



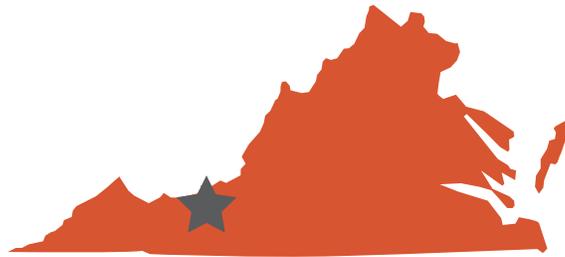
Attachment A-7

NRV Profile Project Cape

New River Valley Profile

Community Behavioral Health Profile for New River Valley, Virginia

September 2014



The CAPE Communities in Virginia:

Floyd
Giles

Montgomery

Pulaski

City of Radford



CAPE | Community Assessment and Education to Promote
Behavioral Health Planning and Evaluation

The CAPE Project was made possible by funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Department of Agriculture's National Institute of Food and Agriculture (USDA NIFA, 2013-48765-21544) and the Regional Rural Development Centers (RRDC). The project would not have been possible without collaboration through Virginia Polytechnic Institute and State University.

This report was released in September 2014.

For more information about the CAPE Project, visit us online at www.healthbench.info.



CAPE | Community Assessment and Education to Promote Behavioral Health Planning and Evaluation

Extended Profile New River Valley, Virginia

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Introduction

This profile was created as part of the Community Assessment and Education to Promote Behavioral Health Planning and Evaluation (CAPE) project. The CAPE project was funded by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and the United States Department of Agriculture's National Institute of Food and Agriculture (USDA NIFA, 2013-48765-21544), and was implemented by the Regional Rural Development Centers in partnership with a number of land grant universities and their local collaborators. A national, competitive application process resulted in the selection of ten pilot communities to be involved in CAPE. The CAPE project's goals were to (1) to assess how local decision makers obtain and use information about community behavioral health trends and (2) to assemble a tool kit to help improve use of available data and community-level interventions to address pressing issues. This document presents a compilation of county, state, and national trends for various community behavioral health indicators from secondary sources as well as the findings from a survey of community leaders administered by the CAPE project. Similar profiles were assembled for each of the other nine CAPE pilot communities. To access the other profiles and to learn about other resources assembled by the project, please visit the project online at <http://www.healthbench.info>.



United States
Department of
Agriculture

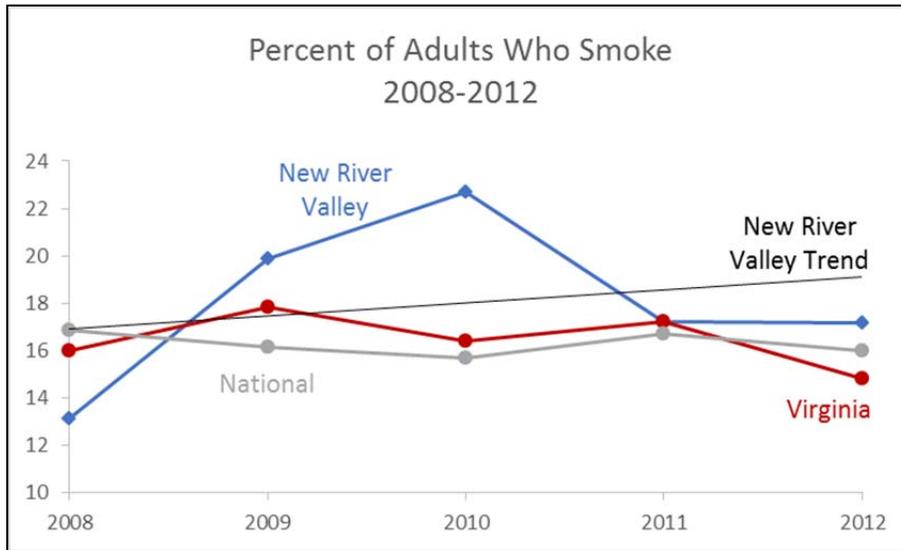
National Institute
of Food and
Agriculture



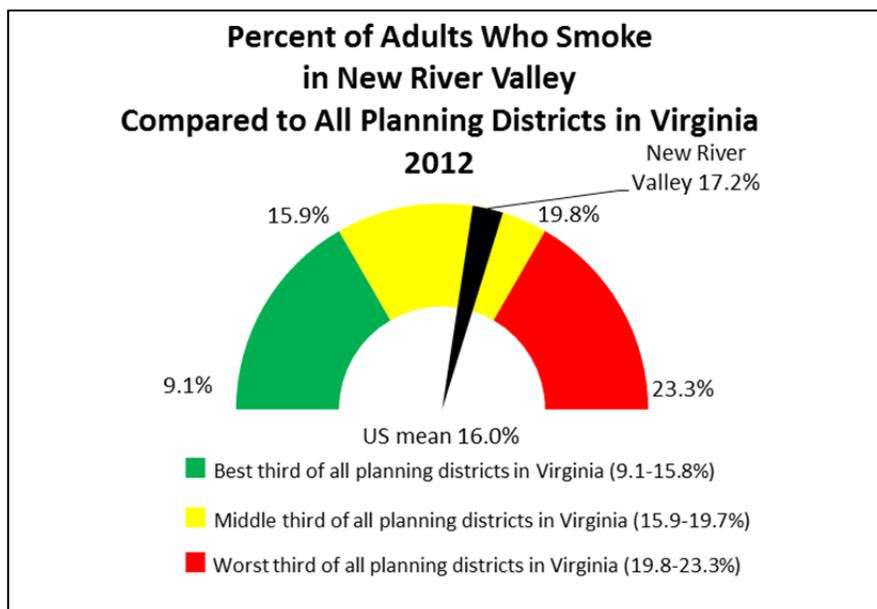
Health Trends in New River Valley, Virginia

Data on several community behavioral health issues in New River Valley were collected and analyzed to show recent trends in local community behavioral health over time, with comparisons (where possible) to state and national trends. This data provides a context for the findings from the CAPE survey of community leaders. Note: Because the Behavioral Risk Factor Surveillance System (BRFSS) suppresses data for Virginia counties and cities with a population lower than 1,000, these counties and cities were not included in the speedometer graphs with draw from BRFSS data below. All counties and cities have been included in data points for the state of Virginia in the trend graphs.

Smoking

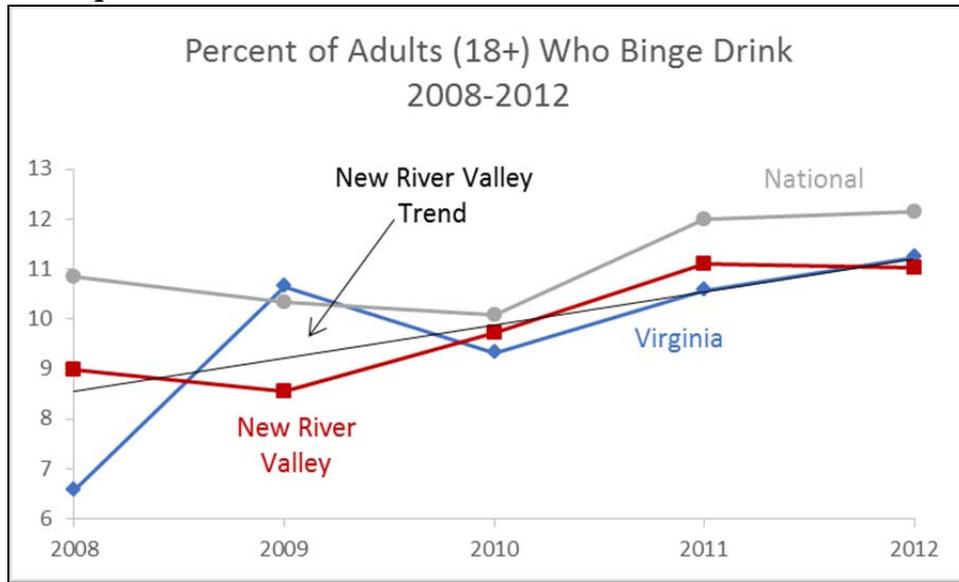


Source: Behavioral Risk Factor Surveillance Survey.

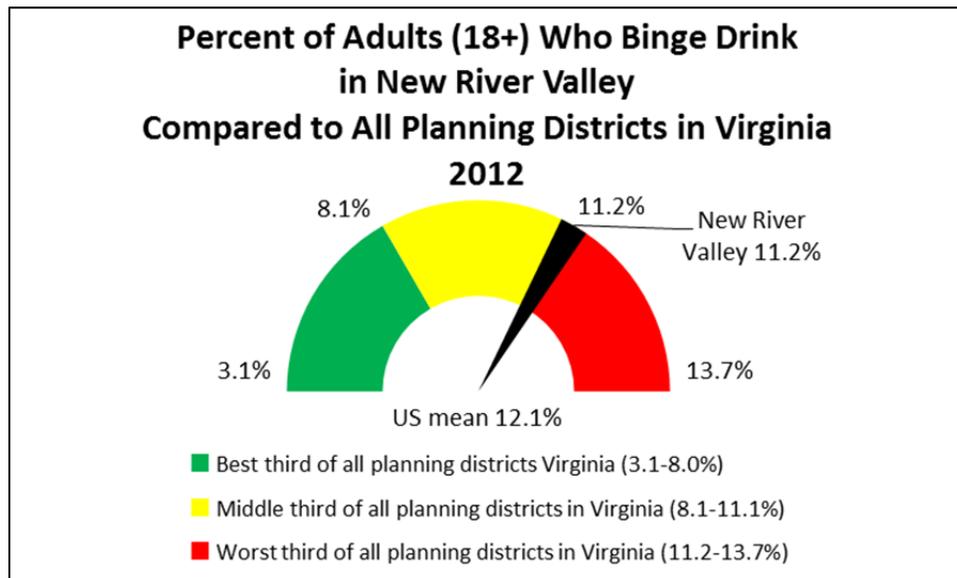


Source: Behavioral Risk Factor Surveillance Survey. Based on 108 counties and cities.

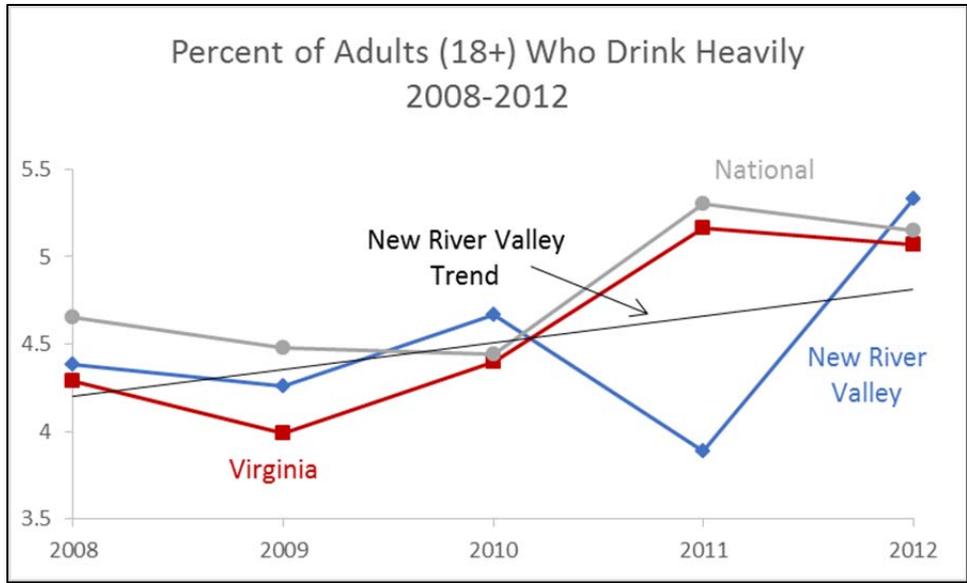
Alcohol consumption



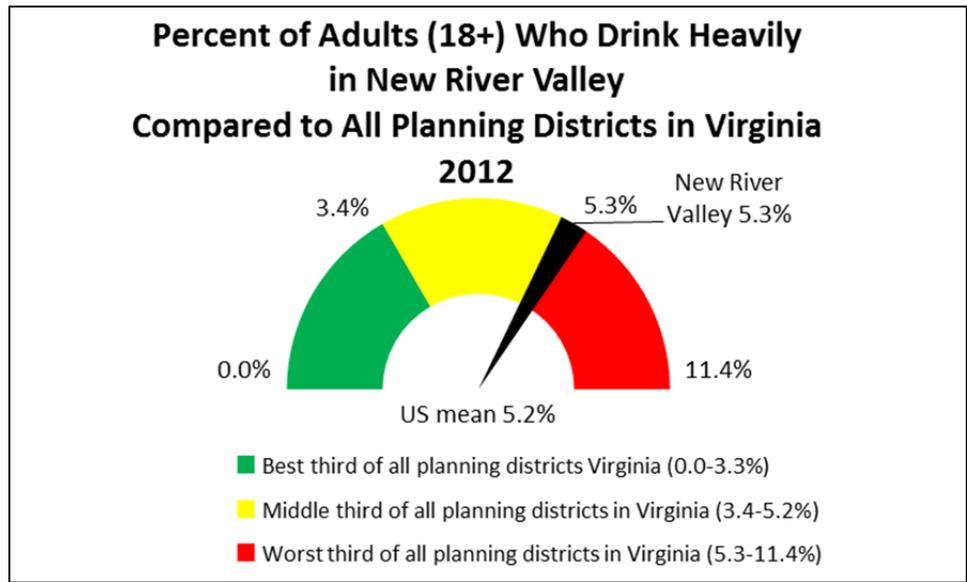
Source: Behavioral Risk Factor Surveillance System. BRFSS defines binge drinking as the consumption of five or more alcoholic beverages for men and four or more alcoholic beverages for women on one occasion.



Source: Behavioral Risk Factor Surveillance System. BRFSS defines binge drinking as the consumption of five or more alcoholic beverages for men and four or more alcoholic beverages for women on one occasion.

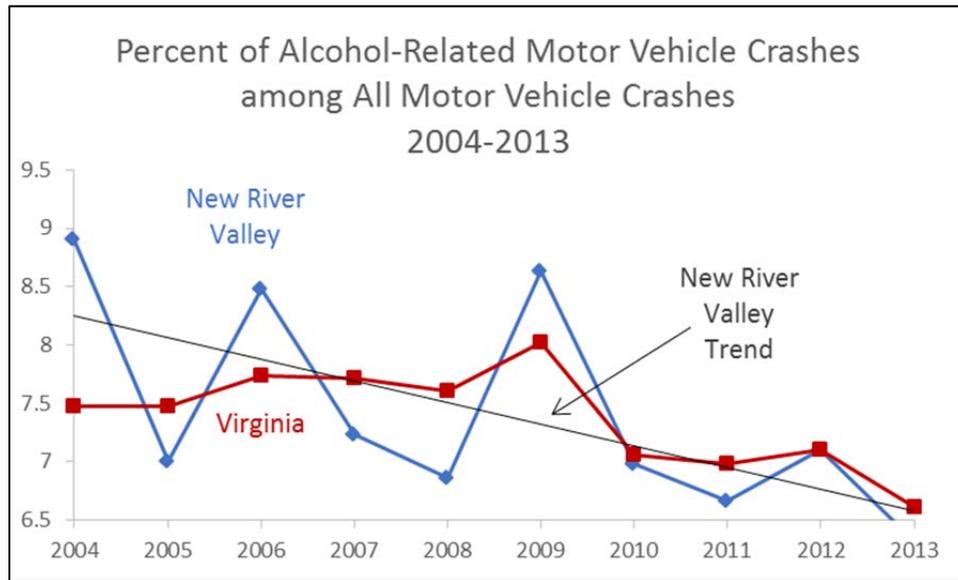


Source: Behavioral Risk Factor Surveillance System. BRFSS defines heavy drinking as the regular daily consumption of more than 2 alcoholic beverages for men and more than one alcoholic beverage for women.

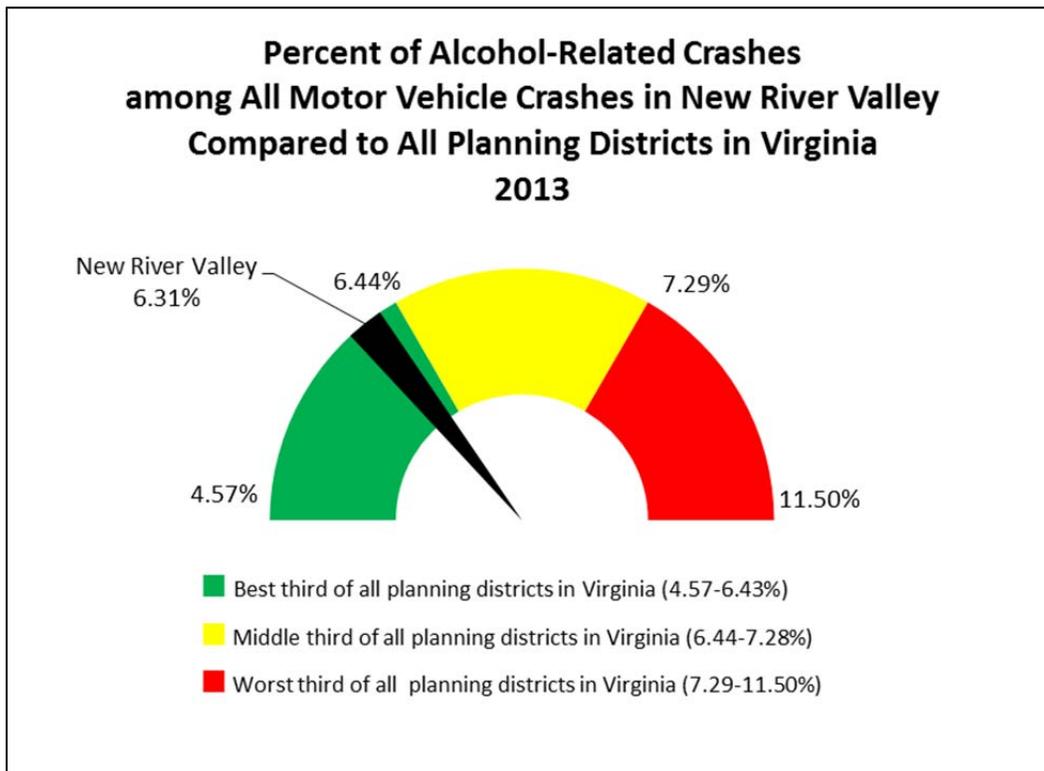


Source: Behavioral Risk Factor Surveillance System. BRFSS defines heavy drinking as the regular daily consumption of more than 2 alcoholic beverages for men and more than one alcoholic beverage for women.

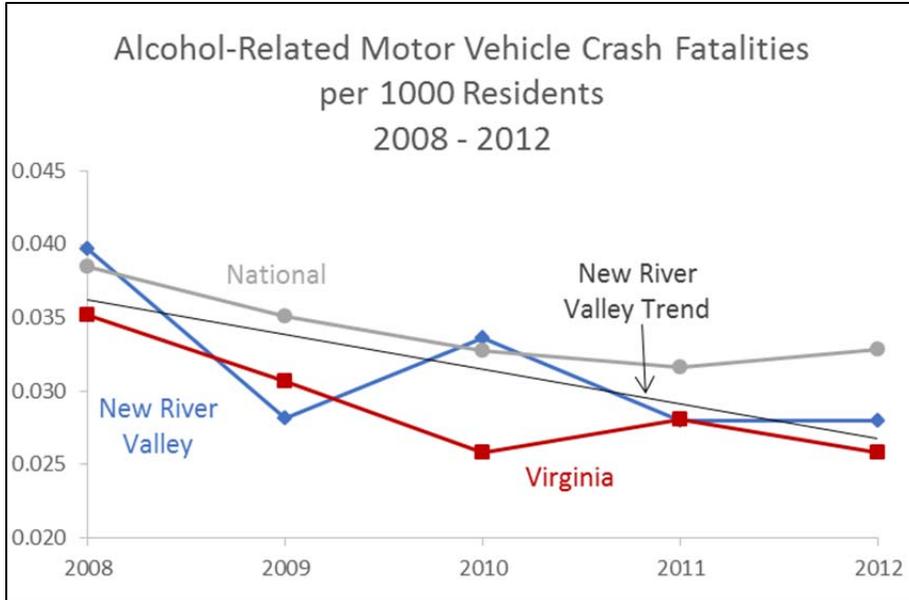
Alcohol-related automobile accidents and deaths



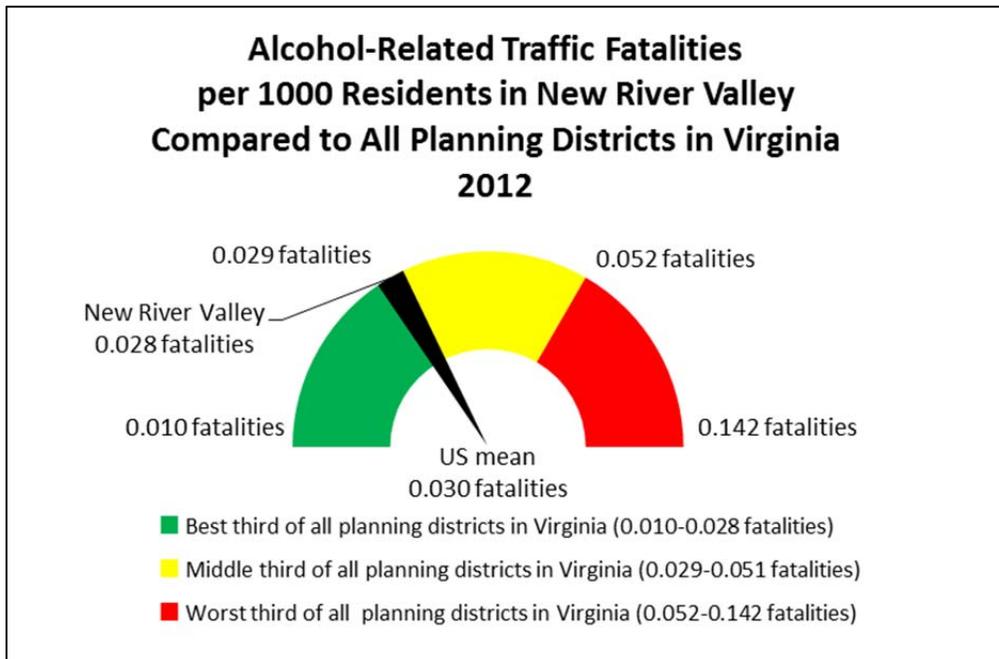
Source: Virginia Department of Motor Vehicles, Virginia Traffic Crash Facts Yearly Publication.



Source: Virginia Department of Motor Vehicles, Virginia Traffic Crash Facts Yearly Publication.

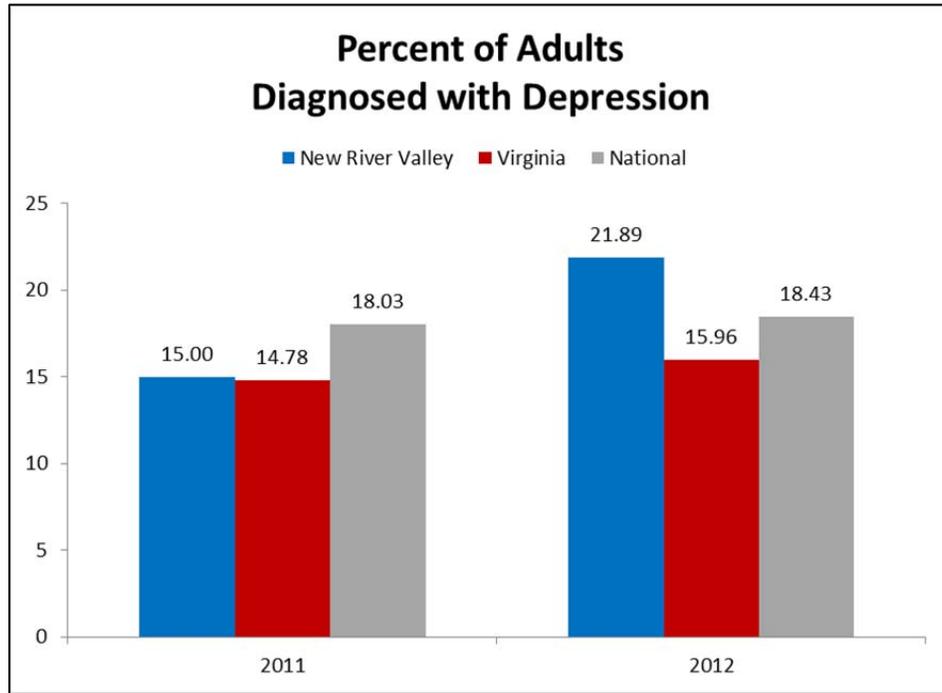


Source: National Highway Traffic Safety Administration Traffic Safety Facts, 2008-2012.

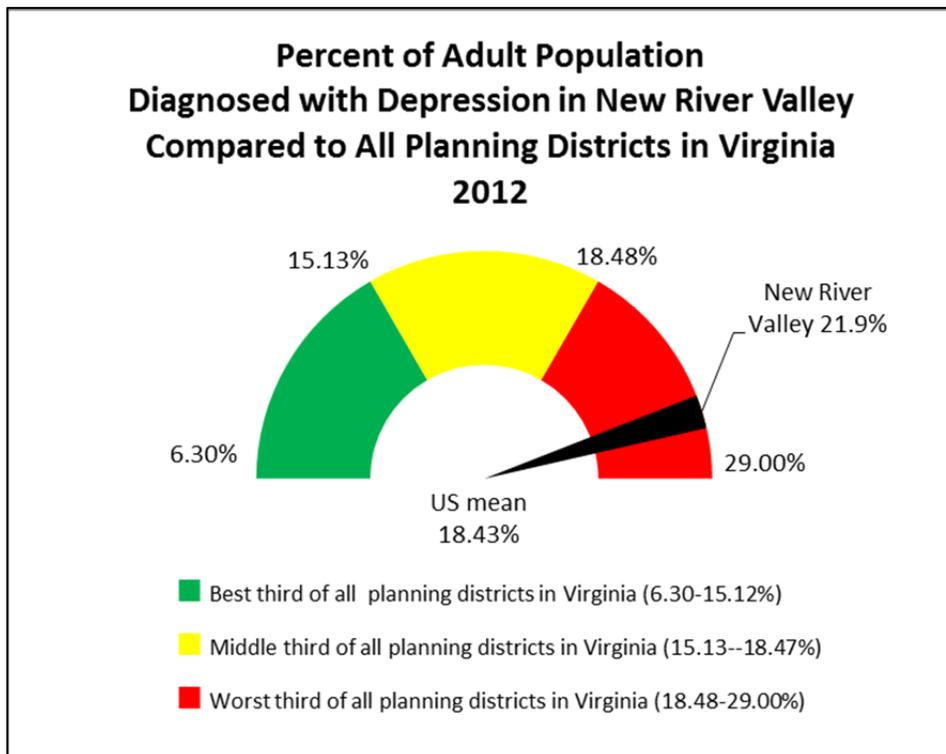


Source: National Highway Traffic Safety Administration Traffic Safety Facts, 2008-2012.

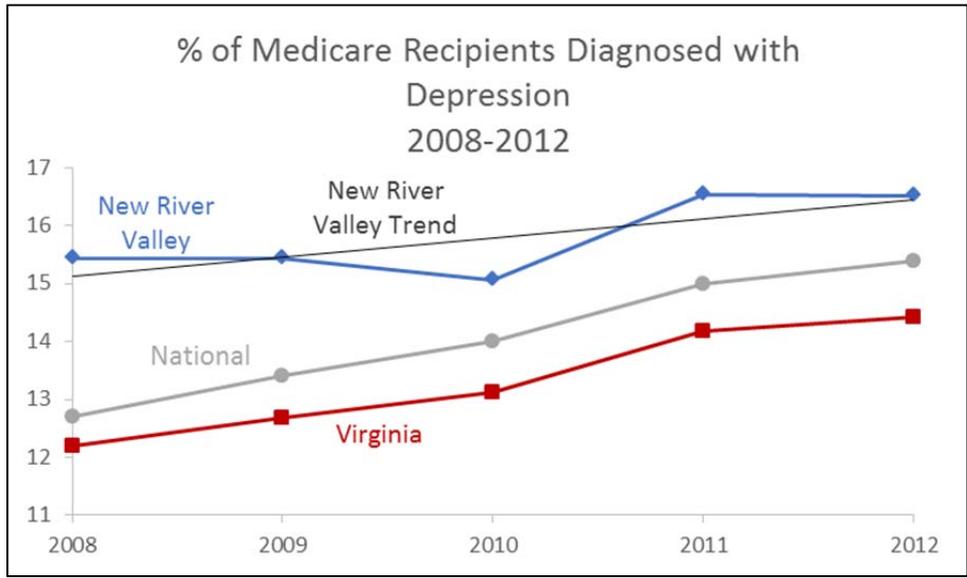
Depression and depression among Medicare recipients



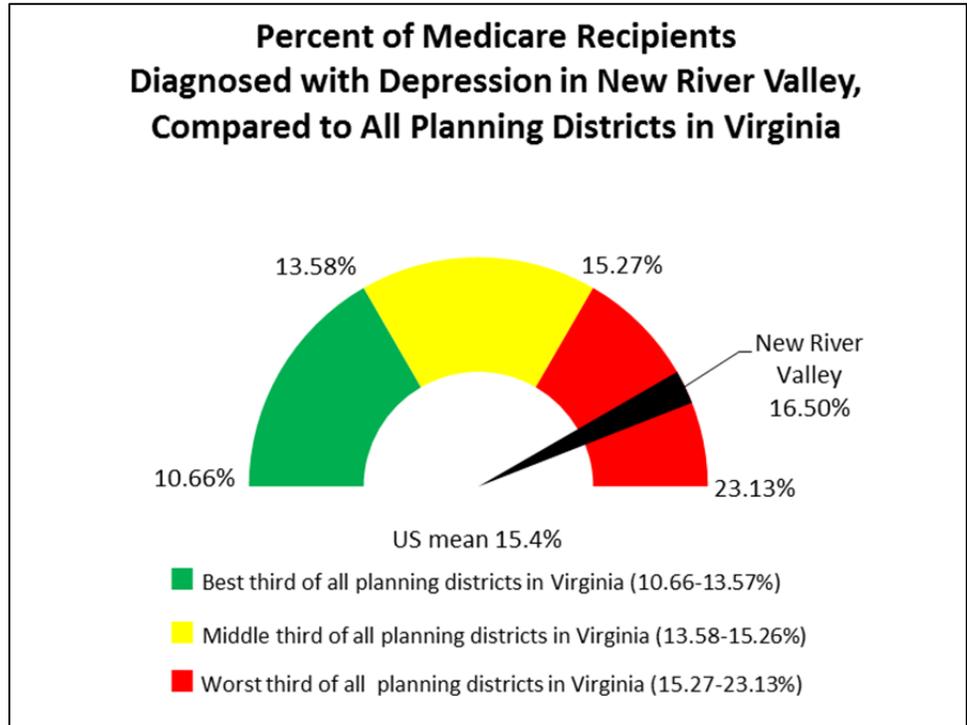
Source: Behavioral Risk Factor Surveillance System.



Source: Behavioral Risk Factor Surveillance System.

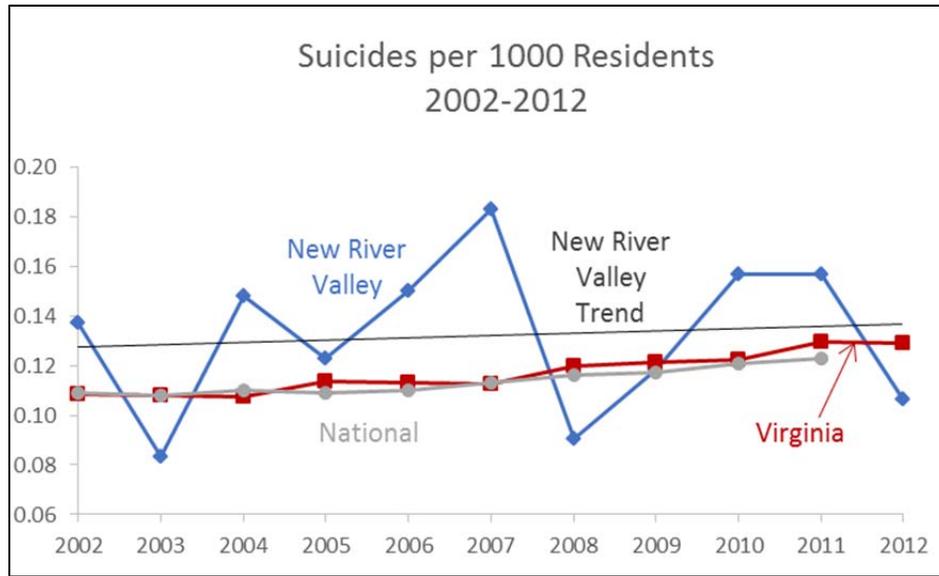


Source: Centers for Medicare and Medicaid Services.

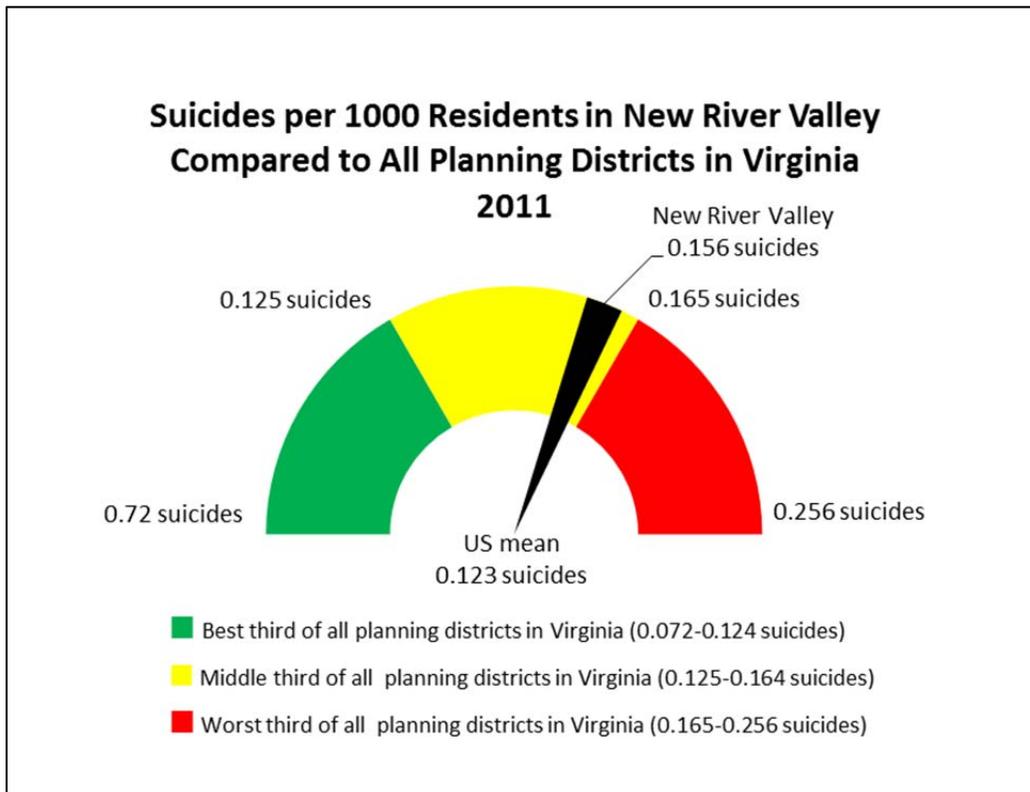


Source: Centers for Medicare and Medicaid Services. Based on 132 counties and cities.

Suicide

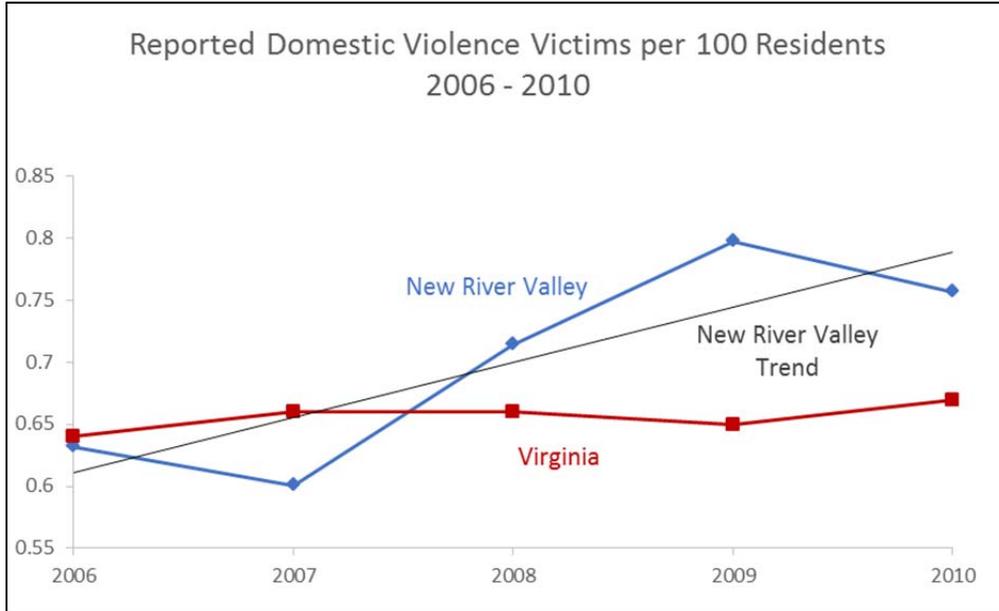


Source: Virginia Department of Health, Statistical Reports and Tables and Web-based Injury Statistics Query and Reporting System (WISQARS).

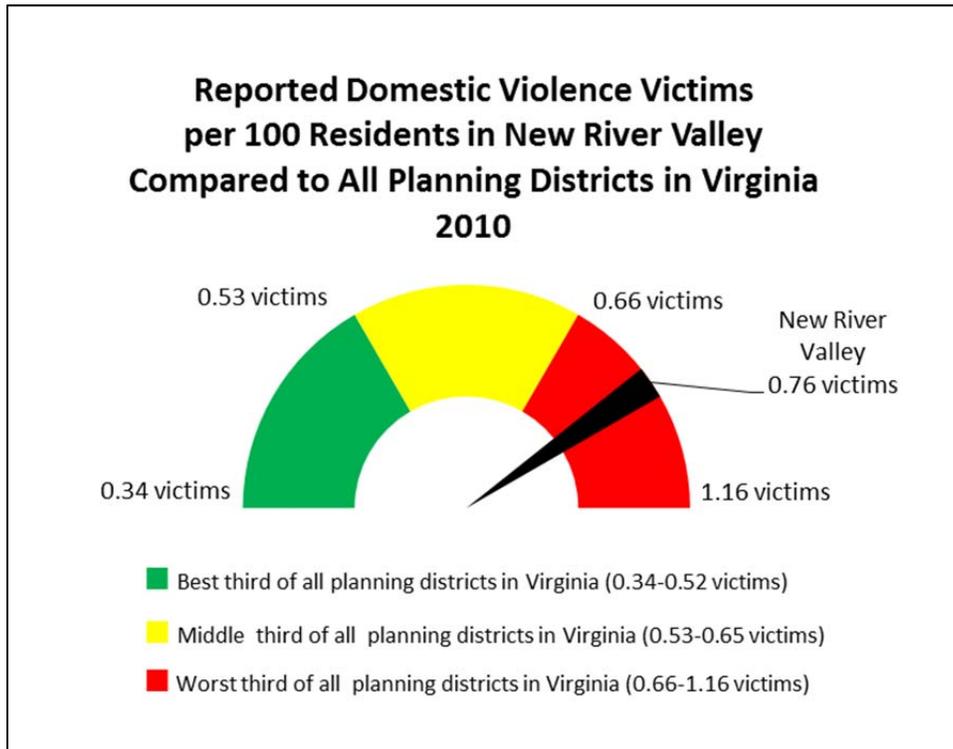


Source: Virginia Department of Health, Statistical Reports and Tables and Web-based Injury Statistics Query and Reporting System (WISQARS).

Domestic violence

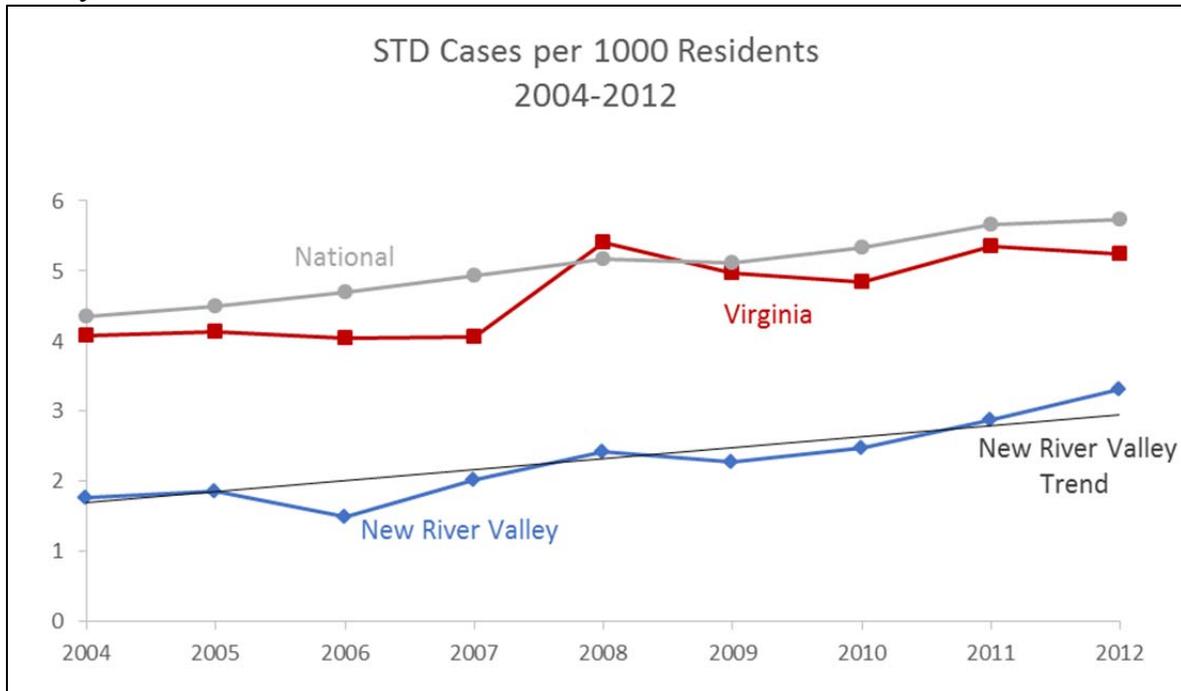


Source: Virginia Department of Criminal Justice Services, Criminal Justice Research Center report “Domestic Violence in Virginia 2006-2010: Statistical Findings from Incidents Reported by Law Enforcement.”

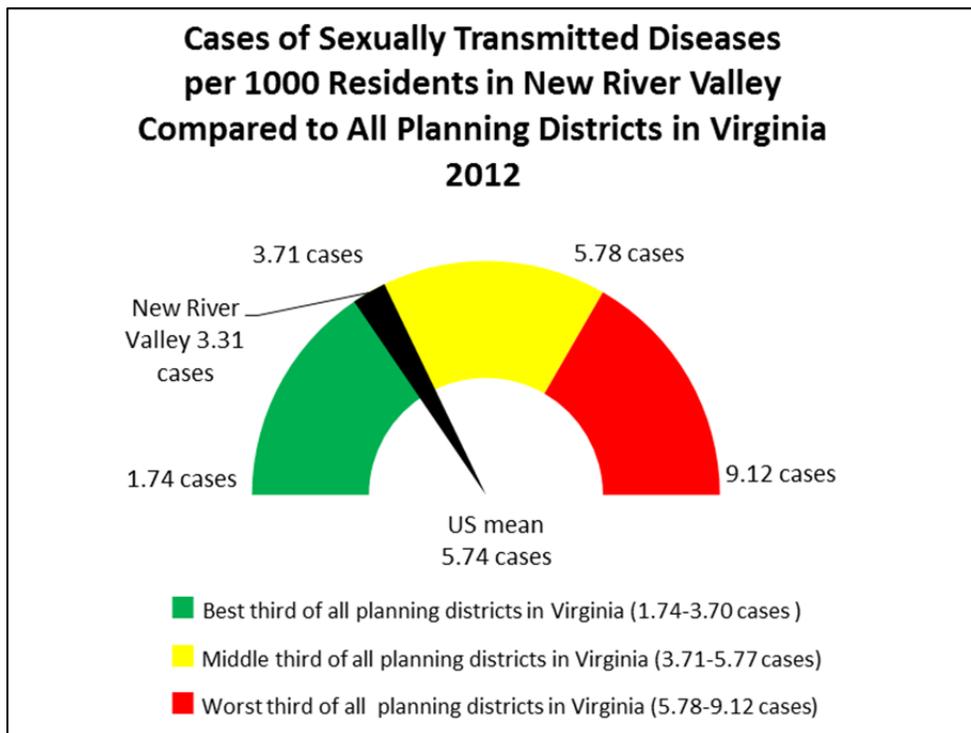


Source: Virginia Department of Criminal Justice Services, Criminal Justice Research Center report “Domestic Violence in Virginia 2006-2010: Statistical Findings from Incidents Reported by Law Enforcement.”

Sexually transmitted diseases

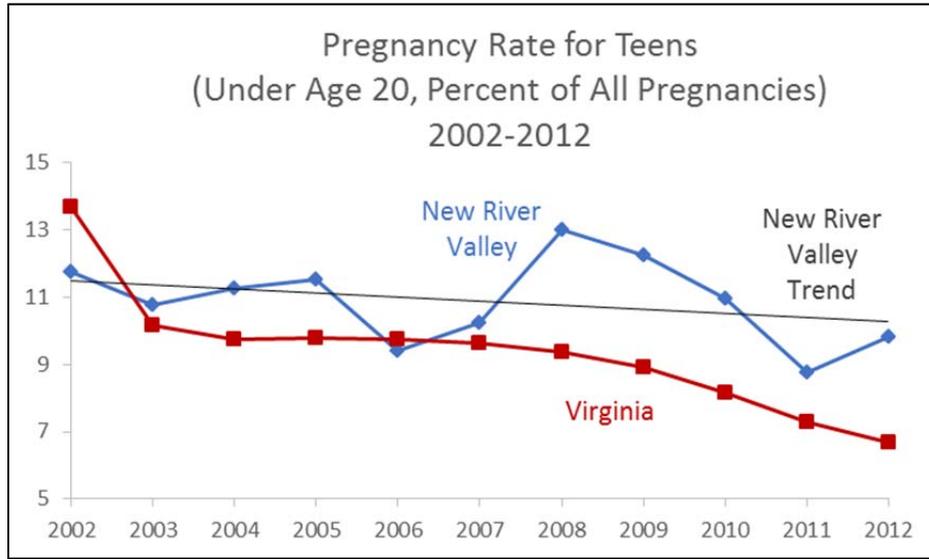


Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. Includes chlamydia, gonorrhea, and syphilis.

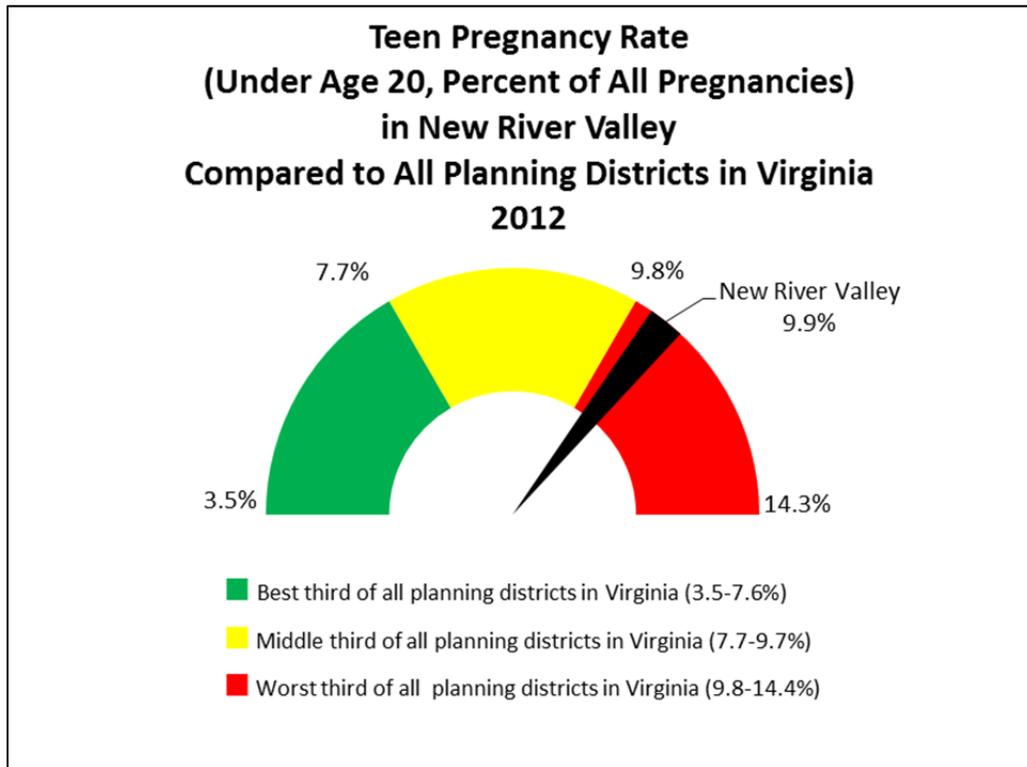


Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. Includes chlamydia, gonorrhea, and syphilis.

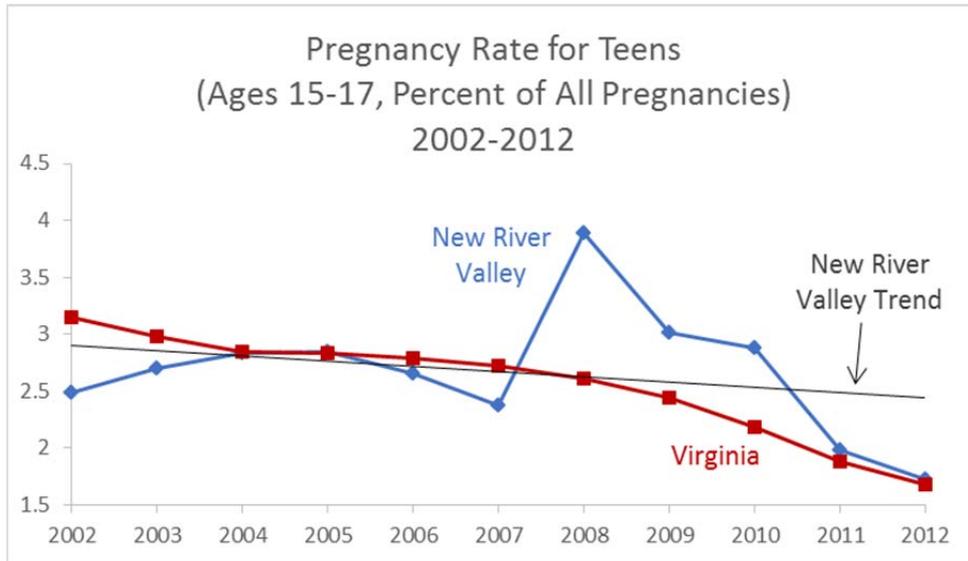
Teen pregnancy



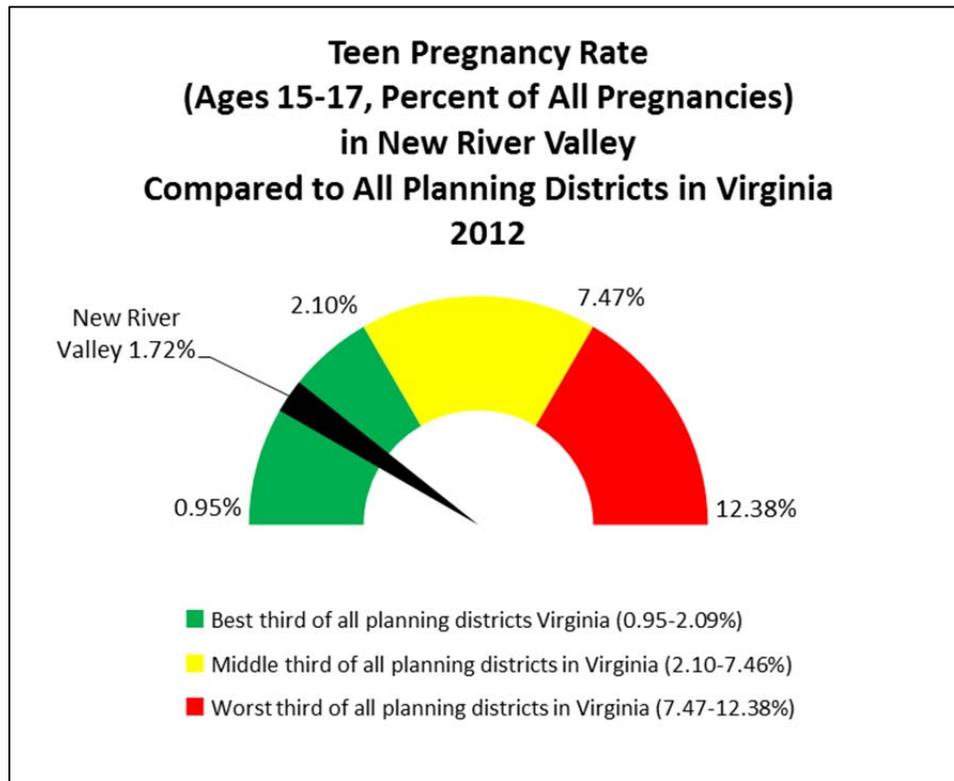
Source: Virginia Department of Health, Division of Health Statistics.



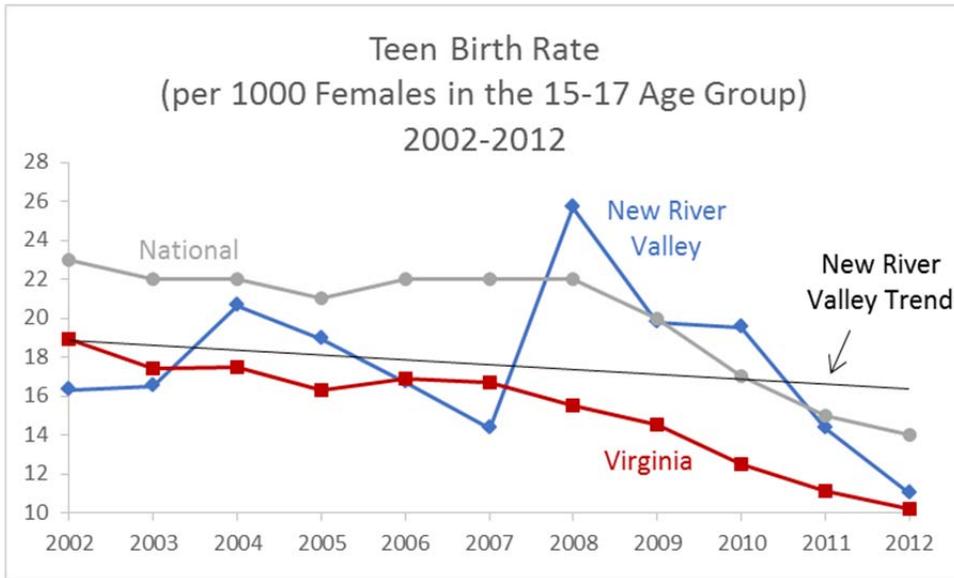
Source: Virginia Department of Health, Division of Health Statistics.



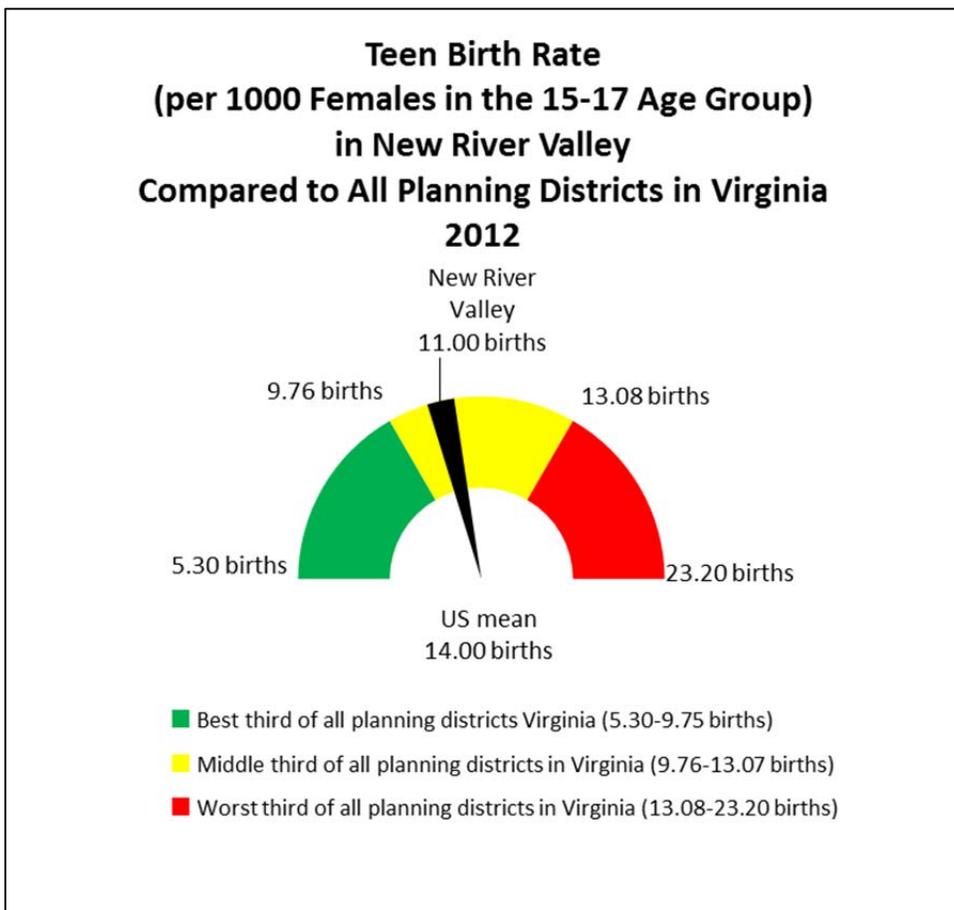
Source: Virginia Department of Health, Division of Health Statistics.



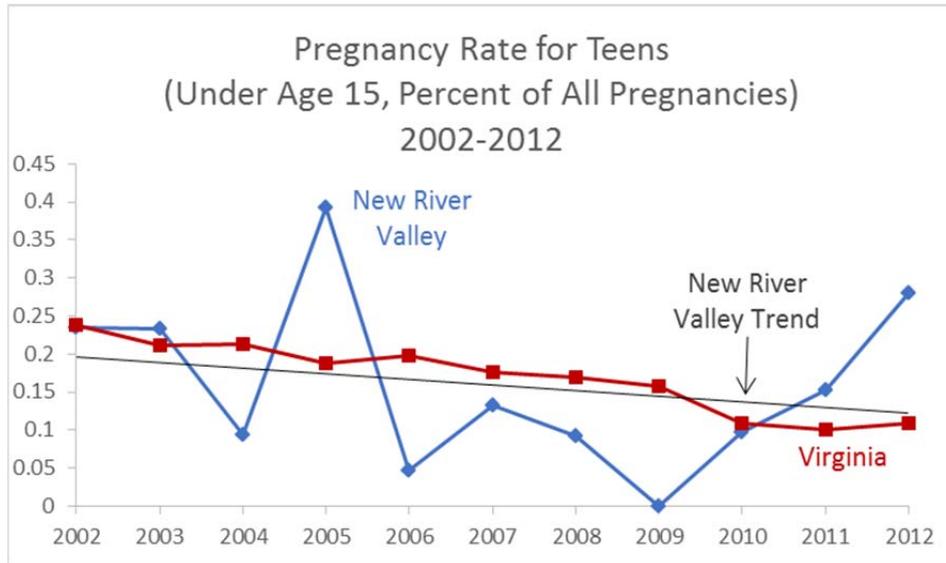
Source: Virginia Department of Health, Division of Health Statistics.



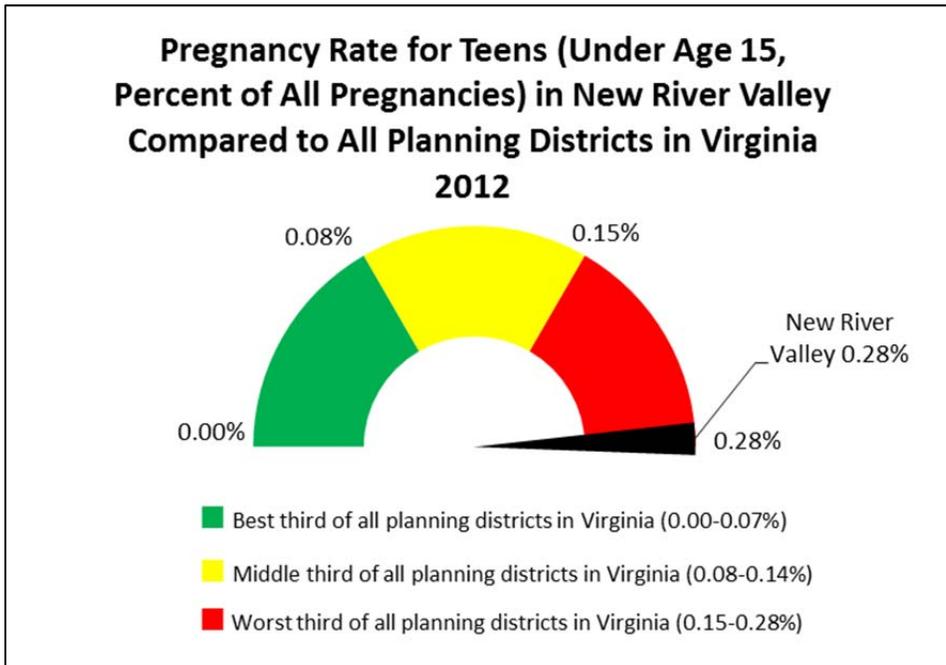
Source: Virginia Department of Health, Division of Health Statistics and Kids Count.



Source: Virginia Department of Health, Division of Health Statistics and Kids Count.

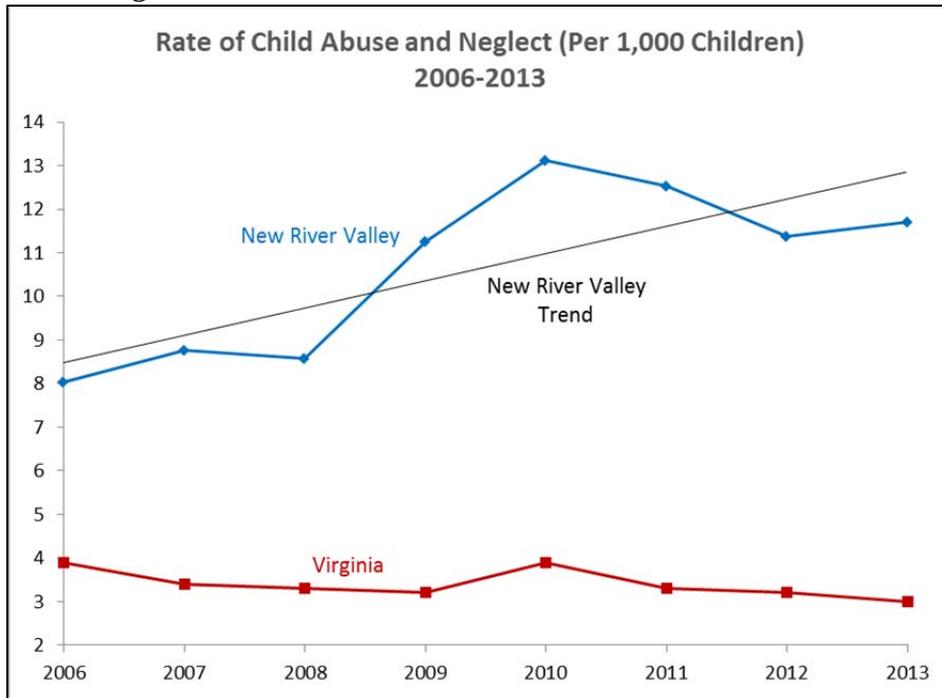


Source: Virginia Department of Health, Division of Health Statistics.

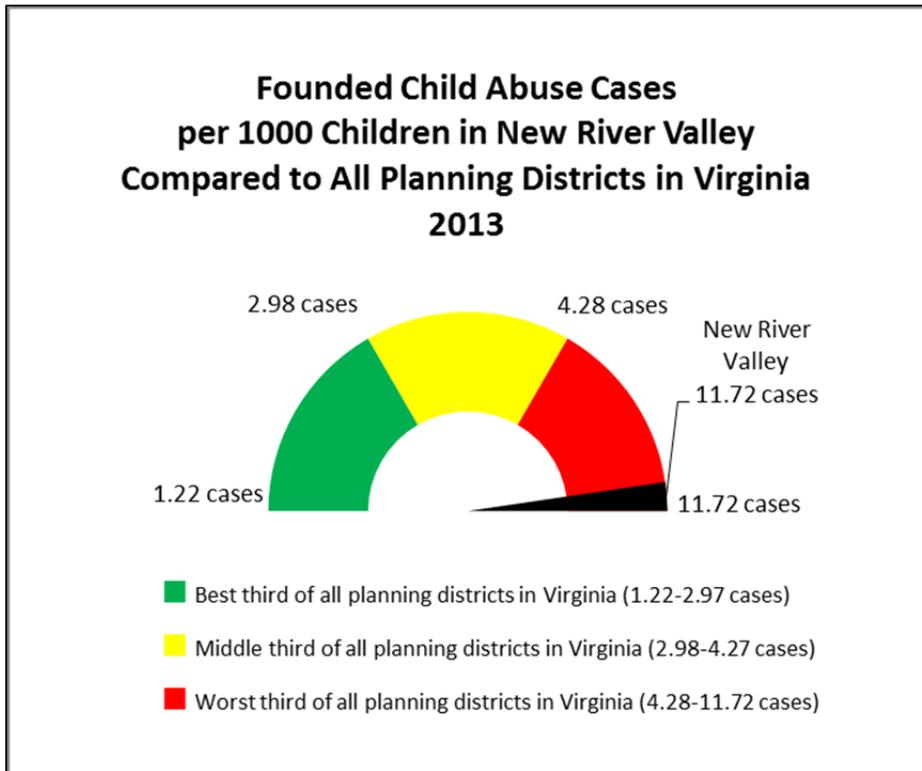


Source: Virginia Department of Health, Division of Health Statistics.

Child abuse and neglect

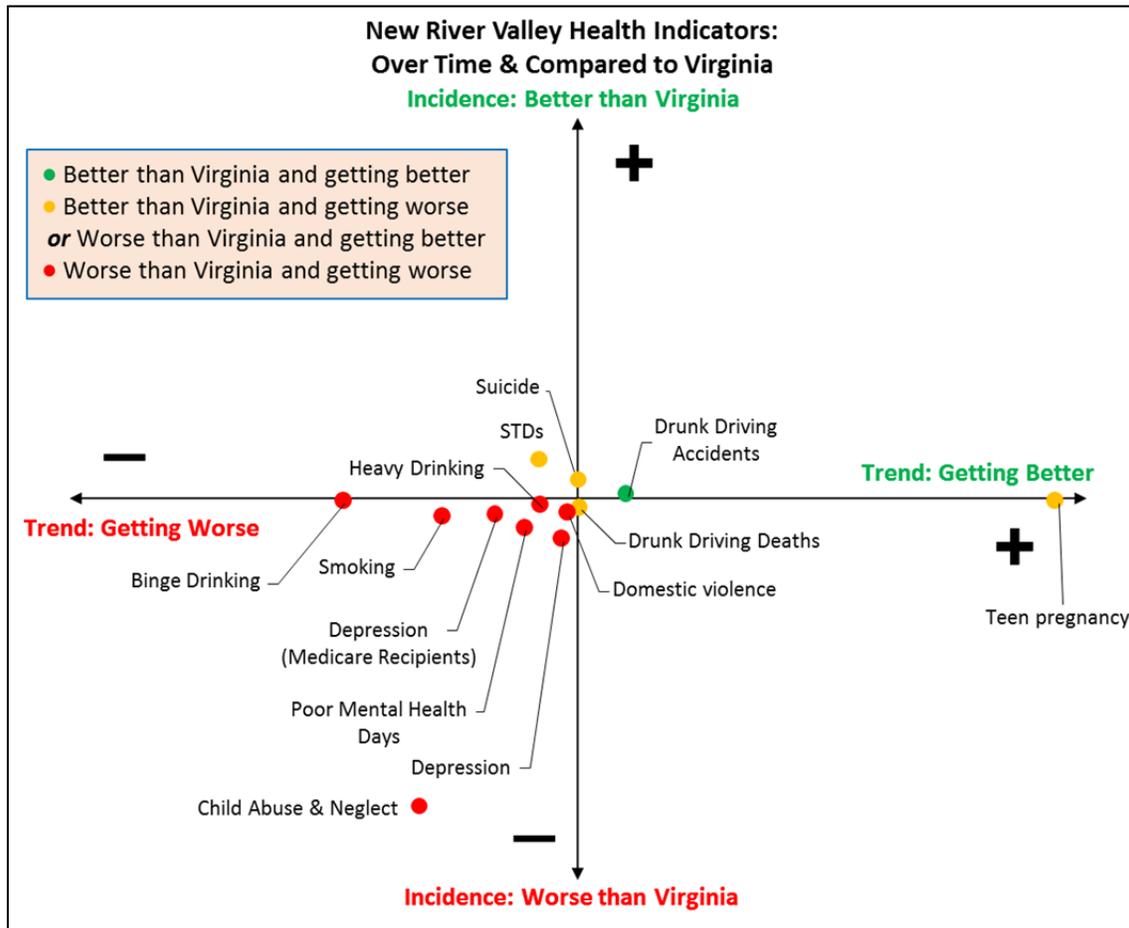


Source: Virginia Department of Social Services and Kids Count.



Source: Virginia Department of Social Services and Kids Count.

Overall picture of behavioral health indicators in New River Valley, Virginia



Health Perspectives: Community Leaders

Community Leaders

The CAPE Project launched a survey online to which 195 community leaders from New River Valley responded. The response rate was 43.8%. The largest group of respondents was substance abuse/mental health treatment professionals (16.0%), followed by hospital/health care unit administrators (12.8%), charitable organization leaders/volunteers (9.6%), and prevention professionals (9.6%). Respondents were reorganized more broadly into four categories: health services, social services, community organizations, and elected/government officials (Table 1).

Role	N	%
Health services	75	39.9
Social services	32	17.0
Community organizations	43	22.9
Elected/government officials	37	19.8

Table 1: New River Valley respondents to the CAPE survey, based on community role.

Within the sample of respondents, 62.0% were female and 38.0% were male. There was a statistically significant difference between sex of respondent and community role ($p < 0.001$; Table 2). Women made up over 70% of those in health services, social services, and community organizations, but 77.8% of elected/government officials were male.

<i>Sex by Role in Community</i>		
Health services	71.6%	Female
Social services	71.0%	Female
Community organization	72.1%	Female
Elected/govt. officials	77.8%	Male
$p < 0.001$		

Table 2: Percentage of majority of respondents within each community role group by sex.

Health Priorities

Community leaders in New River Valley were asked which health or health-related conditions they took into consideration in setting community health priorities, from a list of 22 possible health conditions. Respondents could select as few or as many options as they wished.

The three health areas that were selected most frequently by community leaders in New River Valley were illegal drug use (selected by 76.9%), alcohol abuse (selected by 73.8%), and non-medical prescription use (selected by 66.7%). The three health areas that were least frequently identified as priorities in New River Valley were fetal alcohol syndrome (selected by 25.6%), alcohol-related automobile accidents/deaths (selected by 23.1%), and sexually transmitted diseases (selected by 23.1%). Table 3 shows the ranking of the behavioral health areas based on frequency of selection as a priority by community leaders.

Rank	Behavioral Health Issue	N	%
1	Illegal drug use	150	76.9%
2	Alcohol abuse	144	73.8%
3	Non-medical prescription use	130	66.7%
4	Child abuse	118	60.5%
5	Adult depression	111	56.9%
6	Child neglect	107	54.9%
7	Stress	97	49.7%
8	Anxiety	91	46.7%
9	Physical abuse by domestic partner	89	45.6%
9	Post-traumatic stress disorder	89	45.6%
11	Suicidal thoughts	84	43.1%
12	Youth depression	80	41.0%
13	Mental abuse by domestic partner	78	40.0%
14	Teen pregnancy	71	36.4%
15	School or work absenteeism	67	34.4%
16	Tobacco use	61	31.3%
17	Suicide rate	60	30.8%
17	High school dropout rate	60	30.8%
19	Schizophrenia	56	28.7%
20	Fetal alcohol syndrome	50	25.6%
21	Alcohol-related automobile accidents/deaths	45	23.1%
21	Sexually transmitted diseases	45	23.1%

Table 3: Behavioral health issues ranked based on frequency of selection by community leaders in New River Valley.

Illegal drug abuse and alcohol abuse were within the top three priority behavioral health areas for all four groups of community leaders. However, there were several behavioral health issues with statistically significant differences in selection as a priority based on role in the community (Table 4). For all but one of these, leaders from health services selected the issues as priorities with greater frequency than other groups. Leaders from social services had the lowest selection of the behavioral health issues as a priority for four of the seven; the other three were least selected by elected/government officials.

p<0.001	Health services	Social services	Community org.	Elected/govt. officials
Anxiety	65.3	34.4	37.2	29.7
Suicide rate	52.0	6.3	20.9	27.0
Suicidal thoughts	66.7	18.8	34.9	32.4
p<0.01				
Non-medical prescription use	81.3	68.8	53.5	51.4
Alcohol-related auto. accidents/deaths	22.7	9.4	20.9	37.8
Schizophrenia	44.0	15.6	16.3	24.3
p<0.05				
PTSD	58.7	40.6	44.2	32.4

Table 4: Percentage of community leaders selecting each behavioral health issue, organized by level of statistical significance.

An additional question allowed community leaders to type in other community behavioral health priorities in New River Valley. Leaders indicated that the following were also priorities in community behavioral health:

- Mental health
 - Bipolar disorder; attachment disorder; trauma, chronic trauma; reactive attachment disorder; ADD/ADHD; autism; dementia; hoarding; OCD; emotional disturbance; intellectual disabilities; ODD; self-medication for mental health issues; self-injury
- Healthcare
 - Lack of resources and services; inadequate availability of psychiatric care (children and adults); affordability of medication; access to primary care physician; access to care and health coverage; access to mental health care; history of TDO; hospitalization (voluntary or involuntary)
- Children and youth
 - Children born addicted to drugs (NAS, perinatal substance abuse); children of separation and divorce; children in foster care due to parental drug use; children raised by grandparents due to parental drug use; high rates of foster care; cyberbullying; juvenile delinquency and violent offenses; mental illness and at-risk behaviors in youth
- Senior citizens
 - Elder abuse; elder neglect (sometimes self-neglect or due to poverty); elder exploitation; elder isolation
- Drug use
 - Smoking; opioid addiction; drug abuse
- Other
 - Low socioeconomic status, poverty; sexual assault or abuse; sedentary lifestyle/poor fitness choices; homelessness; indigency [sic] and uninsured status; obesity; parent interview/information with other agencies; poor eating choices; accidental death and injury.

One survey respondent said: “In our community, we have a high rate of generational criminality. With that being said, most, if not all of our offenders could either be diagnosed with Anti-Social Personality Disorder or at minimum exhibit and possess many of the associated thinking errors and lack many necessary pro-social values and beliefs. The research indicates that Cognitive-Behavioral Therapy is necessary and successful with this population. As an agency, we spent a substantial amount of time evaluating an individual's cognitions and attempt providing programming [that] promotes pro-social thinking and behaviors.”

Data Sources

After selecting a certain health or health-related condition as a priority, community leaders were asked where they got their information or data about that issue. Community leaders could select from federal statistics, state government, local government, media reports, or clientele/stakeholders. For 16 of the 22 health issues, the largest percentage of respondents indicated they got their data or information from clientele/stakeholders (Table 5).

Clientele/stakeholders were the primary source of data or information for the top thirteen behavioral health issues in New River Valley. The largest percentage of respondents indicated the state government was the source of data for the suicide rate, high school dropout rate, and sexually transmitted diseases.

<u>Behavioral Health Issue</u>	<u>Source</u>	<u>%</u>
Non-medical prescription use	Clientele/stakeholders	42.1%
Illegal drug use	Clientele/stakeholders	39.1%
Physical abuse by domestic partner	Clientele/stakeholders	59.5%
Mental abuse by domestic partner	Clientele/stakeholders	64.1%
Alcohol abuse	Clientele/stakeholders	50.0%
Fetal alcohol syndrome	State government and Clientele/stakeholders	37.5% †
Alcohol-related automobile accidents/deaths	Media reports	38.2%
Tobacco use	Clientele/stakeholders	43.4%
Child neglect	Clientele/stakeholders	36.3%
Child abuse	Clientele/stakeholders	30.7%
Adult depression	Clientele/stakeholders	56.8%
Youth depression	Clientele/stakeholders	56.1%
Anxiety	Clientele/stakeholders	57.9%
Stress	Clientele/stakeholders	67.9%
Suicide rate	State government	27.5%
Suicidal thoughts	Clientele/stakeholders	62.3%
Schizophrenia	Clientele/stakeholders	55.3%
Post-traumatic stress disorder	Clientele/stakeholders	44.2%
Teen pregnancy	Local government and clientele/stakeholders	27.1% †
High school dropout rate	State government	35.3%
School or work absenteeism	Clientele/stakeholders	59.3%
Sexually transmitted diseases	State government	28.6%

Table 5: Sources of data for largest percentage of respondents for each behavioral health issue in the CAPE survey. † denotes that the listed percentage was the highest percentage for multiple sources.

There were statistically significant differences in the source of data or information based on role in the community for 8 of the behavioral health issues (Table 6). Across these eight different behavioral health issues, community leaders from health services and social services tended to rely much more on clientele/stakeholders as their source of information or data, compared with those from community organizations and elected/government officials.

p<0.01	Health services	Social services	Community org.	Elected/govt. officials
Non-medical prescription use	45.5 C/S	71.4 C/S	26.3 SG, MR	35.7 LG
p<0.05				
Illegal drug use	43.6 C/S	62.5 C/S	26.9 SG	33.3 C/S
Youth depression	58.8 C/S	100.0 C/S	41.7 C/S	33.3 LG, MR
Stress	70.3 C/S	87.5 C/S	69.2 C/S	41.7 C/S
Suicidal thoughts	68.2 C/S	83.3 C/S	66.7 C/S	44.4 MR
PTSD	50.0 C/S	69.2 C/S	41.2 FS	37.5 MR
School/work absenteeism	63.6 C/S	71.4 C/S	66.7 C/S	54.5 LG
STDs	33.3 C/S	40.0 SG	50.0 SG	75.0 MR

Table 6: Sources of data or information for eight behavioral health issues based on community role, organized by level of significance. (C/S: clientele/stakeholders; SG: state government; FS: federal statistics; MR: media report.)

One statistically significant difference appeared in data sources based on respondents' sex, for the issue of child abuse (p<0.01). Local government was the primary source of information or data about child abuse for 34.4% of male respondents, while clientele/stakeholders were the primary source for 31.3% of female respondents.

Data Familiarity

A list of 23 sources of data was presented to the community leaders, who were asked to indicate how familiar they were with each one. Levels of familiarity leaders could select from included not familiar, aware of but do not use, consult but less than once a year, or consult once a year or more. Of the 23 data sources, the largest percentage of community leaders from New River valley was not familiar with 12 sources (Table 7). As the least familiar data source, 81.3% of community leaders were not familiar with Area Health Resource File. The most familiar data source was the Centers for Disease Control & Prevention (CDC), with 41.0% of leaders indicating they consult the CDC once a year or more.

Source	Level of Familiarity	%
Centers for Disease Control & Prevention	Consult yearly or more often	41.0%
Substance Abuse and Mental Health Services Administration	Consult yearly or more often	36.6%
National Institutes of Health	Consult yearly or more often	34.3%
National Institute of Mental Health	Consult yearly or more often	31.0%
State Government Department of Education	Consult yearly or more often	29.6%
US Department of Energy	Aware of but do not use	59.1%
Veterans Administration	Aware of but do not use	50.3%
Housing and Urban Development Homeless Management Information Systems	Aware of but do not use, Not familiar	38.0% †
US Department of Education	Aware of but do not use	35.3%
Bureau of Labor Statistics	Aware of but do not use	33.1%
National Data Archive on Child Abuse and Neglect	Aware of but do not use	32.9%
National Center for Health Statistics, National Vital Statistics System	Not familiar	34.9%
Bureau of Justice Statistics	Not familiar	37.2%
National Survey on Drug Use and Health	Not familiar	39.4%
US Decennial Census	Not familiar	41.8%
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	Not familiar	43.0%
National Center for Injury Prevention and Control	Not familiar	46.6%
US Department of Agriculture Supplemental Nutrition Assistance Uptake Data	Not familiar	49.1%
National Intimate Partner and Sexual Violence Survey	Not familiar	56.2%
Web-based Injury Statistics Query and Reporting System	Not familiar	58.5%
Behavioral Risk Factor Surveillance System	Not familiar	67.5%
Institute for Health Metrics and Evaluation	Not familiar	74.1%
Area Health Resource File	Not familiar	81.3%

Table 7: Largest percentage of community leader respondents' level of familiarity with select data sources. † denotes multiple levels of familiarity as the highest percentage.

Differences in level of familiarity with four data sources were statistically significant for four data sources (Table 8). Leaders from health services were most familiar with the CDC and National Institute of Mental Health. Elected/government officials were primarily aware of but did not use three of the sources.

p<0.001	Health services	Social services	Community org.	Elected/govt. officials
CDC	55.2 CYOM	51.9 CLOY	35.9 CYOM	51.9 ADNU
p<0.01				
Behavioral Risk Factor Surveillance System	57.6 NF	85.2 NF	66.7 NF	76.9 NF
p<0.05				
National Vital Statistics System	34.3 NF	42.9 CLOY	36.8 NF	44.4 ADNU
National Institute of Mental Health	41.8 CYOM	44.8 ADNU	33.3 CLOY	40.7 ADNU

Table 8: Levels of familiarity with different data sources by role in community, organized by level of statistical significance (CYOM: consult yearly or more often; CLOY: consult less than once a year; ADNU: aware of but do not use; NF: not familiar).

There were also significant differences in data familiarity based on respondents' sex (Table 9). Male respondents were slightly more familiar with US Department of Energy, Veterans' Administration, and Web-based Injury Statistics Query and Reporting System. Female respondents were slightly more familiar with Behavioral Risk Factor Surveillance System, CDC, and Housing and Urban Development's Homeless Management Information System.

p<0.01	Male	Female
US Department of Energy	42.3 ADNU	66.4 ADNU
Veterans Administration	32.1 ADNU	58.2 ADNU
Web-based Injury Statistics Query and Reporting System	60.8 NF (17.6 CLOY)	57.7 NF (29.7 ADNU)
p<0.05		
Behavioral Risk Factor Surveillance System	59.6 NF (23.1 ADNU)	70.6 NF (13.8 COYM)
CDC	35.2 CLOY	49.1 COYM
HUD Homeless Management Information System	45.3 NF (0.0 COYM)	34.2 NF (14.4 COYM)

Table 9: Levels of familiarity with different data sources by respondents' sex, organized by level of statistical significance (CYOM: consult yearly or more often; CLOY: consult less than once a year; ADNU: aware of but do not use; NF: not familiar).

Training and Assistance

Community leaders were asked if they had ever sought assistance getting better information about health trends in the community. 56.9% of community leaders responded that they had sought assistance. When asked to specify where they had gotten assistance, community leaders indicated they had sought assistance from multiple sources, although the highest responses were for expert consultation and web search/internet (Table 10). One respondent said, "There are so many data sources out there, but often [I] look for ones with the best search format at least to the county level. The problem is mostly understanding the baseline source of data, and being able to extract data at a useful level. Then connecting to issues that get public and political attention such as child abuse, domestic violence, incarceration."

<u>Where Assistance Was Sought</u>	<u>N</u>
Expert consultation	25
Web search / Internet	17
Department of Health	7
Local agencies	6
Workshops, conferences, seminars, training	3
Community health needs assessments	3
Rural Health data portal	3
County health rankings	3
Centers for Disease Control & Prevention	2
Researchers, universities	2
Publications/research articles	2
New River Valley Community Services (NRVCS)	2
Planning district commission	2
Clients/stakeholders	2
Bureau of Primary Care	1
Community Care Network of Virginia	1
healthindicators.gov (Health Indicators Warehouse)	1
Virginia Rural Health Association	1
Mental Health America of New River Valley	1
Women's Resource Center of New River Valley	1
FOIA agencies for detailed information	1
HRSA Federal Data Warehouse	1
Healthy People 2020	1
Livability report online	1
Youth Risk Behavior Surveillance System	1
Behavioral Risk Factor Surveillance System	1
National Health and Nutrition Examination Survey	1
State agencies	1
State department of human resources management	1
State government website	1
Dartmouth Health Atlas	1
State and federal data	1

Table 10: Responses from community leaders about where they have sought assistance getting better information about community behavioral health.

Elected or government officials were significantly less likely to have sought assistance in getting better information about community behavioral health ($p < 0.001$). Whereas over 60% of leaders in health services, social services, and community organizations had sought assistance, under 20% of elected or government officials had ever sought assistance (Table 11).

Sought Assistance?	% Yes
Health services	64.7
Social services	69.0
Community organization	61.5
Elected/govt. officials	19.2

Table 11: Percentage of leaders by community role who had ever sought assistance getting better information about community behavioral health (significant at $p < 0.001$).

Leaders were also asked if they had ever attended a training program providing information about sources of community health trend information. 43.4% of community leaders indicated that they had attended a training program. The survey asked leaders to list who the provider of the training program was (Table 11).

<u>Training Providers</u>	<u>N</u>
County Health Department	7
Universities	6
New River Valley Community Services	5
Community organizations	4
Virginia Association of Rural Health	3
Community Services Board of New River Valley	2
DSS	2
Networking, experts in field	2
Molly O'Dell	2
Virginia Rural Health Data Center/Portal	2
Local community coalition	1
Mental Health Board	1
American Academy of Child and Adolescent Psychiatry	1
Agency on Aging	1
National Institutes of Health	1
VA Department on Aging	1
AARP	1
American Nurses Credentialing Center	1
Associaiton meetings, conferences	1
Community Anti-Drug Coalitions of America	1
Carilion	1
Community Health Rankings	1
State Police	1
DCJS training from Commonwealth's Attorney's Services Council	1
Free Clinic of NRV	1
GNET	1
Health and healthcare agencies	1
Health district director	1
Lawyers Helping Lawyers	1
Local government agencies	1
Local hospital	1
Regional consortium on substance abuse	1
Montgomery County Prevention Partners Coalition	1
Centers for Disease Control & Prevention	1
New River Valley Planning District Commission	1

Table 11: Community leaders' responses about who has provided training to them about community behavioral health information.

<u>Training Providers</u>	<u>N</u>
PATH	1
PCPC	1
Prevention planning meetings	1
Robert Wood Johnson Foundation	1
Community social workers	1
Local statistics	1
Community Foundation of New River Valley & New River Health District	1
Department of Behavioral Health	1
VaCalc	1
Virginia Community Healthcare Association	1

Table 11 (continued): Community leaders' responses about who has provided training to them about community behavioral health information.

Other Findings

One question asked community leaders to list areas where they perceived gaps in data or information about community behavioral health, and leaders indicated a wide range of issues. Some responses to this question indicated that the question was interpreted by some survey participants as asking about what gaps existed in community behavioral health services in the county. The issues raised were:

- Substance use
 - Affordable treatment for substance abuse disorders, access to such treatment; illegal drugs used, manufactured, distributed; non-medical prescription, over-the-counter drug use; methamphetamine and labs; substance abuse; addiction/drug use and pregnancy; alcohol abuse, binge drinking; skilled professionals to provide substance abuse treatment; conviction data for illegal drug use; opiate detox; children under 18 living with substance using adults; number of local ER visits due to substance use and breakdown; drug use by youth; underage tobacco use; marijuana; synthetic drugs
- Mental health
 - PTSD; anxiety; anxiety and depression education; exposure to trauma; adult depression statistics
- Health services
 - Availability and access to affordable mental health treatment; lack of psychiatric services; appointments within a reasonable period of time; transportation to health care; rate of service use by age and mental illness diagnoses; gap in access between general practitioner prescribing antidepressants and access to emergency services; lack of health coverage; couples treatment other than marriage counseling; differences in provider knowledge; prescribing sources; racial inequalities in medical care
- Data
 - Local data; conflicting information from various sources; no central source to begin the search for information; up-to-date information; gaps between actual incidents of abuse and reported data; ability to understand incremental change in

commuting behaviors; influence of local universities on data; gaps in Virginia YRBS data based on what some schools ask; limited data on 65+

- Children and youth
 - High school graduation rates; child neglect; child abuse; inconsistency in area agencies in responding to child abuse and neglect reports; grandparents raising grandchildren and related stress factors; identification and support for children with behavioral challenges; local data on fetal alcohol syndrome and effects; increasing rates of disorders in children; teen pregnancy; real-time (monthly) data on substance impacted births
- Resources
 - Resources for low income families, upward mobility of clients; peer support; how to get housing, work for women who need to move out of unsafe situations; permanent supportive housing; government investment for mental health and substance abuse issues; most people do not understand the support the government provides
- Disconnects in the community
 - Being able to reach out and educate people; lack of interaction between types of institutions; lack of referring people to religious based organizations; community level response to acute events; community sharing of information about behavioral health issues
- Other
 - Measuring effectiveness of outcomes; health and wellness awareness; connection between behavioral health and employability; homeless population; sexual violence; domestic violence; STDs

Several leaders went into more specific detail in their responses about gaps in information: “Community behavioral health needs to work on 1) better access to specialty mental health services (therapy and psychiatric care) and 2) since reduction of psych beds - in patient has increased these needs.”

“Demand for mental health and substance abuse services is overwhelming. Drilling down to why is complicated, data is conflictual as to why.”

“There are so many different organizations with differing data that you have to be careful of where you pull info from and be sure to cross check the data.”

“There is a HUGE disconnect between local public health and local behavioral health (CSB). We should be partnering on patients that we both see so that the patient can get the best care both mentally and for their medical condition.”

“We are at epidemic levels with illegal prescription drug use (opiates) and methamphetamine use. What I have personally discovered is a lot of illegal drugs are used as a way to self-medicate underlying disorders. Essentially, we need to have more resources for individuals with co-occurring issues.”

“Gaps in substance abuse services... primarily because not many providers are interested in this population and there is little funding to pay for services.”

“Race based medical care, on all levels Blacks do not always receive the same level of care.”

Among the survey participants, 86.1% had ever participated in a webinar. Of those participants, 33.1% thought that webinar was very effective, and 59.2% thought it was somewhat effective. 7.0% thought the webinar was somewhat ineffective, and 0.7% thought it was very ineffective.

Community leaders were asked about their level of activity on social media. 20.8% responded that they were not active at all, 22.6% were infrequent social media users, 29.2% were somewhat active on social media, and 27.4% were very active on social media.

The final question leaders responded to asked them what advice they would give to a new person in a similar role, regarding key sources of information (Table 12). Leaders from New River Valley made over 100 suggestions, but the most popular were web searches/internet, networking, and CDC.

<u>Key Information to New People</u>	<u>N</u>
Web searches / Internet	16
Networking	14
CDC	13
DSS	11
SAMHSA	11
Local statistics	9
Local health department/district	8
Police departments, criminal justice system	8
Federal, local, state resources	7
Local agencies	7
Census data	6
NIH	6
State statistics	6
VA Department of Health, VDH data	6
Community resources	5
Department of Education	4
Kids Count	4
Livability Initiative of the NRV	4
National data	4
NIMH	4
NRVCS	4
Books/library	3
Local government	3
Local providers	3
School system	3
4th Planning District Consortium report	2
American Community Survey	2
Child find data	2
Code of Virginia	2

Table 12: Community leaders' suggestions of key information to new people in a similar role.

<u>Key Information to New People</u>	<u>N</u>
Community Assessment	2
Community health rankings	2
Cooper Weldon Center	2
DBHDS	2
Department of Mental Health	2
Media	2
Mental Health America: NRV Chapter	2
NIA	2
AAIDD	1
Accurately reported local/state data	1
American College Health Association Survey	1
Annie E. Casey	1
APA	1
BJA	1
BRFSS	1
Bureau of Labor Statistics	1
Chief Medical Examiner	1
Childcare related data	1
Christian Counseling	1
College Drinking Prevention	1
Community health educator	1
Community Service Board data	1
Comorbidity index for medical and behavioral health co	1
County records	1
Cultural competence	1
DCJS	1
Department of Behavioral Health	1
Department of Public Health	1
DMAS	1
DOJ	1
Federal laws on McKinney-Vento Homeless Education	1
Food and clothing banks	1
FRAME	1
General Assembly	1

Table 12 (continued): Community leaders' suggestions of key information to new people in a similar role.

<u>Key Information to New People</u>	<u>N</u>
healthindicators.gov	1
HMDA	1
ICMA	1
JLARC	1
Lawyers Helping Lawyers	1
Listservs	1
Local needs assessment data	1
Medicaid	1
Mental Health Association of NRV	1
mentalhealth.gov	1
Monitoring the Future Survey	1
NACO	1
NAMI	1
National Health Rankings by county	1
New River Community Health Digest	1
NRV Community Action and Community Services Board	1
NSDUH	1
OEMS regulations	1
One Care's Blueprint	1
PolicyMap	1
Poverty data	1
PRAMS	1
SCB	1
State Budget Office	1

Table 12 (continued): Community leaders' suggestions of key information to new people in a similar role.

Key Information to New People	<u>N</u>
State Fusion Center	1
State websites	1
Support groups	1
Universities	1
VA Labor & Statistics	1
VA Rural Health Data Portal	1
VA Smart Beginnings School Readiness Report Card	1
VA State Police Crash Data	1
VACO	1
VML	1
VOICES	1
Webinars	1
Woman's Resource Center	1
Youth Risk Behavior data	1

Table 12 (continued): Community leaders' suggestions of key information to new people in a similar role.

Health Searches: Gauging Interest through Google Trends

Google Trends is an online tool to view the volume of searches for certain terms, words, or phrases in a given time period and geographic space. For the following searches, the time period was set from 2004 to 2014, for the state of Virginia. Google Trends data has been included to provide insight into how often community members have been searching for different kinds of behavioral health information online via Google Search, which is the most popular online search engine. Google Trends data is always normalized and relative to search parameters. (For more information on how Google Trends collects and represents data, visit the Google Trends Help Center at <https://support.google.com/trends/?hl=en#topic=4365599>.)

Comparing the top three behavioral health priorities in New River Valley, as determined by community leaders, shows that “alcoholism” was a more popular search over the time period as compared to “prescription drugs” and “illegal drugs” (Image 1). Roanoke appeared as the city with a search volume of 100 on a normalized scale of 0 to 100 for “prescription drugs” relative within the geographic location as of September 2014. For “alcoholism,” Roanoke had a score of 86. There was not enough search volume for illegal drugs to show any regional data for the New River Valley area.

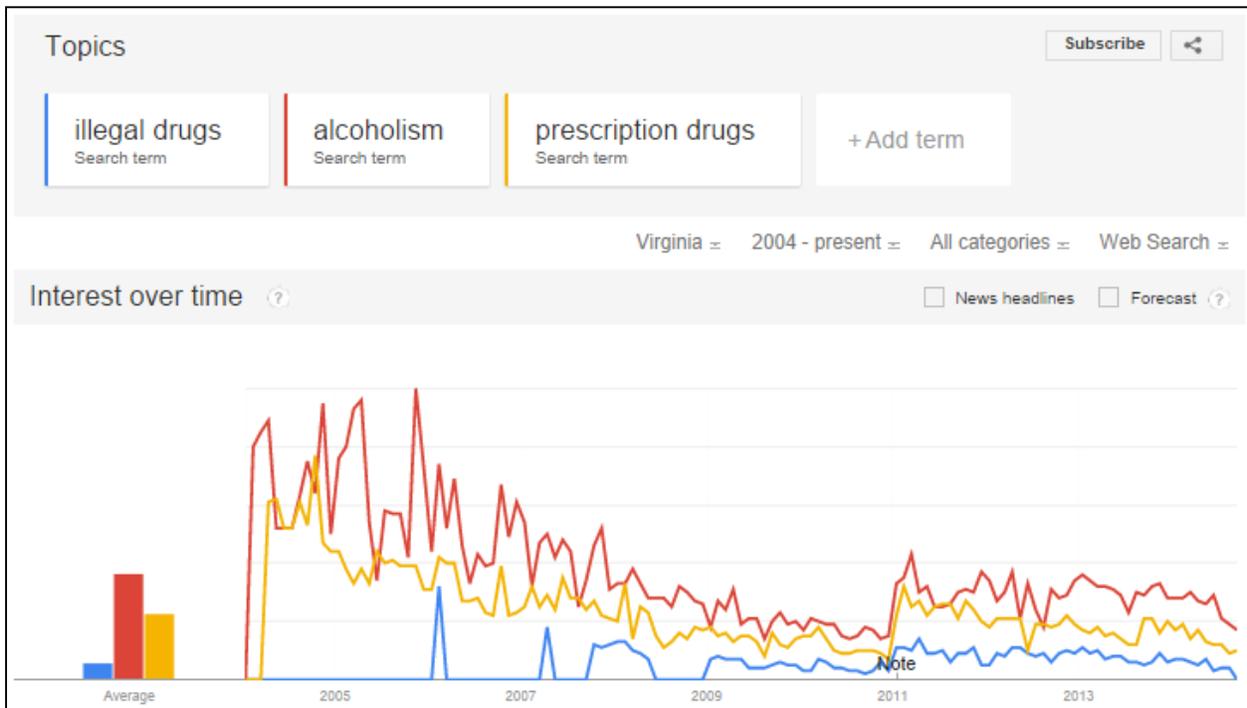


Image 1: Google Trends for three behavioral health related search terms: illegal drugs, alcoholism, prescription drugs.

Generalizing “illegal drugs” to “drugs” shows very different results as seen below (Image 2). For the search term “drugs,” the regional interest shows scores of 86 in Roanoke and 85 in Blacksburg.

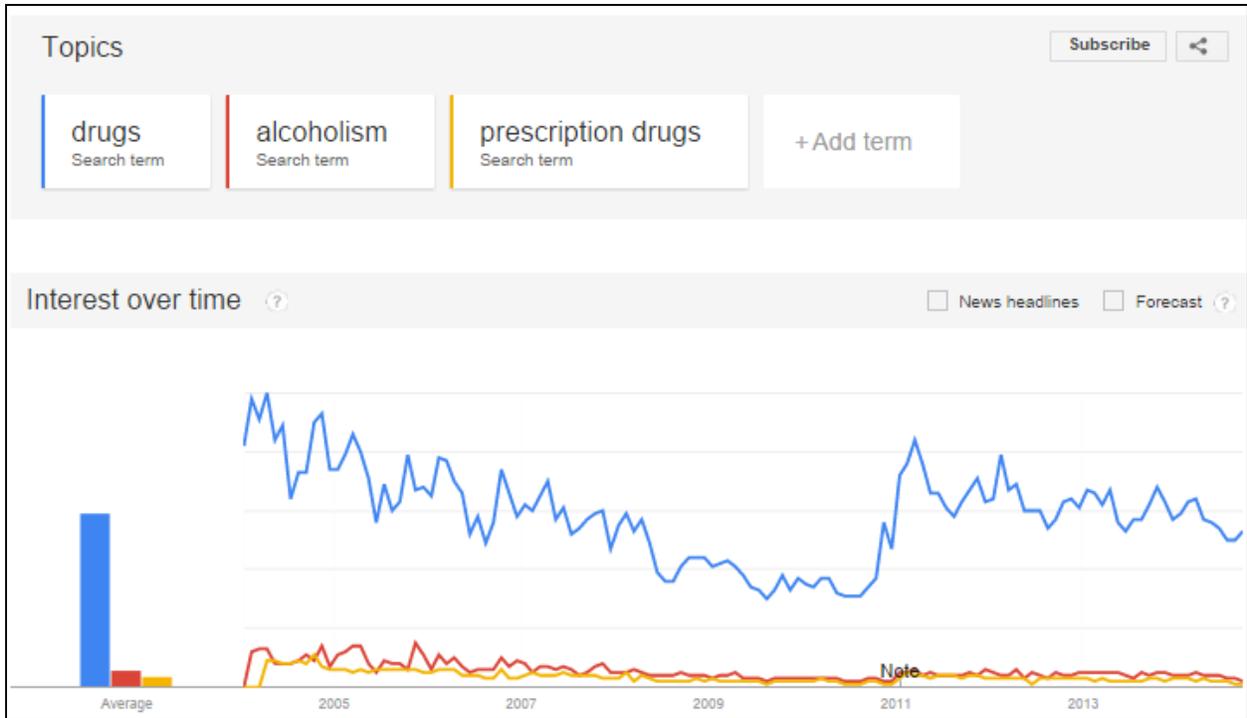


Image 2: Google Trends for three behavioral health related terms: drugs, alcoholism, prescription drugs.

The screenshot below depicts search volumes for various well known illegal drugs, specifically “marijuana,” “cocaine,” “heroin,” “meth,” and “ecstasy” (Image 3). Regionally, for “marijuana” Radford scored 100, Blacksburg scored 64, and Roanoke scored 48. For “cocaine” Radford scored 92 and Blacksburg 66. For “heroin” Blacksburg scored 41. For “meth” Blacksburg scored 26 and Roanoke 19. Regionally, Roanoke scored 53 for “ecstasy.”

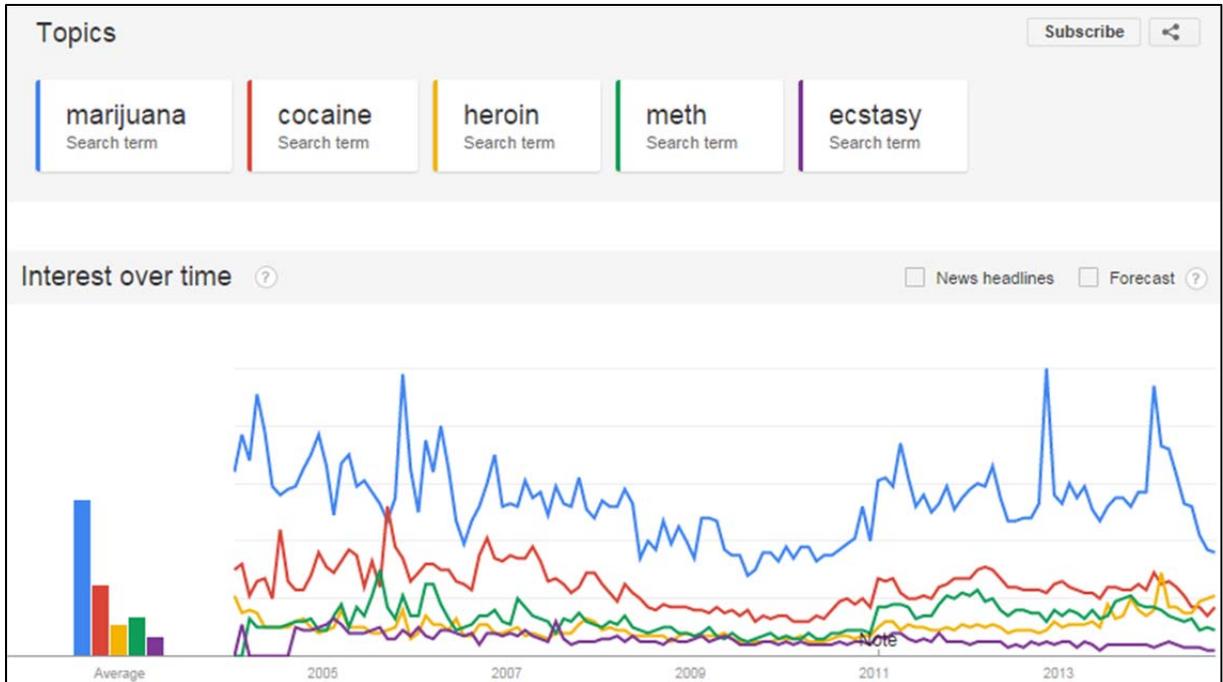


Image 3: Google Trends for five behavioral health related search terms: marijuana, cocaine, heroin, meth, ecstasy.

The next screenshot (Image 4) depicts search volumes for various well-known abused prescription drugs for pain relief, specifically “oxycontin,” “oxycodone,” “Percocet,” “Fentanyl,” and “Xanax.” Regionally, in Roanoke “oxycontin” scored 41, “oxycodone” scored 29, “Percocet” scored 100, and “Xanax” scored 37. “Fentanyl” did not score regionally in New River Valley.

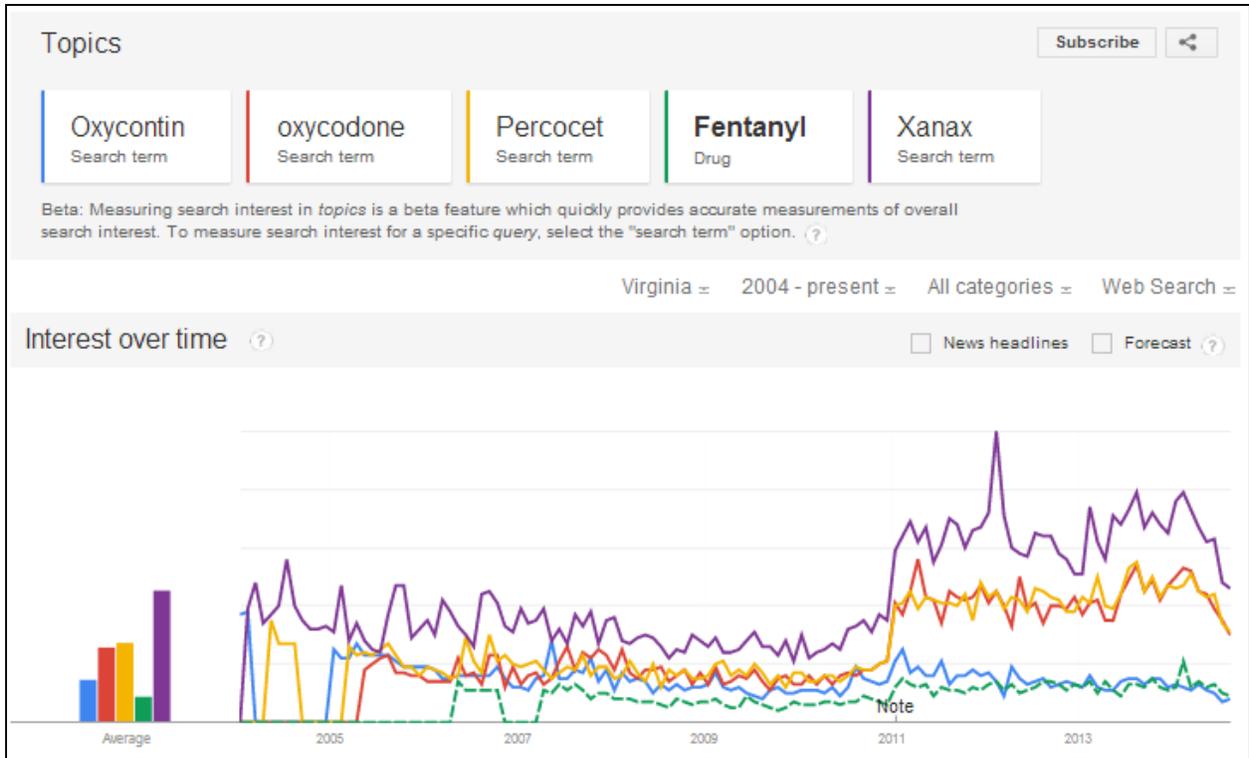


Image 4: Google Trends for five behavioral health related search terms: Oxycontin, oxycodone, Percocet, Fentanyl, Xanax.

Examining the map views of Virginia and the Roanoke-Lynchburg, Virginia area (as defined by Google) shows variation in volume of searches for these five specific prescription pain relievers (Image 5). “Oxycontin” and “Fentanyl” had the lowest search volumes for the Roanoke-Lynchburg area, of the five terms.

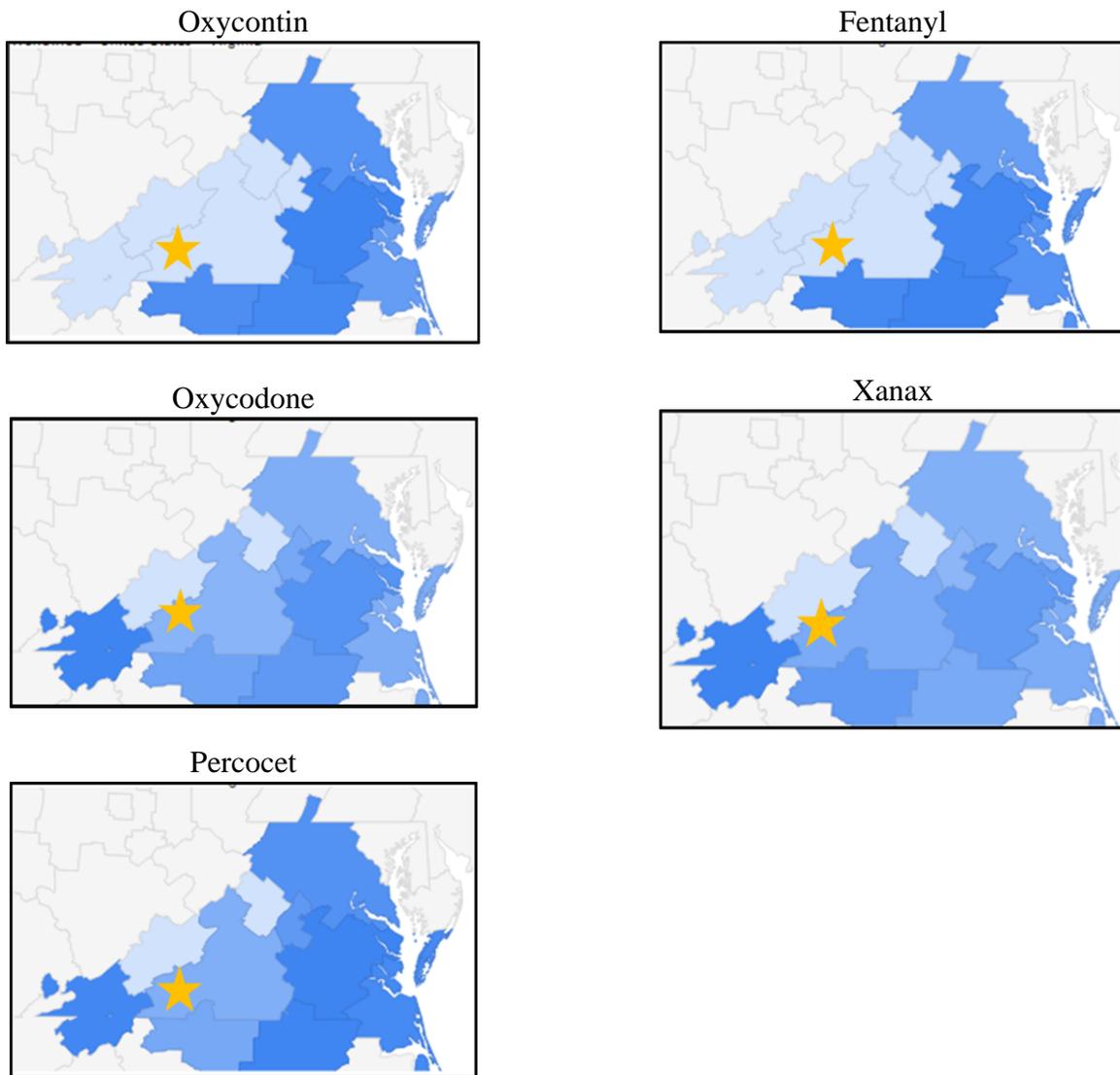


Image 5: Google Trends map views for specific prescription pain relief drugs in Virginia. The star indicates the New River Valley area. Lighter regions indicate lower search volumes with relation to the geographic regions included in the search, whereas darker search volumes indicate higher search volumes.

Alternatively, the next screenshot (Image 6) depicts search volumes for various well known abused prescription drugs for performance enhancement, specifically “Adderall,” “Ritalin,” “Concerta,” “Provigil,” and “Inderal.” Regionally, for “Adderall” Radford scored 100 and Blacksburg 64. For “Ritalin” Blacksburg scored 100 and Roanoke 75.

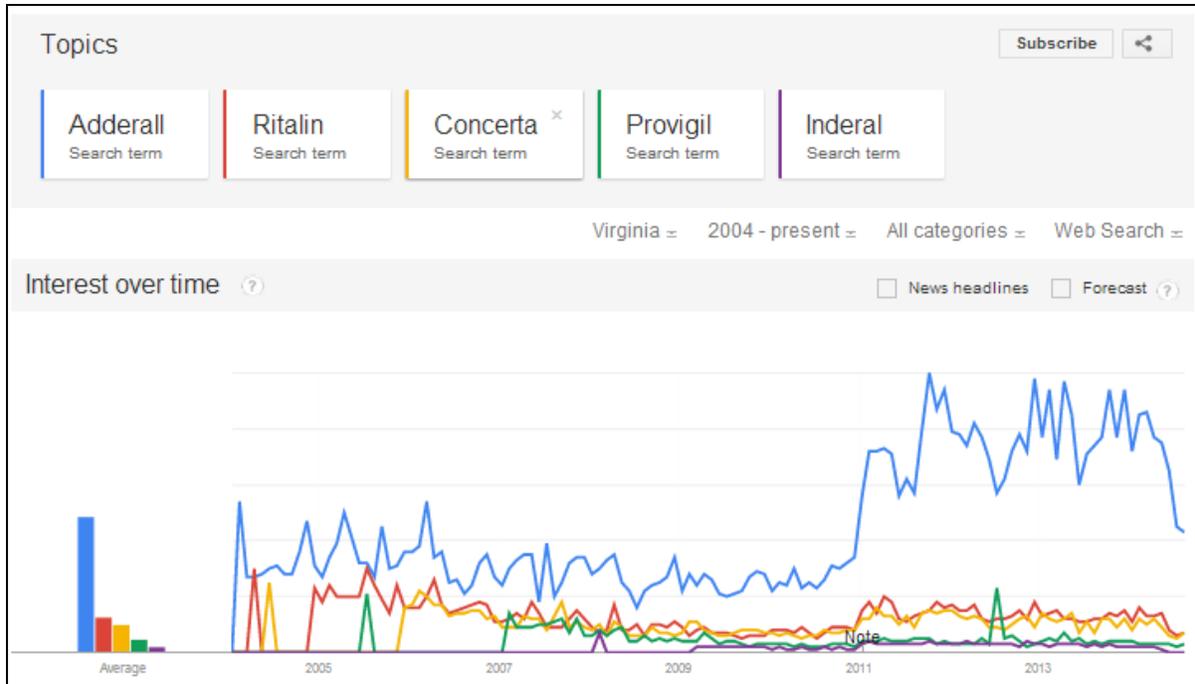


Image 6: Google Trends for five behavioral health related terms: Adderall, Ritalin, Concerta, Provigil, Inderal.

Google Trends maps for each of the five terms display the search volume of the five performance enhancing prescription drugs for the Roanoke-Lynchburg, Virginia area relative to other parts of Virginia. For “Concerta,” “Provigil,” and “Inderal,” the Roanoke-Lynchburg area is similar to several neighboring areas, with low search volumes.

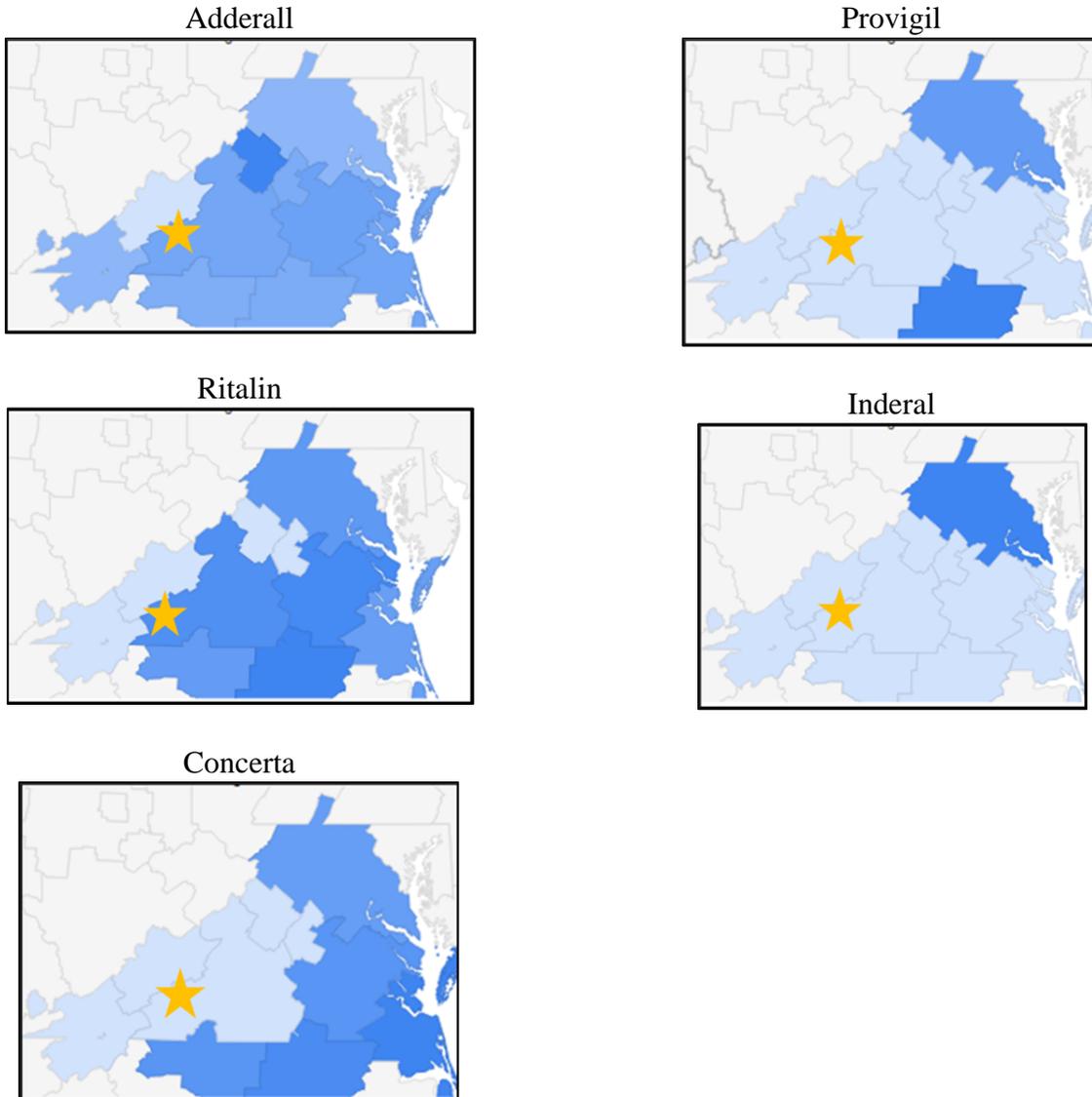


Image 7: Google Trends map views for specific prescription performance enhancement drugs in Virginia. The star indicates the New River Valley area. Lighter regions indicate lower search volumes with relation to the geographic regions included in the search, whereas darker search volumes indicate higher search volumes.

Higher search volumes appeared for “depression” compared to “child abuse” “child neglect,” and “prescription drugs” over the 2004-2014 period (Image 8).

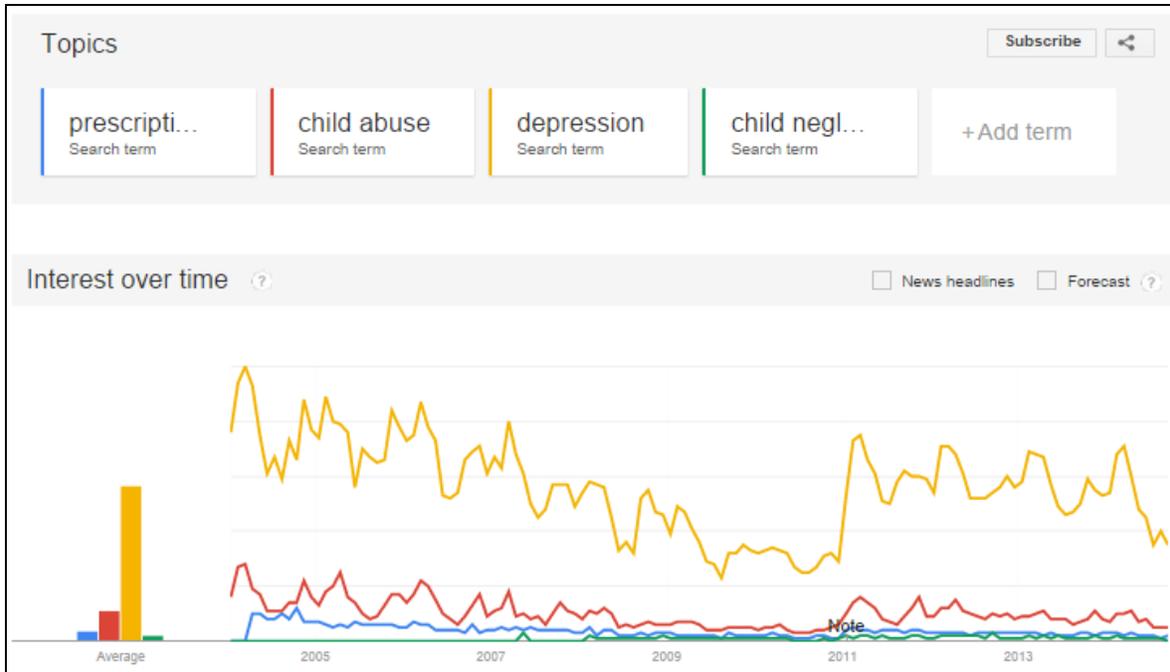


Image 8: Google Trends for four behavioral health related search terms: prescription drugs, child abuse, depression, child neglect.

The screenshot below (Image 9) shows more clearly that “child abuse” has a higher search volume than “prescription drugs” while “child neglect” has a lower search volume. Neither “child abuse” nor “child neglect” have regionally data.

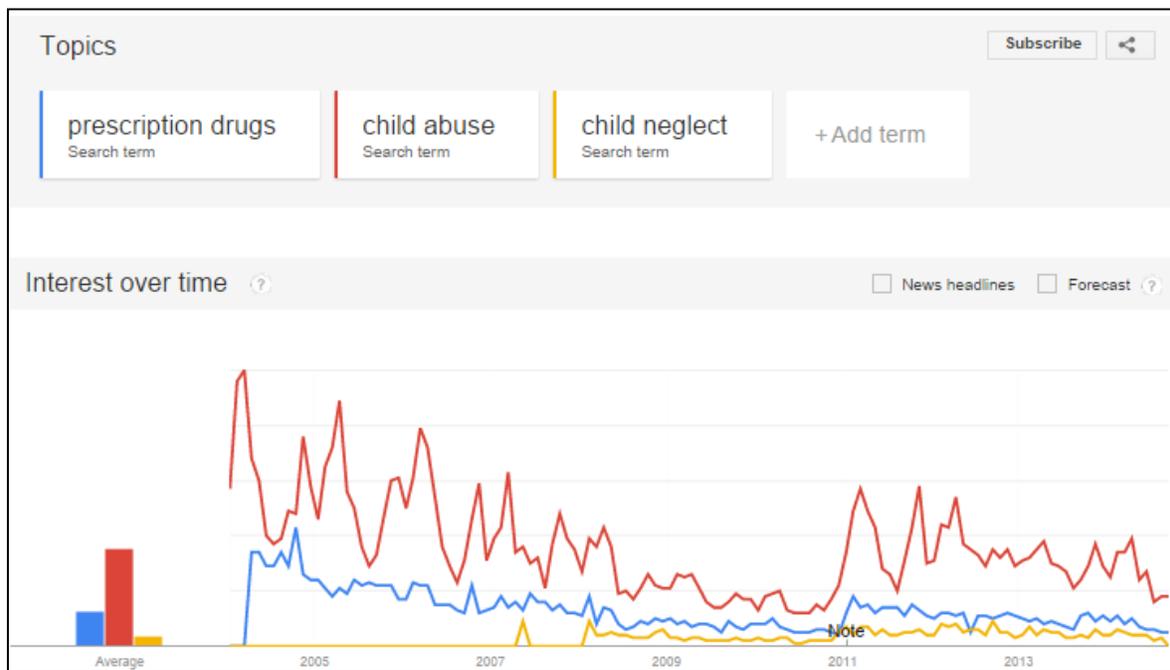


Image 9: Google Trends for three behavioral health related search terms: prescription drugs, child abuse, child neglect.

The terms “stress,” “anxiety,” and “depression” have higher search volumes compared to “domestic violence” and “domestic abuse” (Image 10). The regional interest in “depression” as a search term has a score of 100 in Radford and 65 in Roanoke. “Stress” has a score of 100 in Blacksburg and 54 in Roanoke. The other three terms show no regional data in New River Valley.

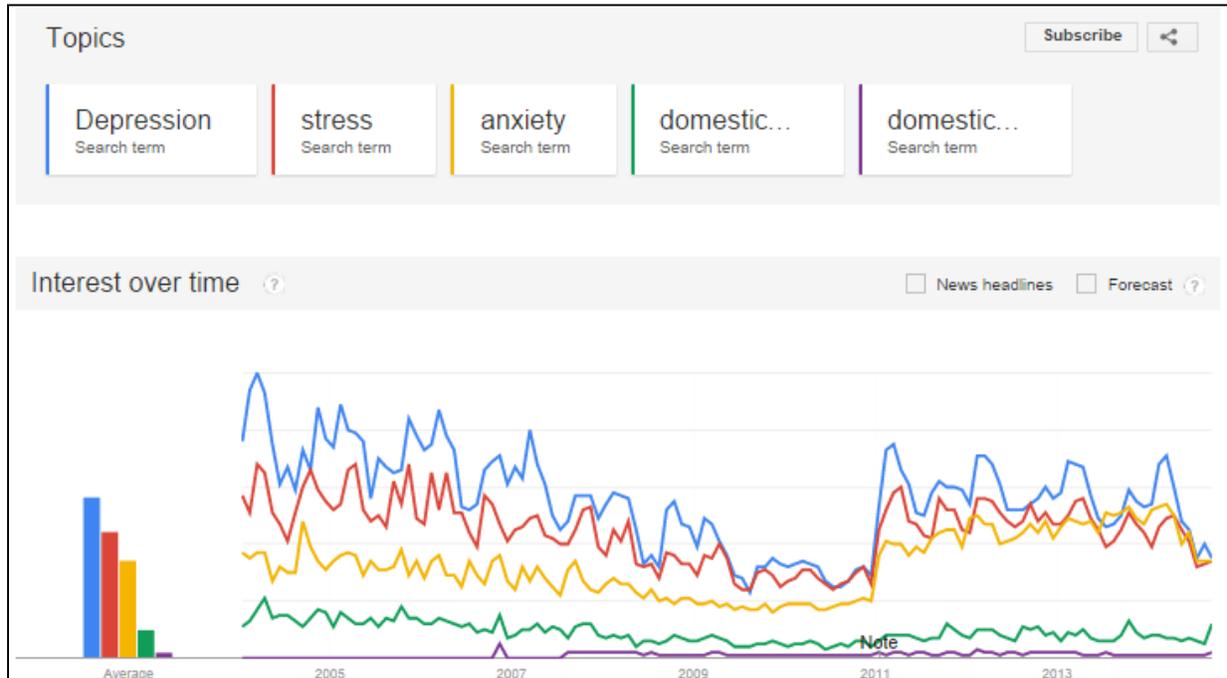


Image 10: Google Trends for five behavioral health related search terms: depression, stress, anxiety, domestic violence, domestic abuse.

“Suicide” has much higher search volumes over time as compared to “domestic abuse,” “PTSD” and “posttraumatic stress disorder,” which all have very similar trend lines (Image 11). Of these terms regionally, “PTSD” has a score of 46 in Blacksburg. No other terms appear in New River Valley.

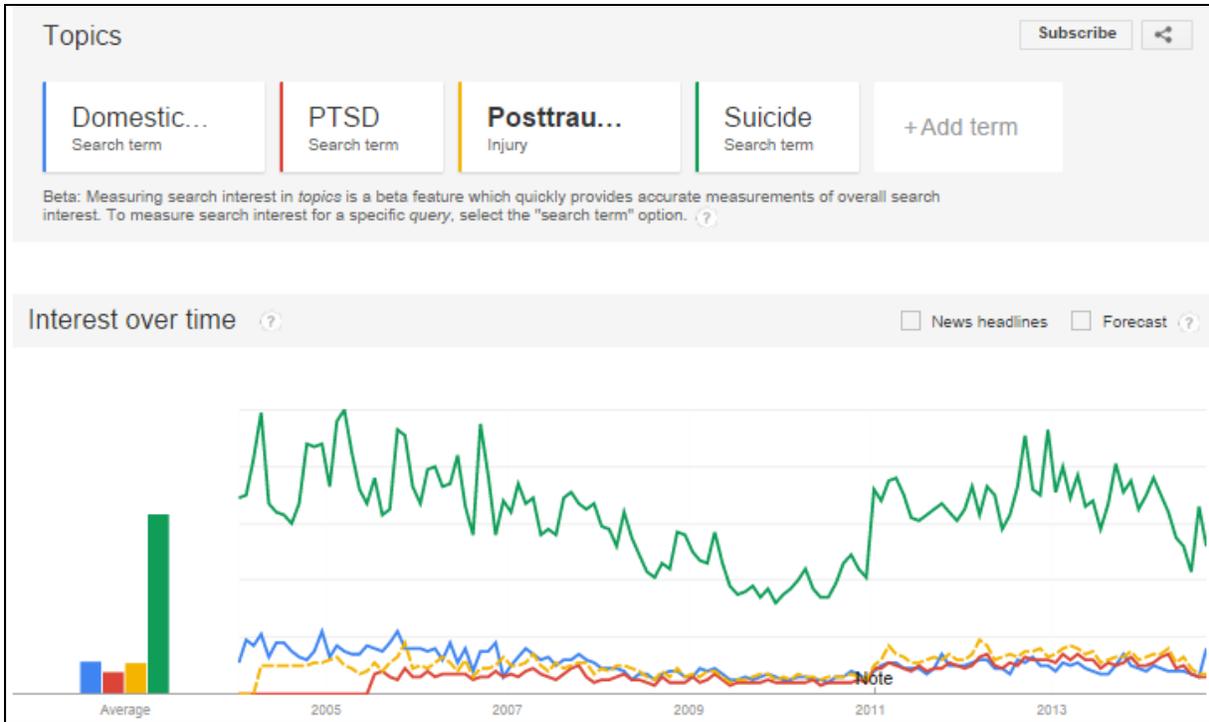


Image 11: Google Trends for four behavioral health related search terms: domestic abuse, PTSD, posttraumatic stress disorder, suicide.

“Suicide” and “depression” have much larger search volumes than “teen pregnancy” and “absenteeism” (Image 12). “Teen pregnancy” scores at 54 in Roanoke; “absenteeism” has no data.

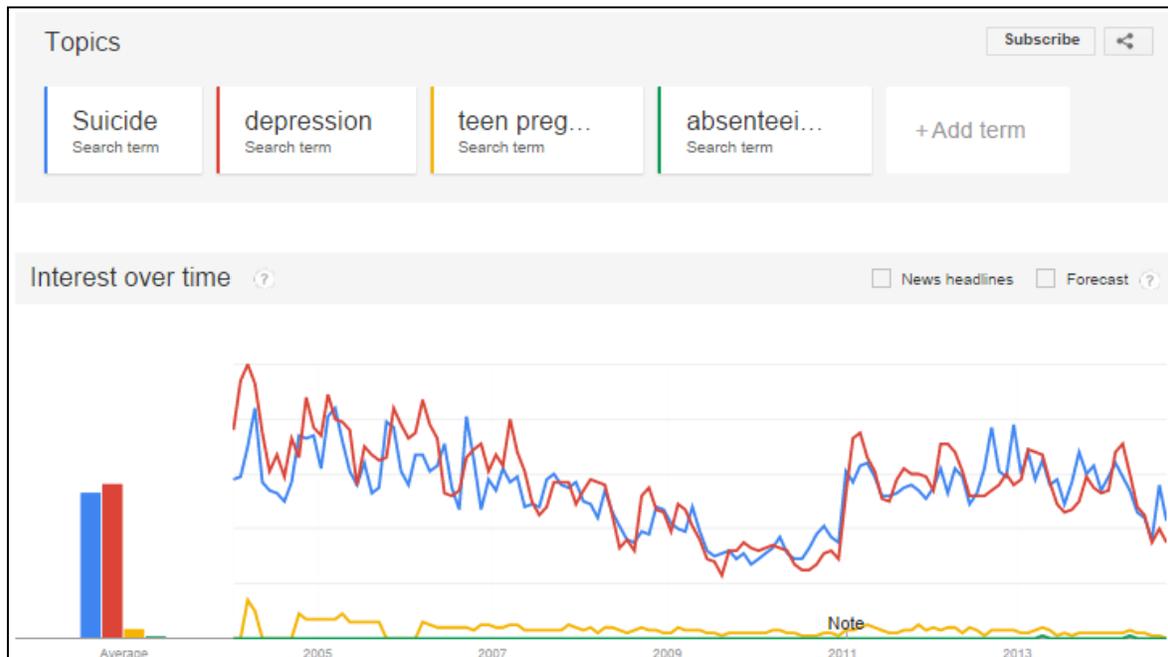


Image 12: Google Trends for four behavioral health related search terms: suicide, depression, teen pregnancy, absenteeism.

The search volume for “tobacco” in Virginia was higher than for “teen pregnancy,” “schizophrenia,” “high school dropout,” or “fetal alcohol syndrome,” the latter two of which comparatively appear as nearly flat lines in the Google Trends analysis (Image 13). Regionally, “tobacco” scores 37 in Blacksburg and 33 in Roanoke, while “schizophrenia” scores 76 in Blacksburg and 64 in Roanoke. All other new terms do not have regional data in the New River Valley area.

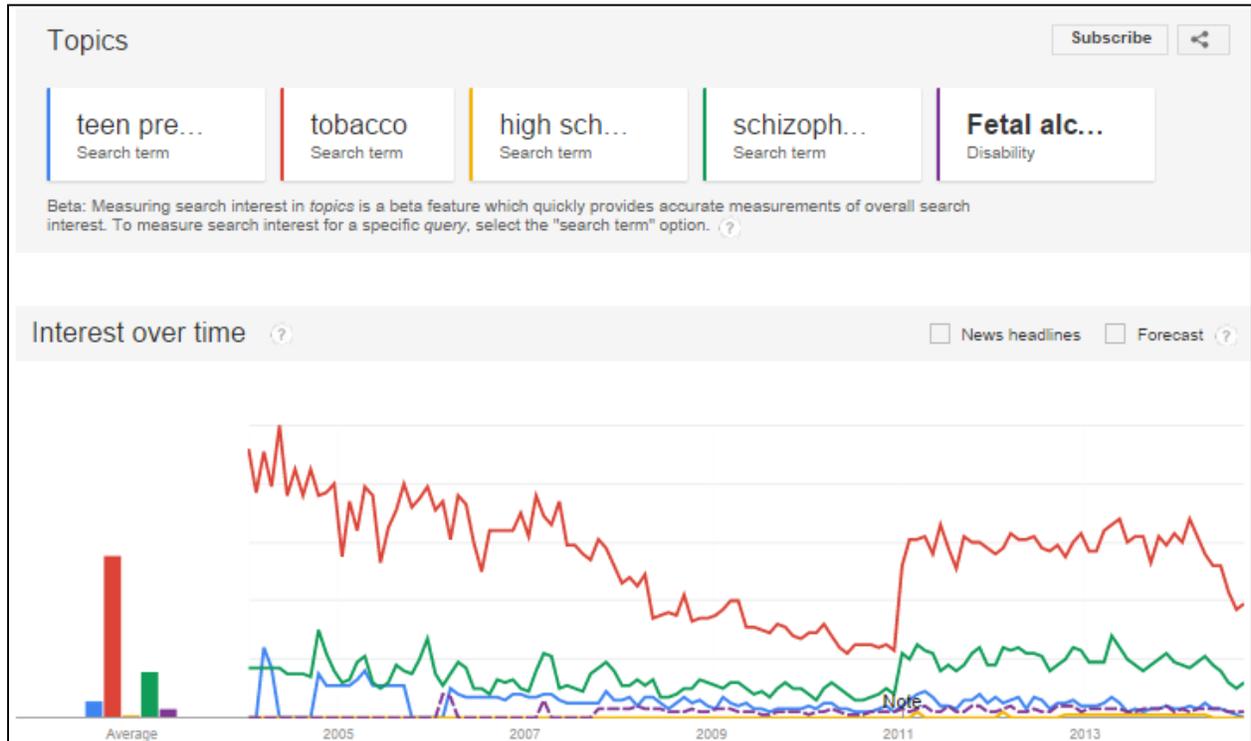


Image 13: Google Trends for five behavioral health related search terms: teen pregnancy, tobacco, high school dropout, schizophrenia, fetal alcohol syndrome.

Although it was the least frequently selected behavioral health priority by New River Valley community leaders, sexually transmitted diseases abbreviated “STD” has higher search volume than “drunk driving,” and “schizophrenia” (Image 14). Regionally, “drunk driving” has a score of 51 in Roanoke and “STD” has a score of 61 in Blacksburg.

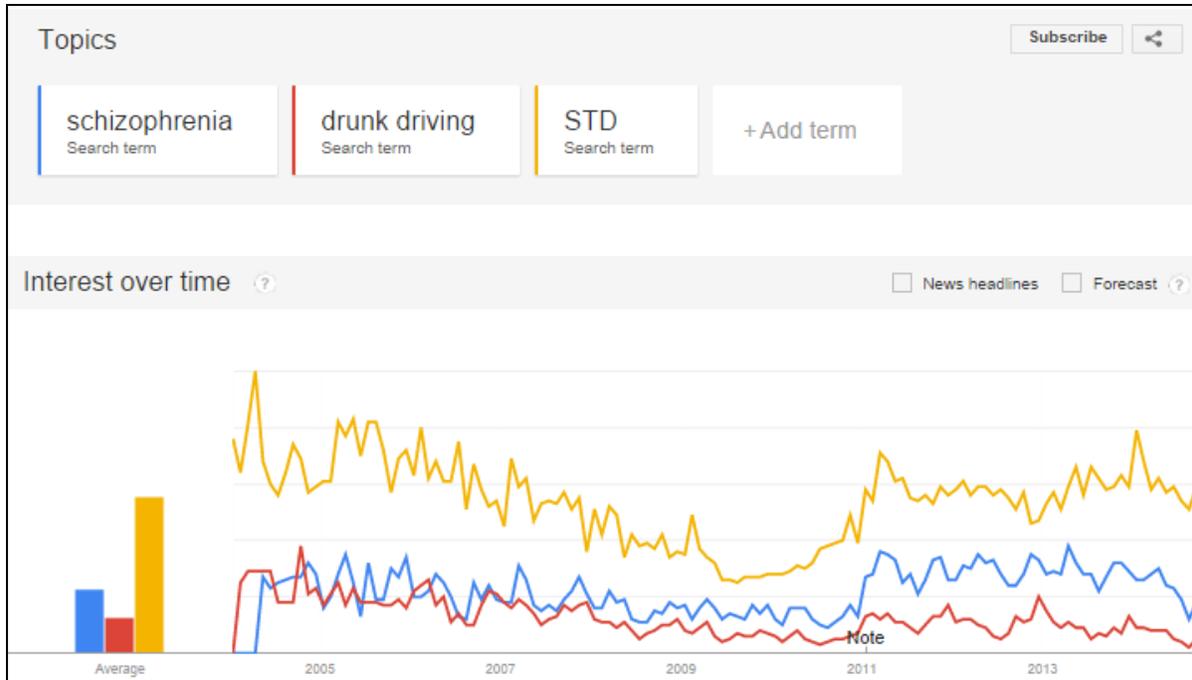


Image 14: Google Trends for three behavioral health related search terms: schizophrenia, drunk driving, STD.

From the above comparisons through Google Trends, the most highly searched terms in Virginia seem to be “drugs,” “depression,” “stress,” “suicide,” and “anxiety” (Image 15).

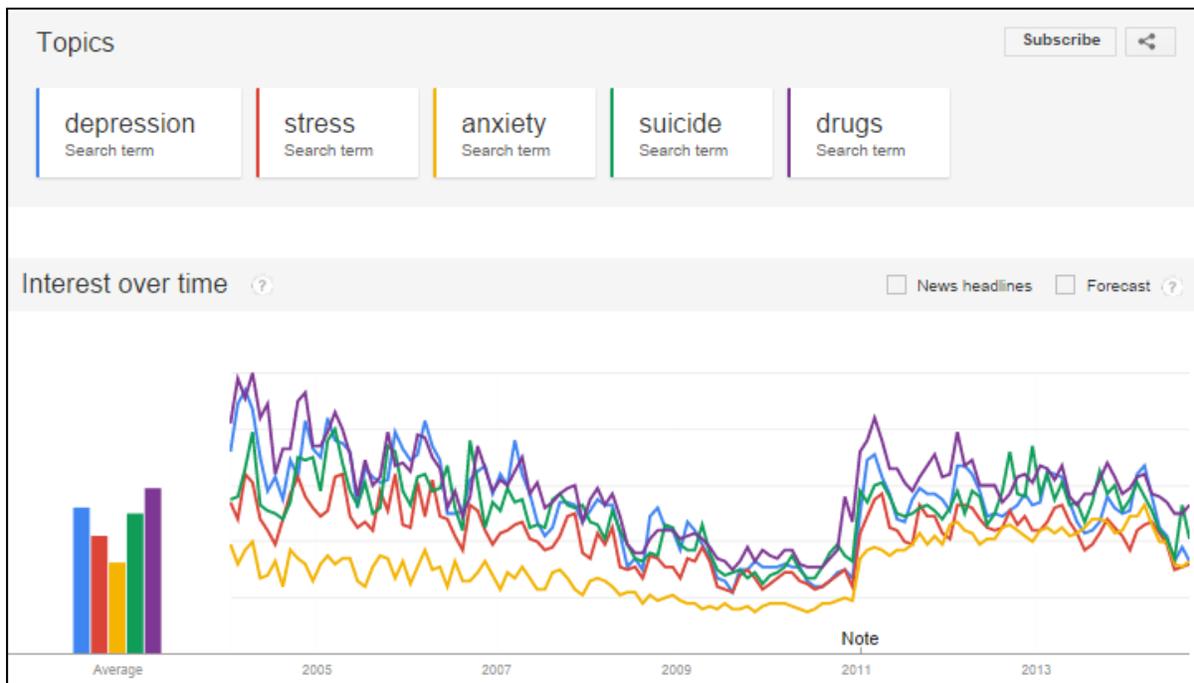


Image 15: Google Trends for five behavioral health related search terms: depression, stress, anxiety, suicide, drugs.

Similarities with Other CAPE Communities

Ten communities participated in the CAPE Project. Those communities are:

- Blount County, Tennessee
- Chittenden County, Vermont
- Clark County, Nevada
- Doña Ana County, New Mexico
- Finney County, Kansas
- Garrett County, Maryland
- Kanawha County, West Virginia
- New River Valley, Virginia
- Orleans Parish, Louisiana
- Pettis County, Missouri

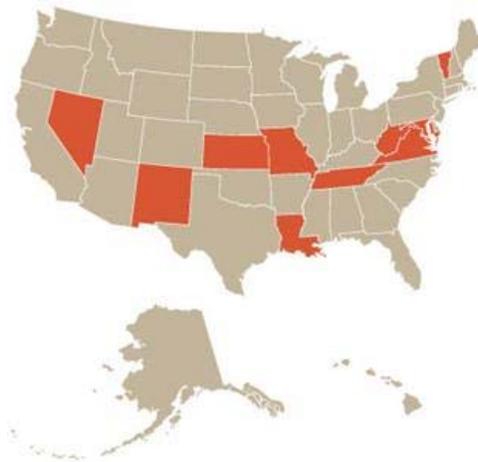


Image 16: States of CAPE pilot communities indicated in orange.

Overall, the survey had 1,034 participants for a response rate of 44.3%. Charitable organization leaders and volunteers had the largest representation in the sample at 13.6%, followed by substance abuse and/or mental health treatment professionals (12.3%), and hospital/health care unit administrators (10.2%). When recoded into more general categories, the largest group of respondents was in health services roles in their communities, and the smallest group was elected and government officials (see Table 13).

Role	N	%
Health services	324	32.6
Social services	224	22.5
Community organizations	281	28.2
Elected/government officials	166	16.7

Table 13: Respondents by community role.

The top three health priorities across all CAPE communities were alcohol abuse (selected by 66.2% of community leaders), illegal drug use (selected by 66.0%), and child abuse (55.9%). The issues selected least often were sexually transmitted diseases (selected by 22.8%), alcohol-related automobile accidents/deaths (21.5%), and fetal alcohol syndrome (19.6%). The full list of health issues ranked by frequency of selection as a priority is below in Table 14. On average, respondents selected 9 health conditions.

Rank	Health Issue	N	%
1	Alcohol abuse	684	66.2%
2	Illegal drug use	682	66.0%
3	Child abuse	578	55.9%
4	Adult depression	556	53.8%
5	Child neglect	550	53.2%
6	Non-medical prescription use	542	52.4%
7	Stress	529	51.2%
8	Anxiety	474	45.8%
9	Youth depression	466	45.1%
10	Physical abuse by domestic partner	457	44.2%
11	Post-traumatic stress disorder	452	43.7%
12	Suicidal thoughts	432	41.8%
13	Teen pregnancy	405	39.2%
14	Mental abuse by domestic partner	399	38.6%
15	High school dropout rate	378	36.6%
16	School or work absenteeism	343	33.2%
17	Tobacco use	324	31.3%
18	Suicide rate	323	31.2%
19	Schizophrenia	272	26.3%
20	Sexually transmitted diseases	236	22.8%
21	Alcohol-related automobile accidents/deaths	222	21.5%
22	Fetal alcohol syndrome	203	19.6%

Table 14: Behavioral health issues ranked by frequency of selection as priorities by community leaders from all CAPE communities.

The ranking of priority health issues varied by role in the community (Table 15). Alcohol abuse was within the top two across all four groups. Illegal drug use was in the top three for leaders from health services, community organizations, and elected/government officials.

	Health Services	Social Services	Community Org.	Elected/Govt. Officials
1	Alcohol abuse	Alcohol abuse	Illegal drug use	Illegal drug use
2	Illegal drug use	Child neglect	Alcohol abuse	Alcohol abuse
3	Non-medical prescription use	Stress	Child abuse	Child abuse

Table 15: Top three behavioral health issues by community role.

Some of the differences in selection of behavioral health topics by community role were statistically significant (Table 16). For health topics that were statistically significant, most often higher numbers of respondents in health services selected health issues as priorities as compared with other groups, typically leaders from community organizations or social services as seen below in Table 16. For example, 67.6% of community leaders from health services selected non-medical prescription use as a priority compared to 36.6% of those in social services. The two exceptions to this are high school dropout rate and school or work absenteeism, which were selected most by leaders from community organizations and social services, respectively. Illegal drug use was most highly selected by elected and government officials.

*** (p<0.001)	Health Services	Social Services	Community Org.	Elected/Govt. Officials
Non-medical prescription use	67.6	36.6	45.2	56.6
Illegal drug use	74.1	55.4	58.7	77.7
Alcohol abuse	75.0	58.0	58.4	71.7
Alcohol-related auto. accidents/deaths	25.3	10.7	17.4	36.1
Adult depression	66.4	50.9	49.1	43.4
Anxiety	61.1	47.3	40.9	25.9
Stress	56.8	57.1	48.4	37.3
Suicide rate	44.4	24.6	23.1	31.3
Suicidal thoughts	55.6	40.6	36.3	28.9
Schizophrenia	39.8	20.1	20.3	21.1
Post-traumatic stress disorder	53.7	40.6	43.4	34.3
STDs	28.4	18.3	23.8	13.9
** (p<0.01)	Health Services	Social Services	Community Org.	Elected/Govt. Officials
Youth depression	50.6	47.8	44.8	34.3
High school dropout rate	29.3	38.4	41.6	39.2
* (p<0.05)	Health Services	Social Services	Community Org.	Elected/Govt. Officials
Tobacco use	37.7	28.6	27.8	27.1
School or work absenteeism	29.6	41.1	33.1	30.7

Table 16: Percentage of community leaders who selected behavioral health issues by role in the community, organized by level of significance.

The USDA divides the United States into four regions: North Central, Northeast, South, and West. Alcohol abuse and illegal drug use were within the top two across all four regions. Alcohol-related automobile accidents/deaths and fetal alcohol syndrome were within the three least selected health priorities for all four regions. Selection of 13 behavioral health topics was statistically significant based on these USDA regions (Table 17). Notably, adult depression was the third most selected issue in the South and West, and seventh for the North Central and Northeast regions. Tobacco use was ranked 8th in the Northeast, compared to 16th in the North Central region and 19th in both the South and West regions. For ten of the thirteen significant differences, the Northeast region had the lowest percentage of leaders selecting the health issues as priorities.

*** p<0.001	North Central	Northeast	South	West
Non-medical prescription use	40.6	63.1	55.0	48.3
Tobacco use	35.1	40.9	26.8	27.5
Adult depression	53.5	41.9	56.9	59.4
Suicide rate	28.7	20.7	31.5	43.5
Post-traumatic stress disorder	33.7	30.5	51.4	50.7
Youth depression	52.0	38.4	47.6	39.6
Teen pregnancy	56.9	34.5	35.5	33.8
** p<0.01				
School or work absenteeism	41.6	26.1	35.1	28.0
Suicidal thoughts	38.6	33.0	43.4	50.2
STDs	28.2	13.3	24.4	23.7
* p<0.05				
Stress	56.4	41.9	53.3	50.7
Schizophrenia	22.8	20.2	28.2	31.9
High school dropout rate	45.0	30.5	34.1	39.1

Table 17: Percentage of community leaders who selected behavioral health issues by USDA region, organized by level of significance.

Statistically significant differences in selection of seven behavioral health topics were also found by sex (Table 18). For six of these issues, female community leaders selected the issues as priorities more often than did their male counterparts.

*** p<0.001	Male	Female
Anxiety	37.6	49.5
Alcohol-related auto. accidents/deaths	27.2	18.3
** p<0.01		
Fetal alcohol syndrome	13.9	21.8
Stress	45.0	54.5
STDs	17.5	25.2
* p<0.05		
Alcohol abuse	70.1	63.6
Illegal drug use	70.4	63.6

Table 18: Percentage of male and female respondents selecting certain behavioral health issues as priorities, organized by level of statistical significance.

Appendix A: CAPE Survey Instrument

Question 1: Please indicate your primary role within the community. (Select one.)

- Adult leader of a youth organization
- Advocacy group leader
- Appointed local government budget officer (for example, City Manager)
- Board/Commission member
- Charitable organization leader/volunteer
- Childcare/day care administrator
- Civic organization member
- Elected official
- Faith organization leader
- First responder/administrator (fire, EMS)
- Hospital or other health care unit administrator
- Housing authority administrator
- Judicial or court system
- Law enforcement professional
- Locally based military leader
- Parent community health advocate
- Parks and recreation administrator
- Prevention professional
- School administrator/volunteer
- Senior services administrator
- Social services administrator
- Substance abuse/mental health treatment professional
- Volunteer/administrator, intimate partner violence shelter

Question 2: Please indicate which health conditions you consider in determining behavioral health priorities for your community or organization. Sources may include published trend and incidence data from official agencies as well as informal interaction with stakeholders. (Click all that apply.)

- Non-medical use of prescription drugs
- Illegal drug use
- Physical abuse by domestic partner
- Mental abuse by domestic partner
- Alcohol abuse
- Fetal alcohol syndrome
- Alcohol-related automobile accidents/deaths
- Tobacco use
- Child neglect
- Child abuse
- Adult depression
- Youth depression
- Anxiety
- Stress

- Suicide rate
- Suicidal thoughts
- Schizophrenia
- Post traumatic stress disorder
- Teen pregnancy
- High school dropout rate
- School or work absenteeism
- Sexually transmitted diseases
- None of the above

Question 3: Are there specific high priority community behavioral health issues in your area that were not listed on the previous question?

- Yes (Go to Question 4)
- No (Go to Question 5)

Question 4: Please indicate the issue and your source of information about that issue.

- (Open response)

Question 5: Which of the following best describes your primary source of information about this condition in your community? (Asked for each health condition selected in Question 2.)

- Federal statistics
- State government
- Local government
- Media reports
- Clientele/stakeholders

Question 6-1: Please indicate how familiar you are with these county or state-level health trend information resources: Area Health Resource File

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-2: Please indicate how familiar you are with these county or state-level health trend information resources: Behavioral Risk Factor Surveillance System

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-3: Please indicate how familiar you are with these county or state-level health trend information resources: Bureau of Justice Statistics

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-4: Please indicate how familiar you are with these county or state-level health trend information resources: Bureau of Labor Statistics

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-5: Please indicate how familiar you are with these county or state-level health trend information resources: Centers for Disease Control & Prevention

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-6: Please indicate how familiar you are with these county or state-level health trend information resources: Housing and Urban Development Homeless Management Information System

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-7: Please indicate how familiar you are with these county or state-level health trend information resources: Institute for Health Metrics and Evaluation

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-8: Please indicate how familiar you are with these county or state-level health trend information resources: National Center for Health Statistics, National Vital Statistics System

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-9: Please indicate how familiar you are with these county or state-level health trend information resources: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-10: Please indicate how familiar you are with these county or state-level health trend information resources: National Center for Injury Prevention and Control

- I'm not familiar with data from this source

- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-11: Please indicate how familiar you are with these county or state-level health trend information resources: National Data Archive on Child Abuse and Neglect

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-12: Please indicate how familiar you are with these county or state-level health trend information resources: National Institute of Mental Health

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-13: Please indicate how familiar you are with these county or state-level health trend information resources: National Institutes of Health

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-14: Please indicate how familiar you are with these county or state-level health trend information resources: National Intimate Partner and Sexual Violence Survey

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-15: Please indicate how familiar you are with these county or state-level health trend information resources: National Survey on Drug Use and Health

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-16: Please indicate how familiar you are with these county or state-level health trend information resources: State Government Department of Education (your state)

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-17: Please indicate how familiar you are with these county or state-level health trend information resources: Substance Abuse and Mental Health Services Administration

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-18: Please indicate how familiar you are with these county or state-level health trend information resources: US Decennial Census

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-19: Please indicate how familiar you are with these county or state-level health trend information resources: US Department of Agriculture Supplemental Nutrition Assistance Uptake Data

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-20: Please indicate how familiar you are with these county or state-level health trend information resources: US Department of Education

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-21: Please indicate how familiar you are with these county or state-level health trend information resources: US Department of Energy

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-22: Please indicate how familiar you are with these county or state-level health trend information resources: Veteran's Administration

- I'm not familiar with data from this source
- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 6-23: Please indicate how familiar you are with these county or state-level health trend information resources: Web-based Injury Statistics Query and Reporting System

- I'm not familiar with data from this source

- I know about the data from this source but don't use it
- I consult data from this source, but less than once a year
- I consult data from this source yearly or more often

Question 7: Please tell us where you see gaps in the community behavioral health trend or comparison information you currently have available to help set your organization's priorities. (Example: types of illegal drugs used.)

- (Open response)

Question 8: What is your most preferred mode of learning about health information specific to your community?

- County or other local government data
- Federal online data sources
- Informal networks
- Newspaper
- Radio
- Social media
- State online data sources
- Television
- Web

Question 9: Have you ever sought assistance in getting better information about health trends in your community?

- Yes (Go to Question 10)
- No (Go to Question 11)

Question 10: Where did you go? (e.g., web search, library, expert consultation)

- (Open response)

Question 11: Have you ever attended training programs that provided an overview of sources of community health trend information?

- Yes (Go to Question 12)
- No (Go to Question 13)

Question 12: Who provided the training, and what aspects were most useful?

- (Open response)

Question 13: Please select your age range:

- 20-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70-79
- 80 or over

Question 14: Have you ever participated in a web-based training (webinar) on any topic?

- Yes (Go to Question 15)
- No (Go to Question 16)

Question 15: How effective was the web based training in getting information?

- Very Effective
- Somewhat Effective
- Somewhat Ineffective
- Very Ineffective

Question 16: How active are you on social media (Facebook, LinkedIn, Twitter, etc.)?

- Very Active
- Somewhat Active
- Infrequent
- Not at all

Question 17: If you were advising a new person who has a role similar to your position, what key sources of information would you direct them to get to know?

- (Open response)

Appendix B: CAPE Survey Methodology

The survey of community leaders was constructed by the CAPE Project team. The survey was administered online through Qualtrics. Potential participants who were identified by the local CAPE team received one e-mail invitation and three reminders before the survey was closed on June 9, 2014.

All data analyses were conducted using IBM SPSS Statistics, Version 19.0 and tables were compiled using Microsoft Excel.

For purposes of analysis, responses for Question 1 (primary role in the community) were recoded into four groups: health services, social services, community organizations, elected/government officials.

- Health services included four categories:
 - o First responder/administrator (fire, EMS); Hospital or other health care unit administrator; Prevention professional; Substance abuse/mental health treatment professional.
- Social services included seven categories:
 - o Childcare/day care administrator; Housing authority administrator; Parks and recreation administrator; School administrator/volunteer; Senior services administrator; Social services administrator; Volunteer/administrator, intimate partner violence shelter.
- Community organizations included six categories:
 - o Adult leader of a youth organization; Advocacy group leader; Charitable organization leader/volunteer; Civic organization member; Faith organization leader; Parent community health advocate.
- Elected/government officials included six categories:
 - o Appointed local government budget officer (for example, City Manager); Board/Commission member; Elected official; Judicial or court system; Law enforcement professional; Locally based military leader.

Appendix C: Secondary Data Information

The secondary data that was used in this report comes from a variety of sources, described by indicator below. Secondary data was compiled and analyzed using Excel. Instructions detailing how to create the trend graph, speedometer graph, and scatterplot that appear in this profile can be found in an accompanying document.

County Health Rankings, an annual measure of various health and health-related issues, is a partnership between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. County Health Rankings is available online at <http://www.countyhealthrankings.org>.

Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control & Prevention, is a telephone survey that takes place in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Palau. It collects health and health-related information from adults in over 400,000 interviews a year. The survey includes a core group of questions asked every year while other questions are asked every other year on a rotating basis. State may also opt to use additional modules about specific health issues, such as anxiety and depression. More information can be found online at <http://www.cdc.gov/brfss>.

Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health & Human Services, releases data in Excel format on 17 chronic conditions including depression. The data are available for US counties, states, and hospital referral regions for the years 2008-2012. More information can be found online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html.

National Highway Traffic Safety Administration (NHTSA) is a federal agency established by the Highway Safety Act of 1970. NHTSA collects data about a variety of motor vehicle-related issues, and among their datasets are the Fatality Analysis Reporting System (FARS), Special Crash Investigations (SCI), and National Automotive Sampling System (NASS). The NHTSA can be found online at <http://www.nhtsa.gov>.

The Web-based Injury Statistics Query and Reporting System (WISQARS) is an online database collected by the Centers for Disease Control and Prevention, including information about fatal and nonfatal injury, violent death, and cost of injury data. It can be found online at <http://www.cdc.gov/injury/wisqars/>.

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas is another online data tool from the Centers for Disease Control and Prevention which gives county and state level information about HIV, AIDS, viral hepatitis, tuberculosis, chlamydia, gonorrhea, and primary and secondary syphilis. It can be found online at <http://www.cdc.gov/nchhstp/atlas/>.

The Virginia Department of Criminal Justice Services publishes reports about different crime trends, including domestic violence. Their report “Domestic Violence in Virginia 2006-2010: Statistical Findings from Incidents Reported by Law Enforcement,” published in September 2012, informs this CAPE report and is available online at <http://www.dcjs.virginia.gov/research/documents/DVReportSept2012.pdf>.

Virginia’s Department of Motor Vehicles publishes annual reports with information about traffic crashes occurring in Virginia, including those which are alcohol-related. Their Traffic Crash Facts Yearly Publications are available online at http://www.dmv.virginia.gov/safety/#crash_data/crash_facts/.

The Division of Health Statistics, a part of the Virginia Department of Health, publishes annual reports about vital statistics including births, low weight births, deaths, cancer deaths, infant deaths, life expectancy, marriages, and teen pregnancy. Their reports are available on their website at <https://www.vdh.virginia.gov/healthstats/stats.htm>.

Appendix D: Google Trends Information

Google Trends information was obtained through doing keyword searches on the website <http://trends.google.com>, a free online tool that allows users to see the volume of searches for certain terms over a period of time. All output is normalized by Google on a scale of 0 to 100, based on geographic region and all included search terms. Google draws its own geographic boundaries that do not consistently match traditional maps or known boundaries. For more information about Google Trends, please visit <https://support.google.com/trends/?hl=en>.

Appendix E: Information on Sources of Data

This section includes information about the 23 sources of data that were included in question 6 of the community leaders survey. Each entry includes the name of the data source, a web address, and a general description.

Area Health Resource File

<http://ahrf.hrsa.gov/>

This data is available annually from 2000 to the present with some missing data due to the U.S. Census' American Community Survey (ACS) not reporting county-level data until 2005. The data includes the number of MDs, dentists, optometrists, pharmacists, veterinarians, nurses, chiropractors, physical therapists, psychologists, sociologists, social workers, audiologists, and speech and language pathologists. The counties have extra information on their primary economic industries and metropolitan status. The data also includes information on the number of health facilities, utilization of medical practitioners, and hospital expenditures. Demographics and Medicare enrollment are also included as well as environmental variables on land area, population density, and air quality.

Behavioral Risk Factor Surveillance System (BRFSS)

<http://www.cdc.gov/brfss/>

The BRFSS is the primary data source provided by the CDC for evaluating local health. The data is at the county-level and most states have annual data going back to 1990. The data includes various measures of health, health-care access, exercise, chronic health conditions, oral health, demographics, disabilities, tobacco use, alcohol consumption, immunization, falls, seatbelt use, drunk driving, breast/cervical cancer screening, prostate cancer screening, colorectal screening, and HIV/AIDS status.

Bureau of Justice Statistics (BJS)

<http://www.bjs.gov/>

The BJS has a wide variety of data on corrections, courts, crimes, employment, expenditures, law enforcement, and victims. Unfortunately, most of the data is only available at the national-level. However, some datasets, such as the Annual Survey of Jails, are reported at the local-level. Most of the data goes back at least to 1990. The National Crime Victimization Survey goes back to 1973 although data from before 1993 is only available in Adobe pdf format.

Bureau of Labor Statistics (BLS)

<http://www.bls.gov/>

The BLS has a wide variety of data, although most of its data is at the regional- or large city-level. At the county-level, the BLS has data on wages and employment. At the regional-level, the BLS also has data on injuries, illness, fatalities, consumer expenditures, labor productivity and

costs, as well as price indices for specific items such as food, housing, and medical care. Most of the BLS data goes back to 1987 and is recorded monthly.

Centers for Disease Control & Prevention (CDC)

<http://www.cdc.gov/>

While the CDC's primary data source is the BRFSS covered above, the organization provides many links to other data sources at the state- and county- levels. Some of these data are covered in detail elsewhere on this page, but there are a few others which are not, including data.gov and healthdata.gov. Many of the resources directly provided by the CDC are also quite useful, including the local surveillance tools and economic impact tools. Familiarity with these mechanisms makes identifying potential community problems straightforward.

Housing and Urban Development Homeless Management Information System (HMIS)

<http://www.hudhdx.info/>

The US Department of Housing and Urban Development (HUD) collects a wide variety of data on the homeless population across the US. Specifically HUD examines the Annual Housing Inventory Count, the Homeless Point-in-Time Counts, and the annual Homeless Assessment Report. This information is not publicly available, and it is fairly difficult to obtain.

Institute for Health Metrics and Evaluation (IHME)

<http://www.healthdata.org/>

The IHME has many resources available for community behavioral health. The U.S. county profiles contain information on smoking prevalence, life expectancy, obesity, and physical activity for every county in the U.S. The IHME also has tools for the visualization of various measures across the U.S. The primary data source for the IHME is the Global Health Data Exchange which has a wide variety of data sets on global health as well as some more local data sets on health statistics within the U.S. Many of these data sets overlap with those commonly available through the CDC and elsewhere.

National Center for Health Statistics, National Vital Statistics System (NVSS)

<http://www.cdc.gov/nchs/nvss.htm>

The NVSS data is available through the CDC and dates back to 1890, although much of this data is only available in Adobe pdf format until the 1970s or 1980s. The data is available by county and by state with information on births and mortality. The NVSS also provides additional programs on fetal death, marriage, and divorce. The National Maternal and Infant Health Survey data and the National Mortality Followback Survey data are also available through the NVSS site. The data can be accessed through interactive tools such as VitalStats and the CDC Wonder database.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
<http://www.cdc.gov/nchhstp/>

The CDC collects data on the reported occurrence of nationally notifiable infection diseases in the U.S., including HIV, hepatitis, some STDs, and TB. The NCHHSTP atlas is an interactive tool for plotting this data spatially. This tool can also be used to download data, graphics, two- and three-way stratifications, and Some of the variables are available since 2000, although many of the county-level data sets are only available for the most recent year.

National Center for Injury Prevention and Control
<http://www.cdc.gov/injury/>

This is another resource available from the CDC. The Web-based Injury Statistics Query and Reporting System (WISQARS) is the primary mechanism for accessing this data. The WISQARS system allows users to search, sort, and view the injury data to create reports, charts, and maps. The CDC tracks fatal injuries, non-fatal injuries, and violent deaths. The data includes information on the intent, causes, body region, nature, and geographical location of the injuries as well as the demographics of these injured persons.

National Data Archive on Child Abuse and Neglect (NDACAN)
<http://www.ndacan.cornell.edu/>

The NDACAN has a few important data sets for understanding problems pertaining to children. The unfortunate difficulty for working with any of these datasets is that the data are collected in separate files by year, which must be combined and aggregated before any panel analysis. The primary data source is the National Child Abuse and Neglect Data System, which has case-level data available annually from 1995. There are data sets at the case-level, agency-level, and state-level for this system. These data are available from 20 states throughout the U.S. The data has information on the child's demographics, disabilities, living arrangements, types of maltreatment, foster-care status, and behavioral problems. The system also has information on the perpetrator's demographics, relationship to the child, and prior issues.

Another important resource from the NDACAN is the Adoption and Foster Care Analysis and Reporting System (AFCARS), which is available annually from 1995. The data is available in two files per annum, the foster care file and the adoption file, each of which has case-level data on the incidence of child relocation. These datasets have information on the child's demographics, disabilities, behavioral problems, and prior arrangements as well as detailed information on the new caretakers and living situation.

National Institute of Mental Health (NIMH)
<http://www.nimh.nih.gov/index.shtml>

The NIMH is an institute of the NIH. The NIMH supports research on mental health through grants to investigators at institutions and organizations throughout the United States and through its own intramural research effort. NIMH community data is not centrally collected, and researchers wishing to find specific data sets should search the scholarly literature.

National Institutes of Health (NIH)

<http://www.nih.gov/>

The NIH is a biomedical research facility primarily located in Bethesda, Maryland, USA. An agency of the United States Department of Health and Human Services, it is the primary agency of the United States government responsible for biomedical and health-related research. The NIH both conducts its own scientific research through its Intramural Research Program (IRP) and provides major biomedical research funding to non-NIH research facilities through its Extramural Research Program. Accordingly, the NIH is responsible for a wide variety of collected data about health statistics. However, as is similar to the NIMH, much of the community-level data has not been collected into one central location, and instead, individuals wishing to find specific data sets should search through scholarly articles to locate particular projects which involve the kinds of data they are seeking to use.

National Intimate Partner and Sexual Violence Survey (NISVS)

<http://www.cdc.gov/violenceprevention/nisvs/>

The NISVS, published by the CDC, contains detailed information on incidence of intimate partner violence, sexual violence, and stalking. The survey was conducted in 2010 and reports information on both female and male victims. Reports of the survey can be found which detail general information, state-level information, intimate partner violence specific statistics, and finding based on sexual orientation. The information of sexual violence victimization includes: prevalence information, prevalence of rape by race/ethnicity, type of perpetrators, number of perpetrators, sex of perpetrators, age at the time of first rape, and rape victimization. The reports also include information on the following stalking: prevalence, prevalence by race/ethnicity, tactics used, types of perpetrators, number of perpetrators, sex of perpetrators, and age of at the time of first stalking victimization. Finally, the report includes the following information on intimate partner violence: prevalence, prevalence by race/ethnicity, overlap of rape/physical violence/stalking, prevalence of sexual violence, prevalence of physical violence, prevalence of stalking, prevalence of psychological aggression, prevalence of control of reproductive or sexual health, victim-perpetrator relationship, number of perpetrators, and age at the time of first victimization.

National Survey on Drug Use and Health (NSDUH)

<https://nsduhweb.rti.org/>

The NSDUH is an annual nationwide survey involving interview with approximately 70,000 randomly selected individuals aged 12 and older. NSDUH is funded by SAMHSA, and the project is supervised by SAMSHA's Center for Behavioral Health Statistics and Quality (CBHSQ). NSDUH provides data on national- and state-level estimates of the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs), and mental health in the U.S. Tables of the data are available by year from the SAMSHA website.

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov/>

SAMHSA has an excellent array of data, although much of their data is not publicly available. Besides the NSDUH data, SAMHSA also provides Emergency Room Data (DAWN), Facilities Data (N-SSATS), and Treatment Data (TEDS). DAWN provides data from 2004 to 2011 annually on 10 metropolitan areas in the U.S. These datasets look at the number of drug-related emergency room visits over the selected period with various other measures such as the misuse and abuse of drugs, nonmedical use of pharmaceuticals, alcohol related visits, underage drinking, suicide attempts, persons seeking detox, adverse reactions, and accidental injections. N-SSATS is the National Survey of Substance Abuse and Treatment Services which has annual data on treatment facilities going back to 2000. This data is available at the facility-level through the SAMHSA public-use data files website. TEDS is the Treatment Episodes Data Set which looks at admissions and discharges to substance abuse treatment centers. TEDS has individual-level data going back to 1992 and is also available through the SAMHSA public-use data files website.

State Government Department of Education (Virginia)

<http://www.doe.virginia.gov/>

Each state department of education typically provides information on the school districts and schools within their state. While some of this information may require restricted-use licenses, some of this information is publically available (perhaps at only the district level).

U.S. Decennial Census

<https://www.census.gov/>

The U.S. Census is a well-known tool for analyzing many personal and household statistics. It should be noted that the entire census is not commonly available for use because it is recorded at the individual-level for the entire U.S. Instead researchers commonly use micro-data which is available from websites such as ipums.org. This micro-data must be handled carefully because it involves using a system of weights which some people may not be familiar with. An alternative to using the decennial data is to use the ACS data which is available annually from 2000. The ACS represents a 1% sample of the U.S. population. Both the ACS and the Census provide individual-level data which some users may wish to aggregate to the state- or county-level. The U.S. Census bureau has many tools for analyzing the data. The interactive maps allow the user to plot population, race, ethnicity, age/sex, and housing status at any level for the most recent census. CensusExplorer provides similar maps of economic and demographic conditions by state and by county for the U.S. American FactFinder, State and County QuickFacts, and Easy Stats allow users to quickly locate current information about any particular places in the U.S.

US Department of Agriculture Supplemental Nutrition Assistance Uptake Data

<http://www.ers.usda.gov/data-products/supplemental-nutrition-assistance-program-%28snap%29-data-system.aspx>

This data consists of time-series data at state- and county-levels estimating the participation and benefits of the Supplemental Nutrition Assistance Program (SNAP). The benefit data was imputed by the BEA and re-imputed by the ERS. The SNAP data is combined with various demographic variables, including the total population and number of persons in poverty. All the data is available annually from 1997 and for a few selected years before.

US Department of Education

<http://nces.ed.gov/>

The National Center for Education Statistics (NCES) is the primary data location for the US Department of Education. From there, it is possible to find out information on colleges (current), public school districts (annual), public schools (annual), private schools from 2003-2004, public libraries in 2005, and various bibliographies including citations of the National education Longitudinal Study of 1988 and the Education Longitudinal Study of 2002. For each school district, the NCES collects the schools in that district, the total number of students, classroom teachers, student/teacher ratio, number of ELL students, and the number of students with IEPs. There is also more data which is available through restricted-use licenses.

US Department of Energy

<https://www.data.gov/energy/>

The U.S. Energy Information Administration (EIA) API provides access to public data on energy production and consumption in the US. Currently, EIA's API contains the following main data sets: 408,000 electricity series organized into 29,000 categories, 30,000 State Energy Data System series organized into 600 categories, 115,052 petroleum series and associated categories, 11,989 natural gas series and associated categories, 132,331 coal series and associated categories (released Feb 25, 2014), 3,872 Short-Term Energy Outlook series and associated categories (released May 27, 2014), and 368,466 Annual Energy Outlook series and associated categories (released May 27, 2014)

Veteran's Administration (VA)

<http://www.va.gov/vetdata/>

The VA provides limited data on the veteran population, its distribution, expenditures on veteran care, utilization of veteran care services, as well as maps, reports and surveys. Much of this data (population and expenditure data) is available at the county level and goes back to 1996.

Web-based Injury Statistics Query and Reporting System (WISQARS)

<http://www.cdc.gov/injury/wisqars/index.html>

WISQARS is an interactive database system provided by the CDC which provides customized reports of injury-related data. WISQARS provides data on fatal injuries, non-fatal injuries (that

resulted in hospitalization), and violent deaths. WISQARS has data going back to 1980, although most of the data only goes back to 2000. Using the WISQARS system, it is possible to make cost of injury reports and detailed maps of the patterns of injury across the U.S. by state and by county. These maps can be customized to particular demographic characteristics which may be of interest to the user.



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