injury categories:

Suicide / self-inflicted injury: intentionally self-inflicted injury that results in death or injury (attempted suicide).

Homicide / assault: injuries inflicted by another person with intent to injure or kill, by any means. Excludes injuries due to legal intervention and operations of war.

Legal intervention: injuries inflicted by the police or other law-enforcing agents, including military on duty, in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order, and other legal actions. Excludes injuries caused by civil insurrections.

Operation of war: injuries to military personnel or civilians caused by war or civil insurrection, including those occurring during the time of war or insurrection and after cessation of hostilities.

Transport-accident categories:

Transport accident: any accident involving a device designed primarily for, or being used at the time primarily for, conveying persons or goods from one place to another.

Public highway: land open to the public as a matter of right or custom for purposes of moving persons or property from one place to another.

Traffic accident: any vehicle accident occurring on the public highway. A vehicle accident is assumed to have occurred on the public highway unless another place is specified, except in the case of accidents involving only off-road motor vehicles, which are classified as non-traffic unless the contrary is stated.

Non-traffic accident: any vehicle accident that occurs entirely in any place other than a public highway.

Pedestrian: any person involved in an accident who was not at the time of the accident riding in or on a motor vehicle, railway train, streetcar, etc.

Pedal cycle: any land transport vehicle operated solely by pedals.

Pedal cyclist: any person riding on a pedal cycle or in a sidecar or trailer attached to such a vehicle.

Motorcycle rider: any person riding on a motorcycle or in a sidecar or trailer attached to such a vehicle.

Healthy People 2010 Injury-Related Goals And Objectives

Selected objectives- for complete list go to:
http://www.healthypeople.gov/Publications

Healthy People 2010 Chapter 15 - Injury And Violence Prevention

Goal: Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.

Objectives:

HP 15-1	Reduce hospitalizations for nonfatal head injuries.
HP 15-2	Reduce hospitalizations for nonfatal spinal cord injuries.
HP 15-3	Reduce firearm-related deaths.
HP 15-4	Reduce the proportion of persons living in homes with firearms that are loaded and unlocked.
HP 15-5	Reduce nonfatal firearm-related injuries.
HP 15-6	Extend state-level child fatality review of deaths due to external causes for children aged 14 years and under.
HP 15-7	Reduce nonfatal poisonings.
HP 15-8	Reduce deaths caused by poisonings.
HP 15-9	Reduce deaths caused by suffocation.
HP 15-10	Increase the number of states with statewide emergency department systems that collect data on external causes of injury.
HP 15-11	Increase the number of states that collect data on external causes of injury through hospital dis charge systems.
HP 15-12	Reduce hospital emergency department visits caused by injuries.
HP 15-13	Reduce deaths caused by unintentional injuries
HP 15-14	Reduce nonfatal unintentional injuries
HP 15-15	Reduce deaths caused by motor vehicle crashes.
HP 15-16	Reduce pedestrian deaths on public roads.
HP 15-17	Reduce nonfatal injuries caused by motor vehicle crashes.
HP 15-18	Reduce nonfatal pedestrian injuries on public roads.
HP 15-19	Increase use of safety belts.
HP 15-20	Increase use of child restraints.
HP 15-21	Increase the proportion of motorcyclists using helmets.

Healthy People 2010 Injury-Related Goals And Objectives

Selected objectives- for complete list go to:
http://www.healthypeople.gov/Publications

Healthy People 2010 Chapter 15 - Injury And Violence Prevention

Goal: Reduce injuries, disabilities, and deaths due to unintentional injuries and violence. (continued)

Objectives:

HP 15-22	Increase the number of states that have adopted a graduated driver licensing model law.
HP 15-23	Increase use of helmets by bicyclists.
HP 15-24	Increase the number of states with laws requiring bicycle helmets for bicycle riders.
HP 15-25	Reduce residential fire deaths.
HP 15-26	Increase functioning residential smoke alarms.
HP 15-27	Reduce deaths from falls.
HP 15-28	Reduce hip fractures among older adults.
HP 15-29	Reduce drownings.
HP 15-30	Reduce hospital emergency department visits for dog bite injuries.
HP 15-31	Injury protection in school sports.
HP 15-32	Reduce homicides.
HP 15-33	Reduce maltreatment of children.
HP 15-33b	Reduce child maltreatment fatalities.
HP 15-34	Reduce the rate of physical assault by current or former intimate partners.
HP 15-35	Reduce the annual rate of rape or attempted rape.
HP 15-36	Reduce sexual assault other than rape.
HP 15-37	Reduce physical assaults.
HP 15-38	Reduce physical fighting among adolescents.
HP 15-39	Reduce weapon carrying by adolescents on school property.

Healthy People 2010 Injury-Related Goals And Objectives

Selected objectives- for complete list go to:
http://www.healthypeople.gov/Publications

Healthy People 2010 Chapter 18 - Mental Health and Mental Disorders

Goal: Improve mental health and ensure access to appropriate, quality mental health services.

Objectives:

HP 18-1	Reduce the suicide rate.
HP 18-2	Reduce the rate of suicide attempts by adolescents.
HP 18-6	Increase the number of persons seen in primary health care who receive mental health screening and assessment.
HP 18-7	Increase the proportion of children with mental health problems who receive treatment.
HP 18-8	Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.
HP 18-9	Increase the proportion of adults with mental disorders who receive treatment.
HP 18-10	Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
HP 18-11	Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness.
HP 18-14	Increase the number of states with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.

Healthy People 2010 Injury-Related Goals And Objectives

Selected objectives- for complete list go to:
http://www.healthypeople.gov/Publications

Healthy People 2010 Chapter 20 - Occupational Safety and Health

Goal: Promote The Health And Safety Of People At Work Through Prevention and Early Intervention.

Objectives:

HP 20-1	Reduce deaths from work-related injuries
HP 20-2	Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity.
HP 20-5	Reduce deaths from work-related homicides.
HP 20-6	Reduce work-related assaults.
HP 20-9	Increase the proportion of worksites employing 50 or more persons that provide programs to prevent or reduce employee stress.

Healthy People 2010 Injury-Related Goals And Objectives

Selected objectives- for complete list go to:
http://www.healthypeople.gov/Publications

Healthy People 2010 Chapter 26 - Substance Abuse

Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Objectives:

HP 26-1	Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.
HP 26-3	Reduce drug induced deaths.
HP 26-4	Reduce drug-related hospital emergency department visits.
HP 26-5	Reduce alcohol-related hospital emergency department visits.
HP 26-7	Reduce intentional injuries resulting from alcohol- and illicit drug-related violence.
HP 26-19	Increase the proportion of inmates receiving substance abuse treatment in correctional institutions
HP 26-24	Administrative license revocation laws.
HP 26-25	Blood alcohol levels for motor vehicle drivers.

References & Notes

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[31] A note on ICD codes: *the International Classification of Diseases, 9th Revision, Clinical Modification*, was used for coding both morbidity and mortality data from 1979 through 1998, and continues to be used for coding morbidity data; however, the *ICD 10th Revision* is used for coding mortality data from 1999 and after. Thus care must be taken when making comparisons between data coded under different versions of the ICD due to changes in case definitions; revisions to these codes are implemented in October of each year.

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Connecticut Injury Prevention and Control Plan

2008 - 2012

Keeping Connecticut Healthy
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