

**Housatonic Valley
Coalition Against Substance Abuse
Epidemiologic Profile of Substance
Use, Suicide & Problem Gambling**

December 2012

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Abbreviations:

HVCASA	Housatonic Valley Coalition Against Substance Abuse
CADCA	Community Anti Drug Coalitions of America
WCSU	Western Connecticut State University
DUI	Driving Under the Influence
CNAW	Community Needs Assessment Workgroup
FPL	Federal Poverty Level
SA	Substance Abuse
ATOD	Alcohol, Tobacco, and Other Drugs
OTC	Over-the-counter
MCCA	Midwestern CT Council on Addiction
NSDUH	National Survey on Drug Use and Health
CORE	College Population Surveys
YRBSS	Youth Risk Behavior (CT School Surveys)
SAMHSA	Substance Abuse Mental Health Service Administration
DMHAS	Dept. of Mental Health and Addiction Services
MTF	Monitoring the Future Survey

Executive Summary

This profile contains information which helps us accurately describe the demographics and key substance abuse priorities in our sub-region. Data is used to identify levels of consumption and the consequences arising from substance use, misuse, abuse and addictions across our 22 towns. We focus our attention specifically on eight issues: alcohol, tobacco, marijuana, prescription drugs, heroin, cocaine, problem gambling and suicide. Throughout the document there are references to associated behaviors, such as violence and depression, which are important, but for purposes of this report we restrict our individual “profiles” to these eight.

The priority setting process was first conducted at HVCASA in 2006 and we have followed a similar course every two years since. The key participants from our communities have become familiar with this process, which has been a benefit to the overall development of the report.

In the end, our priority ranking matrix looked much the same as it did two years ago. Alcohol/Underage Drinking remains the number one priority (13) with marijuana use (11.6) and prescription drug misuse (11.3), coming in second and third, respectively. No one who participated in this process was surprised with those results. In this profile, we attempt to highlight some of the key points that influenced the ranking, and insert some commentary on the capacity/ level of readiness so prevention folks in our sub-region can plan and implement appropriate strategies. Using hard facts to guide our work has proven to be extremely efficient and helpful in keeping all of our partners on the same page and making measurable progress.

Introduction

This profile contains information that was gathered from a variety of national, statewide and local sources for the purposes of determining prevention priorities for our sub-region. We use the statewide data when there is no local data available, and we use the national data when we lack state level information. We also include as much historical data as possible to help Community Needs Assessment Workgroup participants make inferences about trends. We use the national and state data as comparisons to our data from the sub-region. How do we compare? What are the differences and similarities? The majority of student data was gathered through the administration of surveys at the middle and high school levels across different school systems in our sub-region. Each town and/or school district conducts its own survey; as a result, data are available at the town/school district level but not for the region as a whole. In addition, although each towns/school district utilizes the same basic questions, they differ as to survey target population, i.e. some towns may survey 7th, 9th and 11th graders while others survey all students 8th through 12th grade. This also prevents region-wide data from being presented. To assist the CNAW in recognizing trends, we include recent NSDUH and Monitoring the Future (MTF) survey findings. These provide current regional, statewide and national information for comparisons to local data.

Data concerning the overall population is drawn from other sources including the U.S. Census Bureau, CT Dept of Public Safety, CT Dept. of Education, NHTSA, CT DMHAS, Dept. of Public Health and others including substance abuse treatment providers in our area. We have done our best to determine what evidence was going to help us the most in this process. There is always more data to be interpreted, but we need to act on the information at hand, before it becomes obsolete. Hence, we make some executive decisions about which data is presented and analyzed by the CNAW. We acknowledge limitations of the data throughout this document. In particular, some of the juvenile drug arrest data that was available for our region did not seem accurate, so we were hesitant to include it in our analysis. Instead, we focused more attention on student survey results and school incidence reports. Our area does not have lot of data about problem gambling. We have traditionally had a difficult time creating any broad interest in problem gambling prevention, with the exception of our college age population. The local data is scant, and when that is the case we are cautious about drawing any strong conclusions. In addition, while there are not many suicides, and for sound reasons the local level data does not become part of this report. Instead, we look at statewide trends and information from the student surveys conducted across our region and in the state.

Several charts and tables were used during the Community Needs Assessment that contained aggregate data. This was not intended to influence the participants one way or another, it was done to streamline some of the discussions. For instance, we used a table that included combined results from NSDUH surveys administered in 2008, 2009 and 2010. Before we averaged out the results we made sure that there were no significant deviations that would be hidden inside aggregate figures. In some instances (charts) we created aggregate numbers for all of the student surveys administered to specific grades, like seniors or freshmen. Again, we did not aggregate any data if it was going to water down the numbers, only where there were very common responses and trends.

HVCASA's priority setting process started with gathering the data we had access to and assembling it into a format that would be easy for many people with different areas of expertise to read and interpret. A series of three CNAW were held beginning in Fall 2012. We made every effort to maintain a broad cross section of representation and included youth from both public and private schools in our area. As mentioned previously, some CNAW members had assisted with this process before. They get copies of data ahead of time and are encouraged to come to the workgroup with notes and questions. The executive director leads them through a group discussion. At the conclusion, everyone fills out the priority ranking matrix. The rankings results are combined and become part of the packet.

Overview of the HVCASA Sub-Region

Demographics: The Housatonic Valley Coalition Against Substance Abuse (HVCASA) consists of twenty-two towns within the two counties: Fairfield and Litchfield. The service area's total population is 258,430 representing 7.2% of the State's population. The gender split is exactly equal to the nation: 49.2% male, 50.8% female. The state, indeed, both counties, have a slightly higher proportion of females. Danbury with a population of 79,371, is by far the largest city/town followed by New Milford (28,159), Newtown (26,957) and Ridgefield (24,299).

Race and ethnicity: The HVCASA service area is fairly homogeneous with 81.3% of the total population White. In comparison, 70.7% of Connecticut and 63.3% of the nation is White. However, if Danbury is factored out, the proportion of Whites living within the service area increases dramatically to 90.4%. Only Danbury with an Hispanic population of 23.5%, Asian population of 6.2% and African-American population of 6.1% has a significant minority population. Overall, Hispanics constitute the second largest race/ethnic group (10.2%) followed by Asians (3.6%) and African-Americans (2.7%). These data reflect Litchfield County's race/ethnic make-up but present far less diversity than Fairfield County, the state or the nation.

Income: Only four of the twenty-two towns (Canaan, Danbury, North Canaan, and Salisbury) have a lower median household income than the state; and only two (Danbury and North Canaan) have a lower per capita income than the state. On the other hand, towns such as Brookfield, New Fairfield, Newtown, Redding, Ridgefield, and Sherman are significantly wealthier.

Level of poverty: Reflecting income, the level of poverty in most of the towns in the HVCASA service area is considerably lower than in the two counties, the state, and the nation. Overall, 5.0% of the population live below 100% of the Federal Poverty Level (FPL) and 14.5% live below 200% of the FPL. In comparison, statewide, 10.9% live in poverty and 24.2% live under 200% of the FPL. Nationally, the rates are even higher: 15.9% and 35.2% respectively. However, pockets of poverty do exist: in Salisbury and Sharon nearly a fourth of the population live below 200% of the FPL. In North Canaan nearly a third (31.8%) live below 200% FPL. In addition, in Danbury, by far the largest city in the region, almost one-fourth (23.9%) live below 200% of the FPL. Recent data indicates that in Danbury the percent of children living in poverty (17.% presently) went up 80% between 2010 and 2011. The economy can have its own impact on substance use, as we have seen in the past, so this is another very important indicator to follow.

Educational Attainment: The HVCASA service area has greater educational attainment (for persons 25 and older) than both the state and nation. Within the 22 town region, 9.1% did not graduate high school compared to 10.9% for Connecticut and 14.1% for the nation. At the other end of the spectrum, 42.8% of service area residents have a B.A. or graduate degree compared to 36.2% (CT) and 28.5% (U.S.). Not surprisingly those towns with the greatest levels of poverty (e.g. Danbury and North Canaan) have the highest proportion of residents without a high school diploma (17.6% and 17.4% respectively). In addition, the wealthy towns (e.g. Redding, Ridgefield, and Sherman) have high rates of educational attainment.

Source: 2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Alcohol

Key Points:

National, statewide and local data confirm that alcohol is the most commonly used substance among youth and adults.

HVCASA sub-regional priority ranking matrix indicates that it is rated highest for magnitude and changeability.

Overall Consumption Rates:

Alcohol consumption in the HVCASA sub-region is about the same as the state rate. About 60% of the population reports past month use. This is slightly higher than the rest of the country which hovers about 50% for past month use. However, the consequences, especially when measured with respect to population of some of our smaller communities, hit our area very hard. Between 2009 and 2010, there were 10 motor vehicle fatalities where alcohol was the contributing factor.

According to student surveys from our region:

Past 30 day use: Approximately one-fourth to two fifths of **all student respondents** stated they had used alcohol during the last 30 days. The older the student, the more likely he or she is to have had a drink during the past 30 days. At the same time, there not does appear to be any discernible trend among males and females. Generally the use is fairly similar, with some school districts reporting higher use among males; other districts among females.

Age of onset: According to college surveys administered in our region, the age of first use for 18-20 year olds has been steadily increasing over the last eight years. Our high school surveys indicate that the average age of first use is about 13 years old.

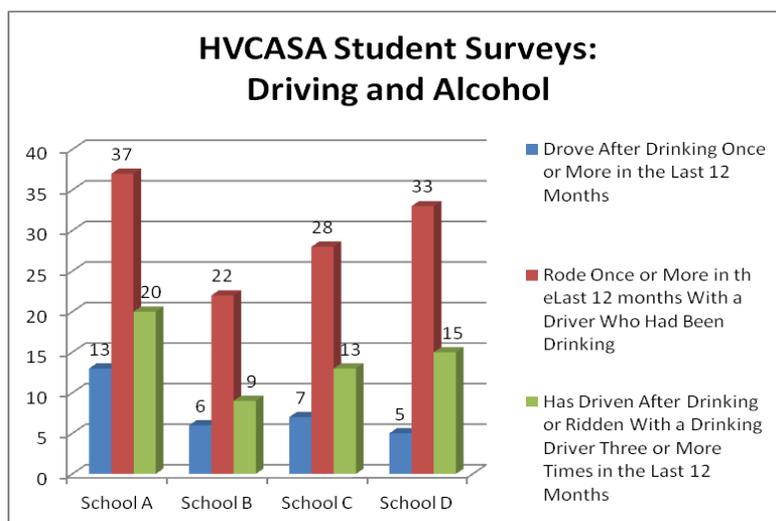
Past 30 day use among high school seniors is 54.35% while considerably fewer, **18.45%** of the **freshman class** reports having had a drink during the same timeframe.

Student Alcohol Perceptions	Seniors	Freshmen	% Differ
Avg. Perception of Risk	61.27%	61.38%	0.11%
Avg. Perceived Parental Disapproval	66.23%	85.48%	19.25%

Perceived Risk and Perception of Parental Disapproval statistics from our student surveys both correlate with increased use. When perception of risk is high, use decreases. The same is true for parental disapproval. The interesting data included here is the similarity between the younger and older students perception of risk. Both

Source: Search Institute 2008-2011

parties are not legally allowed to consume alcohol. The risk associated with underage drinking is low, especially when compared to perception of risk with tobacco, as we will see later on. There are many issues that require focus, but we should not forgo raising more awareness for alcohol-related risks.



For our region, DUI arrests for people between the ages of 10-20 years old, decreased 43.48% (From 69 in 2005, to 39 in 2010). This would indicate less underage drunk driving is actually happening, but it is also possible that enforcement has slacked off. In general, youth drinking and driving patterns mirror those of adults in the same state, and our adult DUI arrests are about 23 per 10,000 for 21 and older in the sub-region. When we discuss the survey results with students and ask them why they rode in a car when the driver had been drinking they indicate that often the “drinking” driver is a parent. We must keep raising awareness about buzzed and drunk driving among both youth and adult populations. Addressing any of these populations will surely have a positive impact on the others.

Some of our CNAW suggested that, since rates of past 30 day use among youth remained fairly high, perhaps young

people are choosing to stay at the house or location where they drank, instead of getting on the road. According to the CDC, over the 20 years between 1991 and 2011, the prevalence of self-reported drinking and driving among high school students aged 16 and older declined by 54%, from 22.3% down to 10.3%. National trends support improvements in our local data. Certainly, the adoption of Graduated Licensing Laws has helped reduce the incidence, as fewer young people actually have driver’s licenses. The economy,

specifically gas prices, may be contributing to a decrease in young drivers on the road also. Still, nationally, one in 10 US high school students 16 and over, reported drinking and driving in the past 30 days and 85% of those students also engaged in binge drinking during the past 30 days. We need to continue reducing teen access to alcohol and opportunities to drink and drive.

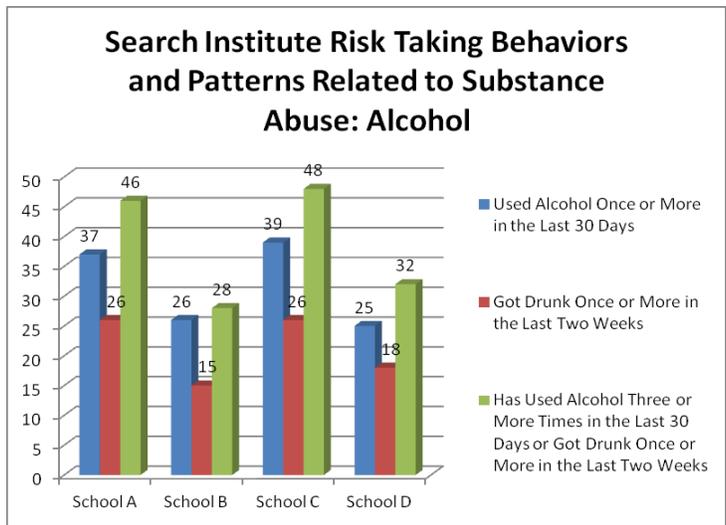
Liquor law arrests pertaining to underage drinking have been effective during the past six years in our sub-region. There were 171 arrests made of people 21 years of age or older in the past 6 years, who were buying for, providing or selling to minors. There have been 433 arrests of people ranging from age 10 to 20 in the past 6 years. This age group includes people using fake ID's to purchase alcohol or having been in possession of alcohol. Members of the CNAW indicated anecdotally that law enforcement is active and adults are starting to pay more attention to the laws.

Alcohol dependence remains the number one reason why people from our service area seek treatment.

Capacity to address the problems associated with alcohol abuse and underage drinking in our sub-region is fairly strong and the priority ranking for "changeability" is high.

- Local coalitions have acquired funding streams dedicated to reducing underage drinking.
- Local officials address the issues around underage drinking in their respective communities.
- Police provide enforcement and educational support.
- Schools are upholding to strict policies and using breathalyzers and providing alternative activities and opportunities for youth
- Social norms campaigns promoting alcohol free activities are flourishing.

This past year, students at a local high school designated grant money for HVCASA to provide alcohol awareness and harm reduction programs for all the members of the junior class. They identified underage drinking, and drinking and driving, as their top priorities. This is clearly a sign that youth must have a voice in our planning.



Marijuana

Key Points

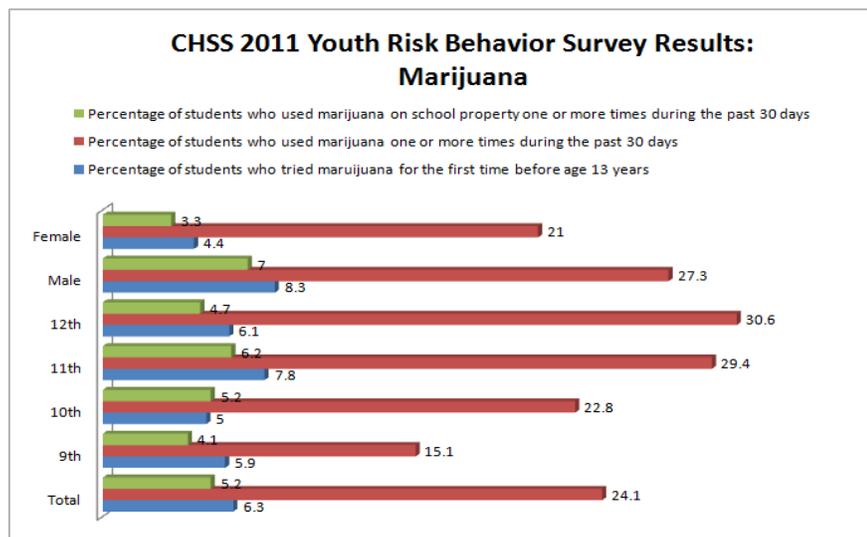
Marijuana use is prevalent among youth and perception of harm is low

Recent changes to marijuana laws in CT are a barrier to prevention efforts

According to the NSDUH surveys since 2008, overall past year marijuana use in our sub-region is 12.3%. The same data for the state of Connecticut is 13%. The northeast (12.2%) is closer to the HVCASA region and the U.S. figures are about 11.1% from the same survey period.

Student surveys from our sub-region indicate that 30% of students report smoking marijuana during the past year and 20% say they smoked it during the past 30 days. Clearly, use is much more common among this age group than the overall population.

In the HVCASA region were surveyed about marijuana use in the past thirty days. The average percent of sophomore students who had used marijuana in the past thirty days was 15.38%. This number doubles when compared to the seniors past thirty day



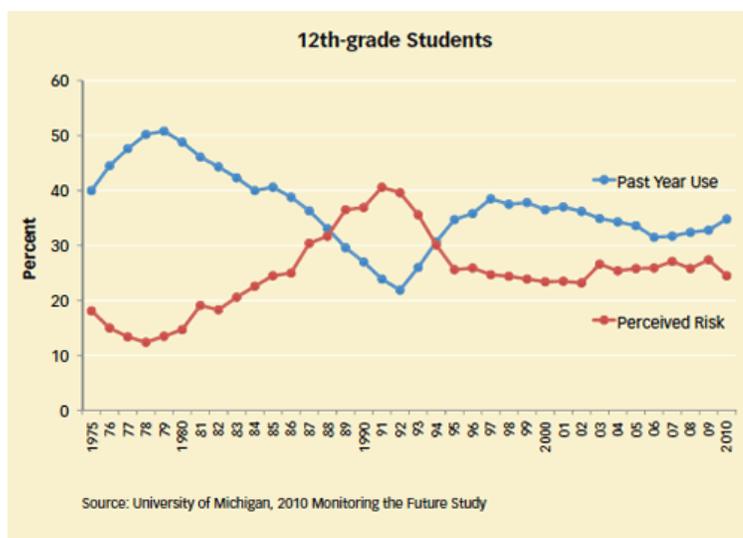
use (32.60%). The increase implies that somewhere between those formative years, marijuana is perceived as less dangerous and/or perception of parental disapproval drops. While the negative effects of marijuana use are not given the national spotlight of tobacco and alcohol prevention, it is the only illegal drug of the three. We must ask ourselves why the dangers of marijuana use are overshadowed by alcohol and tobacco.

According to MCCA, a treatment provider in the HVCASA region, marijuana abuse continues to be the number one reason why young people (under 18) seek treatment in our sub-region. Stigma around marijuana use is very low. According to some of our school surveys, the perception of harm for marijuana

use is less than perception of harm for tobacco use. In one school, there was evidence that the perception of parental disapproval was lower for marijuana than tobacco.

Anecdotally, the CNAW reported that parents are not as concerned with marijuana use among youth as they should be. It is seen as the lesser of evils and indeed, we have seen photos on Facebook that show adults smoking pot (and drinking) with teenagers at parties. We assume that parental disapproval is lower than it should be in our area.

The chart below describes 12th grade perception of harm of marijuana as collected in MTF surveys starting in 1975 until 2010.



Local survey information resembles this trend.

Recently, CT laws have been amended so that it is no longer a crime to be in possession of less than ½ of an ounce of marijuana. It is an infraction and the penalty is a fine: \$150 for the first offense and \$200-\$500 for the second offense. In addition, if you are under 21, your license will be suspended for 60 days. This sends a message that marijuana use is being treated much the way we deal with underage alcohol possession. Unfortunately, the details of this newer legislation are not widely understood and many people in our area think that “decriminalization” is the same as “legalization”. We have a lot of work to do in this area. Another barrier we face for reducing marijuana use is the adoption of medical marijuana legislation that took effect October 1st 2012.

Tobacco

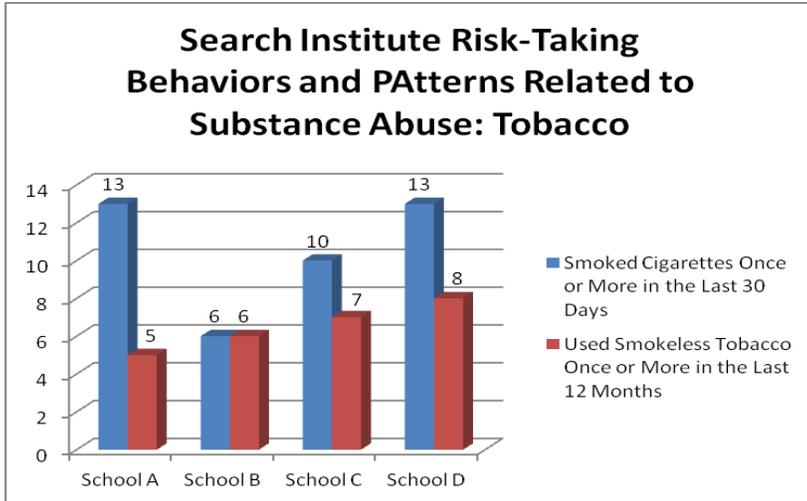
Key Points

High perception of harm overall

Cigarette use in the HVCASA sub-region is slightly lower than the state, the northeast and the U.S.

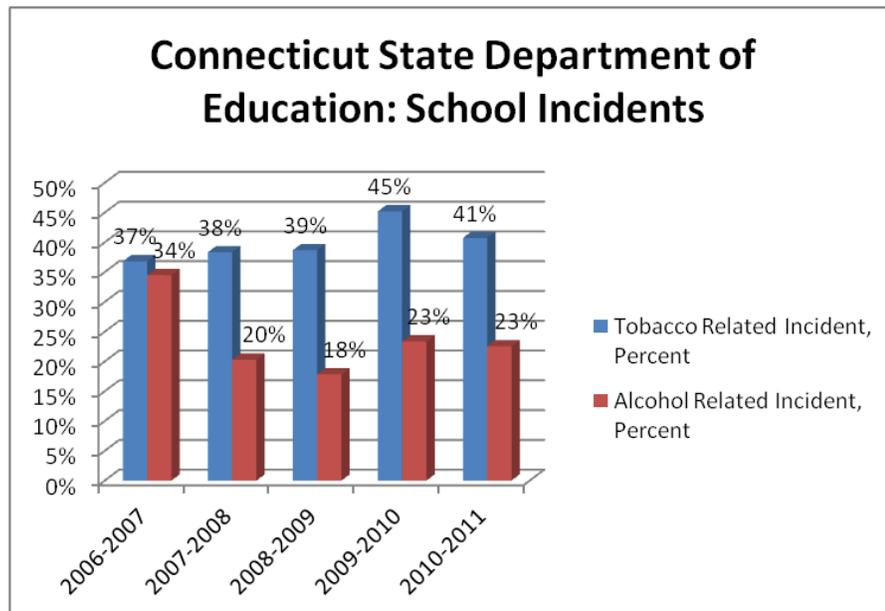
Compliance rate steadily improve among area tobacco merchants

Overall use of cigarettes in our sub-region is about 21.2% according to the NSDUH averages over 2008, 2009 and 2010. Results from our student surveys indicate that between 6% and 13% of students report past month use. We do not have smokeless tobacco data for the overall population, but there is a much lower rate of use reported for chew tobacco than smoked tobacco among our students.



The most compelling data around tobacco use in our sub-region pertains to perception of harm and perception of parental disapproval. These indicators are known to correlate with patterns of use. In our sub-region 86.9% of students in grades 9-12 reported perception of harm for tobacco use, while perception of harm of marijuana use was only reported by 71.7% of the same students. Clearly, we have been doing something right in terms of tobacco prevention initiatives. 92.1% of the same sample of 1970 students reported perception of parental disapproval, which was again higher than disapproval of marijuana use, as 90.6%

Tobacco related incidents within our schools have remained between 35% and 40% over the past five years. Each year tobacco has been involved with more incidents and problems than alcohol. As we have seen in student surveys, tobacco ranks very high in terms of perceived risk and disapproval. The average perception of risk for freshmen is 93.6% while the seniors are 91.6%. The average perceived parental disapproval for freshmen is 94.73%, with the seniors at 90.13%. Students are aware of the risks tobacco presents, and it shows in the past thirty day use statistics. Only 7.6% of freshmen claimed to have used the substance within the last month. Meanwhile, just 16.27% of seniors have used tobacco in the past thirty days. These statistics are very low which is encouraging for the anti-tobacco campaign. The only problem is that while tobacco use is down and awareness is up, we still see that more school related incidents have occurred with tobacco being involved. It is good that schools are catching students that are using the substance on school grounds, but the larger issue comes down to how the kids are gaining access to the substance to begin with. The majority of high school students are not legally allowed to purchase tobacco products obviously, so tighter controls need

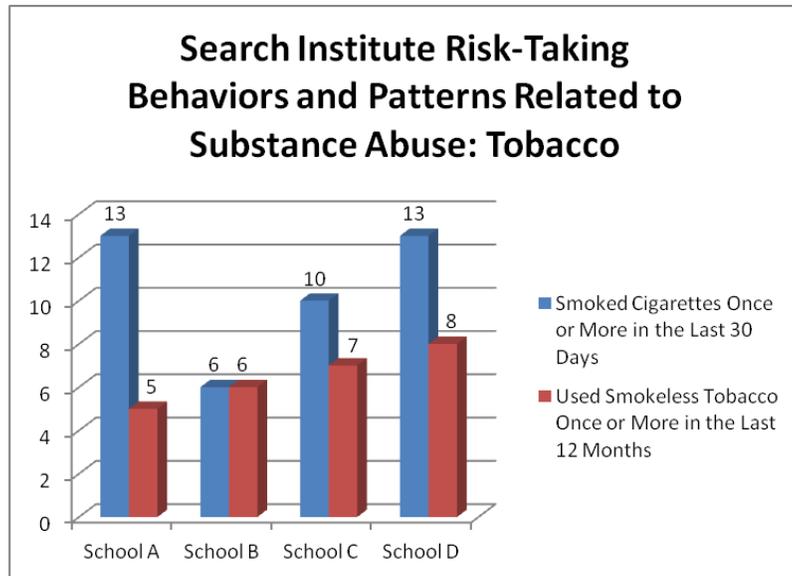


Source: Connecticut State Department of Education 2007-08, 2008-09, 2009-10, and 2010-11 school year data files

to be in place to prevent underage kids from obtaining the substance.

During 2002-2004, 69 tobacco retailers in our region were non-compliant. This represented 15.6% of all the retailers in the area. From 2005-2007, only 14.4% of retailers did not meet inspections. Most recently, during 2008-2010, 425 retailers were compliant while 50 retailers did not meet inspection standards. This puts the most recent percentage at 10.5%, which is the steady improvement we link to prevention efforts, education and enforcement working together throughout the sub-region.

From the evidence below, we can see how cigarette use in just the past 30 days trumps smokeless tobacco use. Primarily young, male athletes have anecdotally been identified as a population at risk for using smokeless tobacco. Coaches and school health personnel have requested more materials directed at these young men.



At the Community Needs Assessment Workgroups, and at meetings with high school-aged students from public and private schools in the sub-region the emerging trend of e-cigarettes was discussed. These products contain nicotine, and can be addictive. They are smokeless because vapor is the “smoke”. It can be flavored, which appeals to younger target markets. We do not yet have any local data about the prevalence of use of these products, but they have been creeping onto college campuses, which usually means they will be at the high schools before too long.

One area that continues to be a concern in our state is the lack of tobacco cessation programs and easy access to nicotine replacement therapy which is costly and is best used in tandem with behavior therapy. There is still a cessation program at Danbury

Hospital, and recent changes to Medicaid in Ct have made cessation coverage more comprehensive, but group and phone counseling are still not covered. Our state still spends well below the \$10.53 per person for Quitlines recommended by the American Lung Association, at \$3.40 per smoker. We continue to raise awareness about these issues.

Capacity to provide science-based, effective, environmental strategies directed at reducing tobacco use and retail non-compliance is alive and well in our sub-region. We often refer to the positive shifts in behaviors and attitudes about tobacco use when we develop plans to address other areas of concern like underage drinking norms, marijuana use and prescription drug misuse.

Prescription Drug Misuse

Key Points

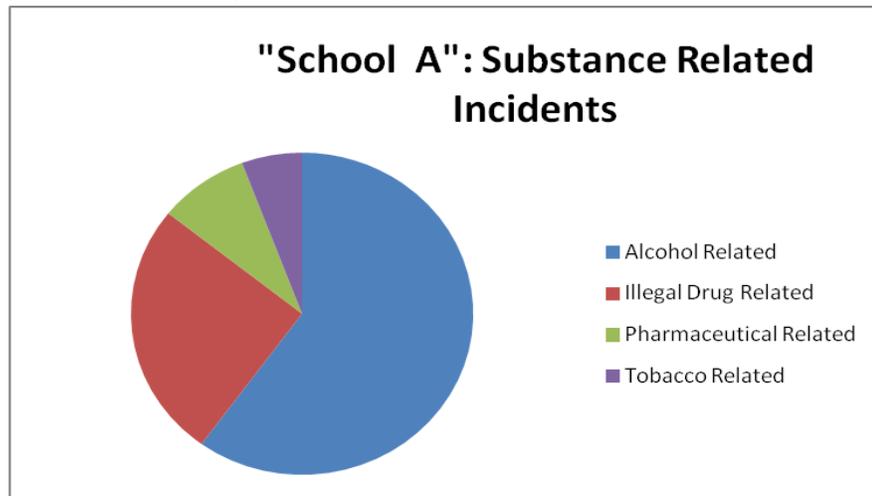
HVCASA coalition members have been tracking Rx drug misuse since 2001

Local student surveys just started capturing this information, hard data is limited

Are current levels of Rx drug misuse affecting the overall decrease in illicit drug use?

The first sign of prescription drug misuse that was discussed at HVCASA was ten years ago, after the Thanksgiving break in 2002. Members of the Drug Free Schools committee, which meets monthly, described reports of parties among college students who were home visiting. Large amounts of unidentified prescription and OTC meds were put in a bowl from which anyone could take whatever they chose. The NSDUH estimates for 2007 ranked the northwestern region of Connecticut as highest (5.94%) in the state for use of non-medical pain relievers among people 12 and older in the state. This increased significantly from 4.78% in 2004. According to the averages of NSDUH surveys from 2008, 2009, and 2010, about 4.5% of the folks responding to the survey in sub-region have misused pain killers in the past year. This is slightly higher than the state (3.9%) and the Northeastern part of the U.S (4.4%)-still lower than the entire nation, which is 4.9%.

Results of the HVCASA area Community Readiness Survey indicate that non-medical use of prescription meds are a most commonly regarded as a "significant" problem for 18-25 year olds. This assertion is supported by information from treatment providers, particularly doctors who prescribe Suboxone in our area. This is not to say that other age groups are not impacted by

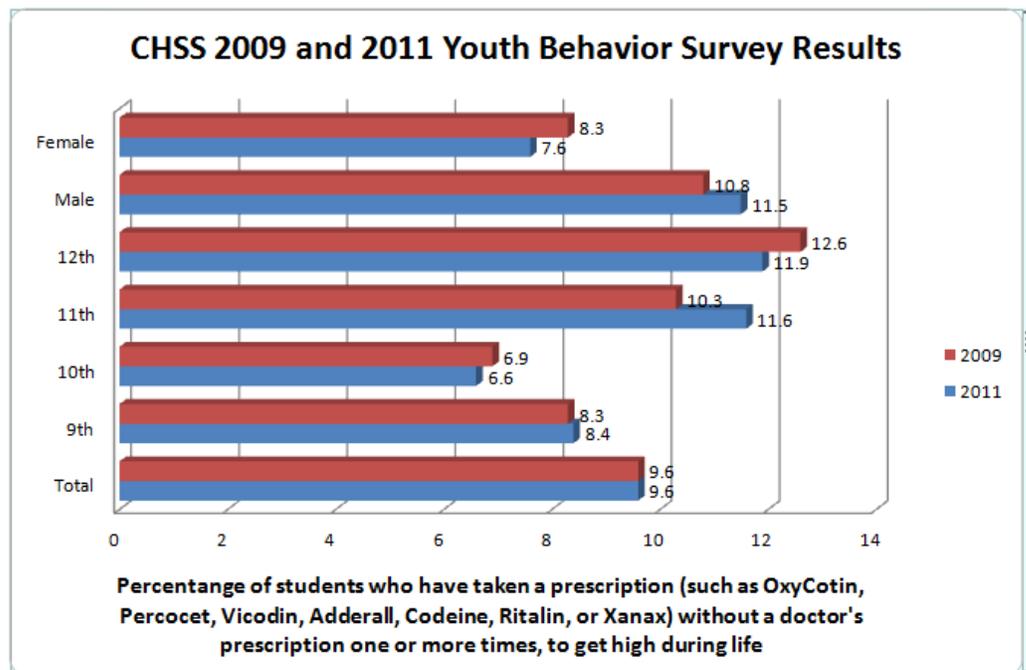


misusing prescription drugs. During 2012, HVCASA received more calls from people in their 30s and older who were looking for treatment programs for their own addictions to pain killers than in previous years. Law enforcement have intervened on some large scale cases of prescription drug distribution locally, as well. We have also noticed an increase in the number of school incidents that are related to pharmaceuticals. School administration discuss prescription drug misuse at freshmen orientations and include policies about OTC and prescription medications in their student handbooks.

(2011 data from one local high school-Search

Survey)

In 2006 the CDC identified sixteen states where the primary cause of death was from drug overdose, surpassing motor vehicle accidents for the first time ever. Connecticut was one of the sixteen states listed. Since 2008, our CNAW have acknowledged that many new heroin users were young people who had developed opiate addictions after misusing prescription drugs like oxycontin and vicodin. School surveys from the state of Connecticut also indicate that 18-25 year olds are not the only population where prescription drug misuse is a



“significant” problem. The graph below shows that about 9.6 percent of the total survey sample has used these substances to get high at least once.

Although the numbers are not high, the percent of increase in the number of people who are seeking treatment is worth noting. Opiate-based addictions are continuing to increase all over our state, even in the smallest of towns served by HVCASA. According to CT DMHAS, one of the more populated towns in our area saw a 98.5% jump in the number of people seeking treatment for opiate addiction between 2008 and 2012. The number of individual cases went from 66 in 2008 to 131 in 2012. Some of these cases can be attributed to heroin, but again, we recognize that many heroin users start out addicted to prescription medicines they perceived to be safe and non-addictive.

The CNAW queried whether increases in Rx drug misuse were lowering the use of illicit drugs.

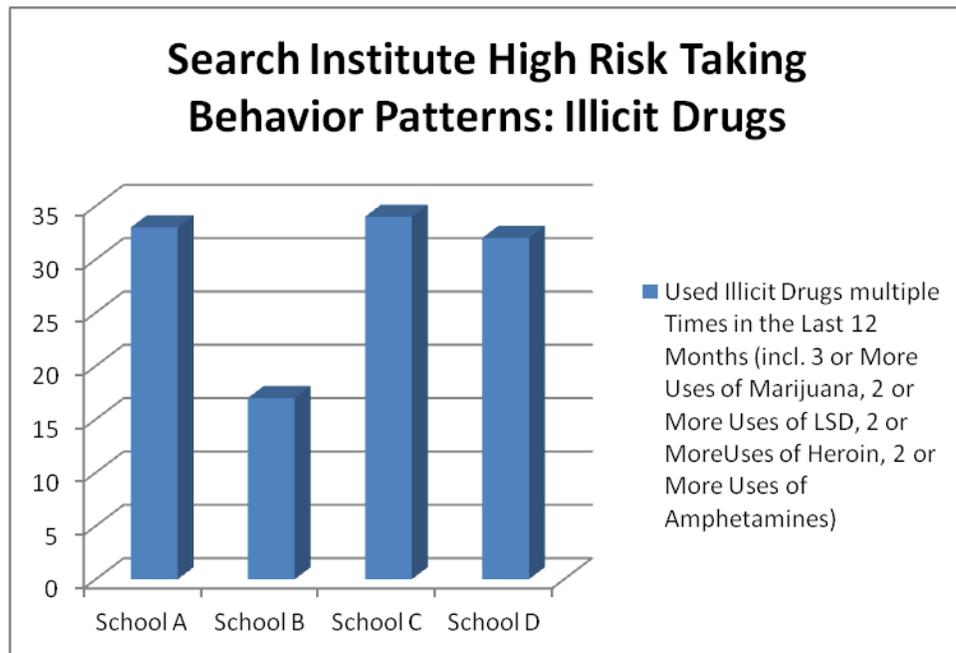
Cocaine

Key Points

Cocaine, both powder and crack, are increasingly evident in the sub-region

Statistics are slim; data is often combined under the heading of “illicit drugs”

Statistics we used in previous profiles from the 2007 NSDUH show that only 2.35% of the people in the northwestern part of Connecticut reported using cocaine in the past year. Our part of the state reported the lowest use, compared to other regions. At the time, we were lower than the state rate of 2.57%. Consumption must have been even lower during 2008 through 2010 as the



NSDUH results show that the HVCASA service area past year cocaine use was 2% of those responding to the surveys. The CT figures averaged out to 1.8% over the same time period.

However, during 2011, local law enforcement began to report that they were seeing more cocaine on the streets. It remains relatively expensive, but it is a trend they are continuing to follow. So far, treatment providers do not report a marked increase in the number of people seeking help for cocaine addiction. This usually takes longer to surface. In 2008, 13% of all treatment admissions statewide were for primary cocaine abuse treatment. This figure remains relatively stable in 2012.

The chart above describes the patterns of use reported by students from four schools in our sub-region. Surveys we administered between 2008 and 2012. The surveys combine cocaine, heroin, and other drugs under the heading of “illicit drugs” in their questions and in the final reports, so we do not know how much of the use can be attributed directly to cocaine in our student surveys. Surveys are conducted among 7th through 12th grades in different years.

A recent Connecticut School Health Survey showed that 4.4% of CT 9th-12th graders reported past month cocaine use. One population that reports use at higher rates our sub-region is the college population which had 4% reporting past month use in 2010, in comparison with their statewide counterparts at just under 3% for past month use. This is small and less than representative sample of that age group.

Drug arrests in the HVCASA region between 2005 and 2010 fluctuated at rates between 17.5 per 10,000 and 20 per 10,000 persons. Again, drug arrest data encompasses all illicit drugs, we do not have individual figures for cocaine arrests alone.

Cocaine is ranked fairly low in comparison with other priorities of the CNAW. We are not neglecting cocaine in our overall prevention planning, instead we address it with the same strategies applied to all other illicit drugs.

Heroin

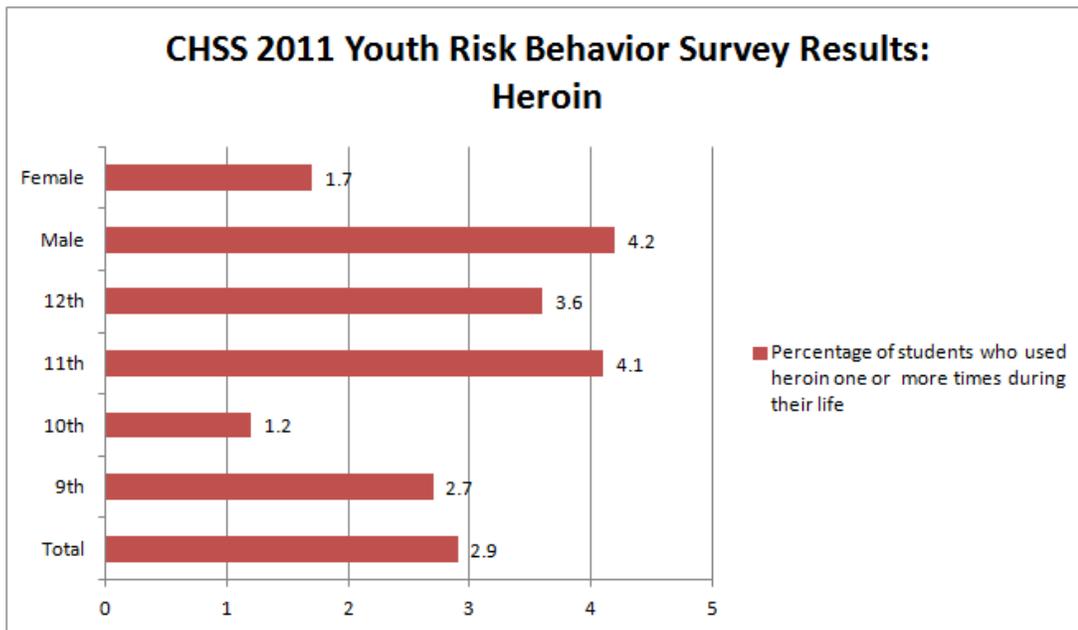
Key Points

The basis of our guidance for determining priorities about heroin use comes from treatment providers and law enforcement.

Heroin remains accessible and relatively inexpensive throughout the sub-region

Support services for family members and young people in opiate recovery have emerged

Every year since 2006 a treatment provider in our area has reported about 1000 male clients and 500 female clients seeking treatment for opiate addiction. This is just one provider and we know that people seek treatment away from their communities, as well. Between 2007 and 2009, drug induced deaths accounted for 59 of the people who died in our sub-region. Since we do not have exact numbers we assume that a certain portion of those deaths arose from heroin overdoses. Local police report that heroin is easy to get and still inexpensive. School substance abuse counselors and social workers have been anecdotally reporting that there are young people who leave school for in-patient treatment in residential programs, who need solid protocol for re-entry into school upon their return. Heroin is not prevalent among the general population of HVCASA, but its consequences-addictions, overdoses, death even over a small portion of our population are impactful for the entire community.



Averages from CT school surveys above collected in 2011 show 3.85% of high school juniors and seniors combined report lifetime use of heroin (at least once). Information from the college age population in our service area ranges between 2% and 3% reporting lifetime use (CORE)

MCCA, a leading treatment provider in our area, notes two trends that directly result from heroin use. One is the increasing number of people from our service area who are seeking treatment for heroin addictions. The second trend is the increased demand for supportive services for family members and those who are closely related to those in treatment. The CNAW was impressed with the number of programs and services that have come about in our sub-region, specifically for this population.

Drug arrests in the HVCASA region between 2005 and 2010 fluctuated at rates between 17.5 per 10,000 and 20 per 10,000 persons. Again, drug arrest data encompasses all illicit drugs, we do not have individual figures for heroin arrests alone.

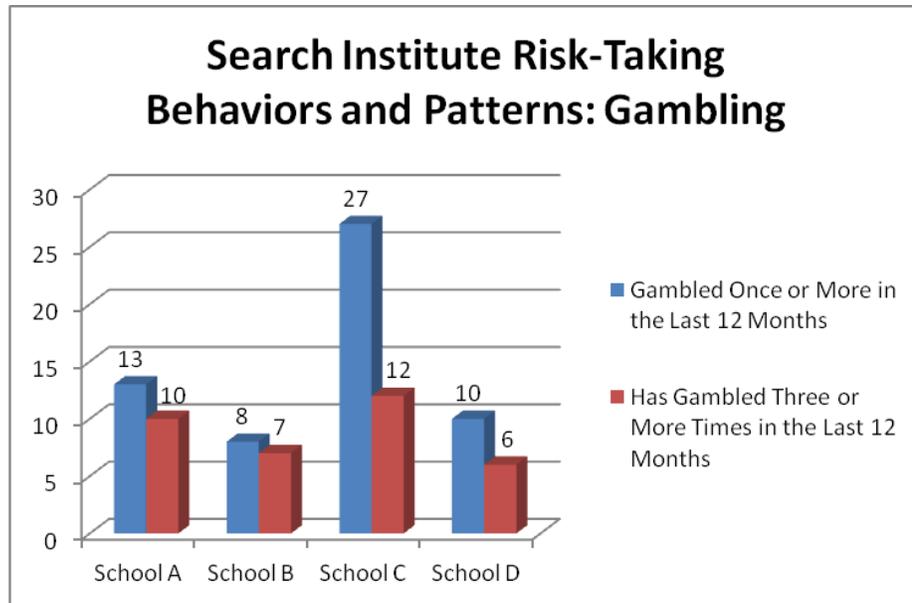
Heroin is ranked lower in comparison with other priorities of the CNAW. We include desired outcomes for heroin in our overall prevention planning with the same strategies applied to all other illicit drugs. The trends around heroin use are closely tied to the misuse of prescription drugs, specifically opioid pain killers. Local coalitions, local healthcare and treatment providers frequently raise awareness, regarding the progression from prescription drug misuse to heroin.

Problem Gambling

Key Points

Remains very low on the radar in out service area

Primary population of concern is the college population



Source: HVCASA-Search School Surveys 2008-2012

HVCASA coalition members have repeatedly ranked problem gambling very low on the priority matrix. Local data is only readily available based on a few questions in the student surveys and in the college (CORE) surveys administered every two years. The CNAW was interested in the data contained in the chart above which indicated one school had a significantly higher amount of gambling than the others. Upon further research, we found that this survey was administered in just after the national basketball championships and spring break. Nonetheless, we intend to track this particular school's gambling data in the future to see if the timing was a contributing factor.

This visual does show that between 8% and 27% of students have gambled in the past 12 months.

College staff, like Resident Advisors (RAs) occasionally request training and education materials for distribution on campus. Internet gambling is the main type of gambling among college students here.

Bettor Choice is a program for problem gamblers, which is available in our sub-region through MCCA. This is an out-patient program, which is statewide. MCCA also offers in-patient programs for problem gambling .

One area of concern around problem gambling is the link between problem gambling and substance abuse and/or suicidal ideation or attempts. Anecdotally, we are aware of financial situations that have led to a "collision" of these factors in few cases locally. If for no other reason , problem gambling awareness should have a more prominent role in all prevention planning here.

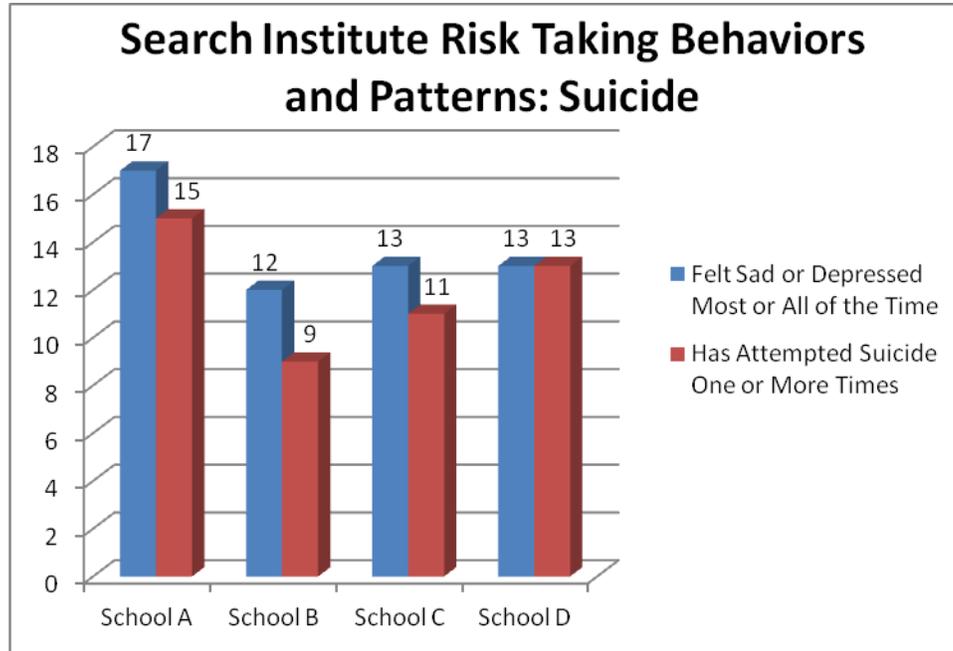
Suicide

Key Points

Data is available at the local level but we use aggregate data for this profile

Most alarming statistics come from youth attitude and behaviors surveys

Between 1999 and 2009 there were a total of 236 known suicides in the HVCASA sub-region.

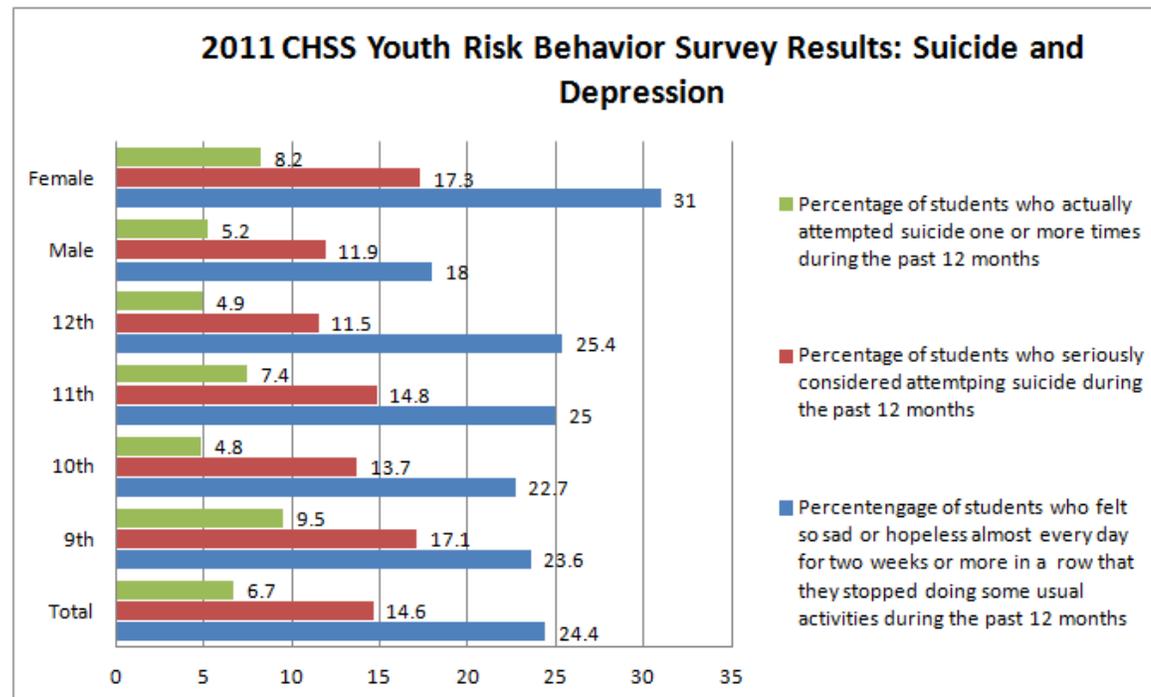


According to the NSDUH averages for our sub-region between 2008 and 2010, 3.8% of respondents 18 and older reported “serious thoughts of suicide” during the past 12 months. Perhaps even more alarming are the results from student surveys in our sub-region and across the state of CT.

At the four schools we surveyed during 2008 and 2012, between 9% and 15% of youth reported having attempted suicide one or more times. Those students who reported “feeling sad or depressed most or all of the time” ranged from 12% up to 17%. Depression, social isolation and tendencies toward suicidal ideation are known risk factors for substance abuse and other negative behaviors. During the course of the four years

we conducted the student surveys, the responses did not vary significantly. It should also be noted that our student samples include 7th and 8th graders whose response rates mirrored that of older students. In other words, unlike substance abuse, findings related to suicide and depression do not increase as the youth progress through high school.

Clearly, we need to shift our approach to mental health promotion. Early prevention and education must become a more integrated piece of the overall delivery of prevention services in schools and communities. New partnerships must be created



and formal plans based on current data have to be developed. We need more funding for this work and we need to begin to change the way people respond to mental health issues at the local level. CT recently acquired federal grant money to provide “gatekeeper training” known as QPR and other funds to build community based and campus-based coalitions who are

trained in suicide prevention and postvention practices. We have just begun to promote these resources in the HVCASA sub-region.

From the student survey data above we can see that females tend to report at a higher rate than their male counterparts for each question. As noted previously in our local data, unlike with alcohol consumption and drug use, younger students do not report at lower rates than older students.

The CNAW wanted to mention that on our priority-ranking matrix, suicide ranked highest (5) for severity of impact. There were a number of discussions about suicides that go unreported. For instance, the potential for “auto”cides where people die in a car accident on dry roads with no apparent medical condition being the cause of death. (Source: The Fatality Analysis Reporting System, National Highway Traffic Safety Administration)

Number of Suicides in HVCASA sub-region and CT			
HVCASA			
1999-2001	2002-2004	2005-2007	2007-2009
47	58	66	65
STATE			
1999-2001	2002-2004	2005-2007	2007-2009
854	813	813	867

Conclusions

After four iterations of the prevention priority ranking process in the HVCASA sub-region, alcohol/underage drinking continues to be the issue of greatest overall concern. We have directed funding and other local resources at addressing the issues around alcohol consumption and underage drinking. Capacity to work towards reducing incidence and related consequences is improving in all of our local communities.

Marijuana use has noticeably increased since 2008 and it is ranked number two on the priority ranking matrix, primarily because of its prevalence of use and low perception of harm. Capacity to address this issue is very good and all of the local coalitions are devoting resources to enhancing awareness, particularly with respect to disseminating recent research on the long-term effects of THC on the brain.

Tobacco use continues to be low and compliance rates among retailers in our region steadily improved over the past 10 years.

The percent of clients reporting heroin as their primary drug at admission began to drop in SFY 2006 and by SFY 2009 was topped by alcohol admissions as the most reported abused substance. Admissions for “other opiates” continued to be on the uptick. Prescription drug misuse remains the number three priority on our matrix. Capacity to address this issue has gained widespread support in our sub-region. The number of DEA sponsored Rx drug take backs organized by the local coalitions have increased 200% in the past two years.

Suicide, depression and mental health concerns are emerging as key areas of concern as we move forward with creating healthier communities in the sub-region. We need to focus more time and energy on integrating effective prevention/health promotion here.

Prevention providers in the HVCASA sub-region have spent considerable time raising awareness about substance use by presenting evidence from local law enforcement, treatment professionals, schools and youth surveys. Over the past few years there have been positive changes with regard to confronting the negative effects of risky behaviors. Our sub-region is also fortunate to have exemplary Local Prevention Councils who work closely with the Regional Action Council to pool resources and provide innovative prevention programs. We have made steady progress in educating adults and youth about risk factors that are present in the affluent suburbs, rural and urban areas that make up a part of the state. Further, we have made strides in enlisting the support of local officials, local businesses and school administration.

CNAW Priority Ranking Matrix - Aggregate Scores

HVCASA 2012

SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	TOTAL
Alcohol	4.5	4.5	4	13
Tobacco	3.5	3	3	9.5
Marijuana	4.1	4	3.5	11.6
Prescription Drug Misuse	3.8	4	3.5	11.3
Heroin	2	3	3	8
Cocaine	2	3	4	9.4
Problem Gambling	1.4	1	2.4	4.8
Suicide	2.3	5	2.8	10.1

Appendix 1: Data Sources

Census Data

Definitions

Age: The age of the person in complete years at the time of census interview.

Sex: Individuals mark either “male” or “female” to indicate their biological sex.

Race: The racial classifications used by the Census Bureau adhere to standards issued by the federal Office of Management and Budget. OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race and that respondents should be offered the option of selecting one or more races. If an individual did not provide a race response, the race or races of the householder or other household members were imputed using specific rules of precedence of household relationship.

Hispanic or Latino Origin: Hispanics or Latinos who identify with the terms “Hispanic,” “Latino,” or “Spanish” are those who classify themselves in one of the specific Hispanic, Latino, or Spanish categories listed on the questionnaire (“Mexican,” “Puerto Rican,” or “Cuban”) as well as those who indicate that they are “another Hispanic, Latino, or Spanish origin.” People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are “another Hispanic, Latino, or Spanish origin” are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Educational Attainment: Respondents are classified according to the highest degree or the highest level of school completed. Educational attainment data are needed for use in assessing the socioeconomic condition of the U.S. population. Government agencies also require these data for funding allocations and program planning and implementation. These data are needed to determine the extent of illiteracy rates of citizens in language minorities in order to meet statutory requirements under the Voting Rights Act. Based on data about educational attainment, school districts are allocated funds to provide classes in basic skills to adults who have not completed high school.

Median Age: The median age is the age that divides the population into two equal-size groups. Half of the population is older than the median age and half is younger. Median age is based on a standard distribution of the population by single years of age and is shown to the nearest tenth of a year.

Poverty Status: To determine a person's poverty status, one compares the person's total family income in the last 12 months with the poverty threshold appropriate for that person's family size and composition. If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered “below the poverty level,” together with every member of his or her family. If a person is not living with anyone related by birth, marriage, or adoption, then the person's own income is compared with his or her poverty threshold. The total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold.

Source

2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Arrests for Driving Under the Influence

Definition

Arrests recorded for driving or operating any motor vehicle or common carrier while drunk or under the influence of liquor or narcotics.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths

Driving under the influence (DUI) is a direct consequence of alcohol or drug misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations

Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Liquor Law Violations

Definition

Arrests recorded for possession of alcohol by minor, sale or provision of alcohol to minors, or fake/false identification. This does not include public drunkenness, driving under the influence or administrative actions taken by the Department of Consumer Protection Liquor Control Commission against liquor permittees.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths

Liquor law violations are a direct consequence of alcohol misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations

Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Drug Law Violations

Definition

Arrests related to narcotic drugs, such as unlawful possession, sale, use, growing and manufacturing of narcotic drugs.

Source

Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths

Narcotic drug law violations are a direct consequence of drug use. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations

Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Alcohol-Involved Motor Vehicle Accidents

Definition

Motor vehicle accidents for which the driver had consumed alcohol (Blood Alcohol Concentration >0.00)

Source

Connecticut Department of Transportation Traffic Accident Viewing System, Newington CT

Strengths

Alcohol motor vehicle involved accidents are a direct consequence of alcohol misuse. The information is routinely collected as part of the Department of Transportation's Traffic Accident Viewing System.

Limitations:

The rates may underestimate the actual occurrence due to underreporting. A person involved in an accident in particular town may not reside in that town.

Fatal Motor Vehicle Accidents while Under the Influence of Alcohol or Drugs**Definition**

Motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source

National Highway Traffic Safety Administration (NHTSA), Fatal Accident Reporting System (FARS)

Strengths

Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations

Alcohol Test Result statistical data obtained from this database should be interpreted with caution. Alcohol Test Results included in this database are actual state-reported data. Estimates obtained by use of this query system may differ from NHTSA's published reports. NHTSA's published estimates are based on data from the Fatality Analysis Reporting System (FARS). Unfortunately, known BAC test results are not available for all drivers and non-occupants involved in fatal crashes. "Property Damage Only" accidents, which occurred on locally maintained roadways from 01/01/2007 to the present are included in the DOT accident file; prior to that date, they were not included in the file. The rates may underestimate the actual occurrence due to underreporting, and also a person involved in an accident in particular town may not reside in that town.

Motor Vehicle Accident Fatalities while Under the Influence of Alcohol or Drugs**Definition**

Total fatalities in motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source

National Highway Traffic Safety Administration (NHTSA), Fatality Analysis Reporting System (FARS)

Strengths

Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations

This indicator may be unstable for less populated areas that have low numbers of annual fatal crashes. While considerable effort has been made to obtain the BAC values for all drivers involved in fatal crashes, these data are not complete. Therefore, NHTSA estimates driver BAC for cases missing data.

Lung Cancer Deaths**Definition**

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes C34 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

Eighty to 90% of all lung cancer is attributable to cigarette smoking. Data on lung cancer deaths are readily available for many years.

Limitations

Death from lung cancer reflects long-term, chronic cigarette smoking, and lung cancer has a long latency period. Therefore, it may be many years before changes in smoking affect population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur and may be unstable for less populated states or when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death.

Alcohol-Attributable Chronic Liver Disease and Cirrhosis Deaths

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes K70, K73, or K74 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

Long term, heavy alcohol consumption is the leading cause of chronic liver disease, in particular cirrhosis, one of the 12 leading causes of death. According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 40% of deaths from cirrhosis in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations

This indicator is only based on deaths; cases of cirrhosis morbidity are not reflected in this indicator. Alcohol-related cirrhosis may have a long latency; there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups.

Alcohol-Attributable Suicides

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X60-X84, Y87.0 as the underlying cause of death.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 23% of suicides in Connecticut were attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations:

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as suicide, are best used at the state or regional levels.

Alcohol-Attributable Homicides

Definition

Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X85-Y09 and Y87.1 as the underlying cause of death. Homicide includes injuries inflicted by others that result in death.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 47% of homicides in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as homicide, are best used at the state or regional levels.

Alcohol-Induced Death**Definition**

Alcohol-induced deaths include alcohol-induced pseudo-Cushing's syndrome; mental and behavioral disorders due to alcohol use; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol-induced acute pancreatitis; alcohol-induced chronic pancreatitis; finding of alcohol in blood; accidental poisoning by and exposure to alcohol; intentional self-poisoning by and exposure to alcohol; and poisoning by and exposure to alcohol, undetermined intent. Alcohol-induced causes exclude accidents, homicides, and other causes indirectly related to alcohol use, as well as newborn deaths associated with maternal alcohol use.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

These deaths are a direct consequence of alcohol misuse.

Limitations

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Drug-Induced Death**Definition**

Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs (e.g., heroin or cocaine), as well as legal prescription drugs and over-the-counter drugs; alcohol is not included. The majority of deaths are unintentional drug poisoning deaths, with suicidal drug poisoning and drug poisoning of undetermined intent comprising the majority of the remainder. Adverse effects from drugs taken as directed and infections resulting from drug use are not included. In 2007, drug-induced deaths were more common than alcohol-induced or firearm-related deaths in the United States.

Source

Connecticut Department of Public Health Mortality Statistics, <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138>

Strengths

These deaths are a direct consequence of drug misuse.

Limitations

The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Alcohol and Other Drug Related School Suspension or Expulsion

Definition

A sanction determined the school administration due to violation of a publicized policy; or serious disruption of the educational process; or endangerment to persons or property.

Source

Connecticut State Department of Education disciplinary offense records

Strengths

Students who use alcohol, tobacco or other drugs at an early age and use substances frequently are more likely than other students to continue to face suspension or expulsion. These data are based on uniform definitions applied to all schools in the state and, therefore, have comparative values.

Limitations

The definition for counting drug or alcohol disciplinary offense is uniformly defined statewide. However, the specific data collection requirements have changed in recent years. Therefore, these data are not necessarily comparable across years. The data should be used with discretion.

Overall school attendance in past year

Definition

Overall school attendance is the number of students attending public school each day of the school year, divided by the number of days school was in session during the school year.

Source

Connecticut State Department of Education. School attendance records

Strengths

Researchers have found that truancy itself seems to contribute to or at least correlate with a diverse array of problems among young people. Studies have established lack of commitment to school and truancy as risk factors for substance abuse, teen pregnancy, delinquent behavior, and school dropout.

Limitations

This indicator is an indirect measure of substance abuse and its consequences.

Tobacco Retailer Violation

Definition

Tobacco retailers who sold tobacco to minors working undercover for the CT DMHAS Tobacco Prevention and Enforcement Program.

Data Source

Connecticut Department of Mental Health and Addiction Services Tobacco Prevention and Enforcement Program

Strengths

Tobacco use by minors is a consequence of access to tobacco products. The Synar Amendment requires states and U.S. jurisdictions to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons under 18. As a result, over the last 14 years, data reported by states and the District of Columbia has indicated a clear downward trend towards reducing tobacco sales to minors. Data on retailer violations have been systematically collected by DMHAS for many years.

Limitations

This indicator may be unstable for areas or subgroups that have small population sizes, which are not routinely subject to inspections by DMHAS.