# DATA CHALLENGES FOR GENDER & HARM REDUCTION

There is a substantial **gap in relevant publicly available data on substance use and treatment in Connecticut with a focus on gender**, particularly with regard to the specific prevalence, trends, outcomes and treatment barriers for women, trans and non-binary, and LGBTQ+ people who use substances.

While this data is increasingly available at the national level, Connecticut specific data sources such as the Connecticut State Epidemiological Outcomes Workgroup Prevention Data Portal, the CT Data Collaborative and Community Health Needs Assessments prepared for local hospitals tend to have analyses by age, race or location and not by gender or sexuality.[1, 2, 3] Some relevant CT data includes:

### *Data on general prevalence*

- Between 2012 and 2021, approximately **27% of overdose deaths in Connecticut were among women**. Data similarly shows **24% of overdose deaths in the New Haven area among females**. North Haven is a notable exception, where males and females are nearly as likely as one another to overdose.[4]
- Contrasted with fatal overdoses, there is **greater parity between sexes in intentional nonfatal overdoses** in CT. This invites further exploration into the specific experiences of women who are overdosing, including both protective factors from fatality and other resulting morbidity.[4]
- In Connecticut, 16.0 percent of men and 11.5 percent of women ages 50 and older reported binge drinking.[5]

### *Data on maternal mortality*

- The Maternal Mortality Review Committee (MMRC) found that **each year more than one-third of pregnancy-associated deaths in Connecticut involve the use of substances**. The MMRC determined that from 2015-2019 substance use disorder contributed to 20 out of 57 pregnancy-associated deaths.
- Eight deaths occurred during pregnancy and 12 occurred between 43-365 days after the end of pregnancy.
- Over half of these deaths were accidental overdoses and all of them were determined to be preventable.

- Given the overall lower likelihood of women dying from substance use, this data invites further exploration into the percentage of female overdoses that are among pregnant people.[6, 7]

Case narratives reviewed by the MMRC show the **significant impact of structural and social determinants** on these outcomes, as well as **gaps in continuity of care and inadequate support**.

- There were substantial rates of homelessness, incarceration, adverse childhood experiences and intimate partner violence among this group.
- Approximately 35% had existing involvement with DCF.
- In half of the cases, the pregnant person reported to their medical provider that they had been or were currently in a substance addiction treatment program.
- The MMRC noted gaps in how referrals were made and missed opportunities for intervention and called for comprehensive coordinated care throughout pregnancy and the postpartum period.[6, 7]

### *CAPTA notification data*

Notifications in compliance with the federal Child Abuse Prevention and Treatment Act (CAPTA) and Comprehensive Addiction and Recovery Act (CARA) have generated state-level data on infants with prenatal exposure to substances.

- In Connecticut, CAPTA notifications submitted by hospitals between April 2019 and June 2020 showed that infants affected by any type of prenatal exposure averaged 5.8% of live births. Of infants that are identified as exposed to only one substance, the most common exposure is to marijuana (78%, n=2,764).
- The Connecticut DPH reports that the rate of Neonatal Abstinence Syndrome / Neonatal Opioid Withdrawal Syndrome (NAS/NOWS) infants increased from 7.4 per 1,000 in 2010 to 11.6 per 1,000 in 2015. The rate then declined each year until 2018, which then stabilized at 9.0 per 1,000 live born infants.[8]
- Of all CT NAS/NOWS cases from 2017-2019 (n=1,001), 89% were infants with Medicaid insurance, and most were White Non-Hispanic and on Medicaid (63%).[9]

A review of CAPTA data found that:

- **Black mothers were disproportionately overrepresented in notifications,** reinforcing well-documented racial disproportionality in toxicology testing at birth and maltreatment reporting.[10] Although 13% of all babies born in Connecticut

- during the study were Black, they represented 22% of all CAPTA notifications. Conversely, white mothers were underrepresented.[11]
- **Black non-Hispanic mothers were also less likely to have a Plan of Safe Care completed and therefore more likely for the notification to become a report to CPS**. This disparity exists despite evidence affirming that substance use rates are the same across racial groups.[11]

Together, data on material mortality and CAPTA data call for more research on the experiences of pregnant and postpartum people who use substances **with a particular view toward understanding the barriers to care and gaps in services**.

The Department of Mental Health and Addiction Services (DMHAS) Women's Services have published information on designated programs including 88 women's specific residential SUD service beds statewide and 48 SUD service beds specifically for pregnant and parenting women with dependent children, however **more data is needed on the usage and outcomes of these dedicated programs**.

### *Data Gaps*

There is a need for increased attention in Connecticut to the following areas:

#### Substance use trends and overdose deaths among LGBTQ+ and gender diverse people in Connecticut

- Results from the 2021 and 2022 National Surveys of Drug Use and Health indicate that lesbian, gay, and bisexual adults are more likely than straight adults to use substances.[12] National data shows sexual minorities were 2-3 times more likely to have used illicit drugs, and that about one third of bisexual people and gay males and one fourth of lesbian females had a substance use disorder in the past year.
- This same report provides state-level data broken down by age, but not by any other categories related to identity.[12]
- National research suggests that Black sexual and gender minorities, LGBTQ youth and other additionally marginalized groups have higher rates of substance use and unique outcomes.[12, 13, 14] No equivalent data was found for Connecticut specifically.
- Data that does exist that is disaggregated by sex subscribes to a gender binary that may leave out non-binary, trans, and other gender diverse people.

More data on the specific usage trends and treatment experiences of LGBTQ+ people in CT is essential to ensure that current programs and policies are responsive to the needs of this community.

### Qualitative data on overdose and drug use experiences and barriers to access to care

- Essential qualitative research has been done by partnerships such as between SWAN, Yale's Community Health Van, and Quinnipiac Valley Health District to better understand overdose experiences in the region.
- However, survey items on barriers to access and experience with harm reduction and drug treatment services did not include gender-specific questions and were not disaggregated by gender.[4]

### Treatment admission and program use

- We were not able to find data on treatment admission by gender. This leaves significant questions on where women and LGBTQ+ people get care, how they are referred to care, and whether their needs are met at these programs.
- DMHAS Women's Services currently oversees a variety of programs that are designed to be gender-specific and trauma-responsive and more information is needed on the efficacy of these initiatives.[15]

### Data that explores intersections and additive modes of marginalization:

- Intersectional data across all axes of marginalization is necessary to best understand harm reduction needs for those most impacted. For example, elevated rates of opioid overdoses exist in both urban and rural areas in CT, with 23.7 deaths per 100,000 people in rural towns and 37.1 in Urban Core cities compared to a 22.8 death state average.[16]
- Given these disparities, it is worth investigating how place impacts trends for cis-women, non-binary and trans people.

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