California State Epidemiological Profile:
Alcohol, Tobacco, and Other Drug Consumption and Consequences

Compendium of Data Indicators from Existing Data Sources

California State Epidemiological Outcome Workgroup (SEOW) Project

June 2009

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Disclaimer

This document was produced by the California Department of Public Health's Epidemiology and Prevention for Injury Control Branch under a State Epidemiological Outcomes Workgroup (SEOW) Project contract with the California Department of Alcohol and Drug Programs (ADP). The SEOW Project is part of a federal initiative created by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP) to assist states and US territories create monitoring systems for alcohol, tobacco and other drugs (ATOD). A consulting firm, Synectics for Management Decisions, Inc., implements the initiative on CSAP's behalf, and oversees the grant with ADP.

Publication of this document does not necessarily reflect the opinions or policies of the sponsoring agencies. The document was produced for ADP as part of its efforts to develop practical and user-friendly ATOD epidemiological profiles for California and its counties.

The suggested citation for this document is:

California Department of Public Health, Epidemiology and Prevention for Injury Control Branch and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs. *California State Epidemiological Profile: Alcohol, Tobacco, and Other Drug Consumption and Consequences*. CDPH: Sacramento, CA, June 2009.

California State Epidemiological Profile: Alcohol, Tobacco, and Other Drug Consumption and Consequences

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Introduction

The California State Epidemiological Outcome Workgroup (SEOW) Project is funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention to assist states in creating monitoring systems for alcohol, tobacco and other drugs (ATOD) in support of its Strategic Prevention Framework (SPF). As a joint project of the California Departments of Alcohol and Drug Programs (ADP) and Public Health (CDPH), the overall mission of the California SEOW Project is to help create institutional capacity within California at both the state and local levels to identify and utilize relevant data sources related to ATOD for statewide and county needs assessments and for use in strategic planning and the Substance Abuse Prevention and Treatment Block Grant applications. Currently, California does not have a comprehensive or integrated ongoing surveillance system for ATOD to provide useful and timely state and county data to inform policy and program development and prevention planning decisions. As part of the project, an SEOW advisory group has been formed to advise the two Departments on how to create state and county level epidemiological ATOD profiles and establish a sustainable surveillance system.

This third State Epidemiological Profile and the companion County-level Profiles provide a compendium of data indicators on ATOD consumption and consequences at the state and local levels respectively as part of the comprehensive SPF needs assessment. The profiles also represent a first critical component in the larger efforts to ensure county and state providers and policy makers have the data, analysis skills, and resources necessary for effectively designing, planning, allocating resources, implementing, and improving ATOD prevention programs.

The immediate short term goals of the SEOW Project are to identify data sources and indicators most relevant for assessing the current patterns of ATOD consumption and consequences and monitoring their trends, and to develop State and County-level Epidemiological Profiles based on these existing data sources. This iteration of profiles focuses almost exclusively on consumption and consequences data indicators, although a few indicators for risk and protective factors are included. The following section outlines the overall methodological approach guiding the project and used in creating these documents.

The data are presented under four broad headings: Availability, Consumption, Consequences, and Selected Risk and Protective Factors. The Consumption section is divided into youth and adult data sources, while the Consequences section is divided into health, traffic, crime, and treatment areas. For each topic the data is displayed by data source. Brief summaries are provided after the presentation of data from each data source. The data sources are more fully describe in Appendix A which provides a general description and information on accessing each of the data sources. The Appendix also lists the indicators selected and highlights strengths and limitations of each source.

The tables and figures provided in these documents represent an initial assessment and selection of existing sources and indicators of ATOD consumption and consequences in California, and three selected counties: Alameda, Fresno, and Riverside. As a work in progress, future iterations of the profiles will incorporate additional indicators of ATOD availability and risk and protective factors.

Methodology

A. Theoretical Framework
1. SAMHSA's proposed Strategic Prevention Framework and SEOW Monitoring System
2. California Department of Alcohol and Drug Programs expanded the framework to serve as an overall Strategic Planning Framework

B. Assessment Phase
1. Initial focus on ATOD consumption and related consequences
2. Creation of a California ATOD Surveillance System
    a. State level data
    b. County-level data
    c. Future goals
        1) Adding additional sub-group analyses
        2) Adding mediating variables (availability, risks/protective factors)
        3) Building analytic capacity to use data effectively as part of the planning and monitoring process

C. ATOD Consumption and Related Consequences
1. Selection of constructs
    a. Criteria: Informed by current literature and Pacific Institute for Research and Evaluation's February 2008 guidelines
    b. Substance types: Primary substances of choice and/or emerging substances
    c. Decision process: Iterative ongoing process
2. Selection of data sources
    a. Criteria: Standard across state and national levels to allow for comparisons; Valid; Consistent; Periodic, Sensitive; Available in disaggregated form at the local level
    b. Decision process: Iterative ongoing process
3. Selection of data indicators
    a. Criteria: Provide "big picture" view of the problem; Focus on what we want to know; Be most useful for prevention planning and prioritization
    b. Decision process: Iterative ongoing process
4. Dimensions of data presentation
    a. Size/Magnitude of problems
        1) Trends over time
        2) Severity of consequences
    d. Comparisons across State/Regions/Counties
        1) Early detection of emerging issues (future component)
        2) Economic costs (future component)
        3). Special populations (future component)
5. Analytic approaches
    a. Apply Strategic Planning Framework to help prioritize and focus resources effectively
    b. Make explicit conceptual and theoretical linkages proposed
    c. Be data and science informed
    d. Evaluate assumptions, practice, and outcomes
6. Strengths and limitations of data sources
    a. Work in progress
    b. Limitations of data sources (e.g., use of self report surveys; archival data sources; changes in questions; agency arrest and government-funded services data with selection biases)
    c. Limited sub-group analyses
    d. Limited mediating variables (e.g., risk and protective factors)

I. Availability

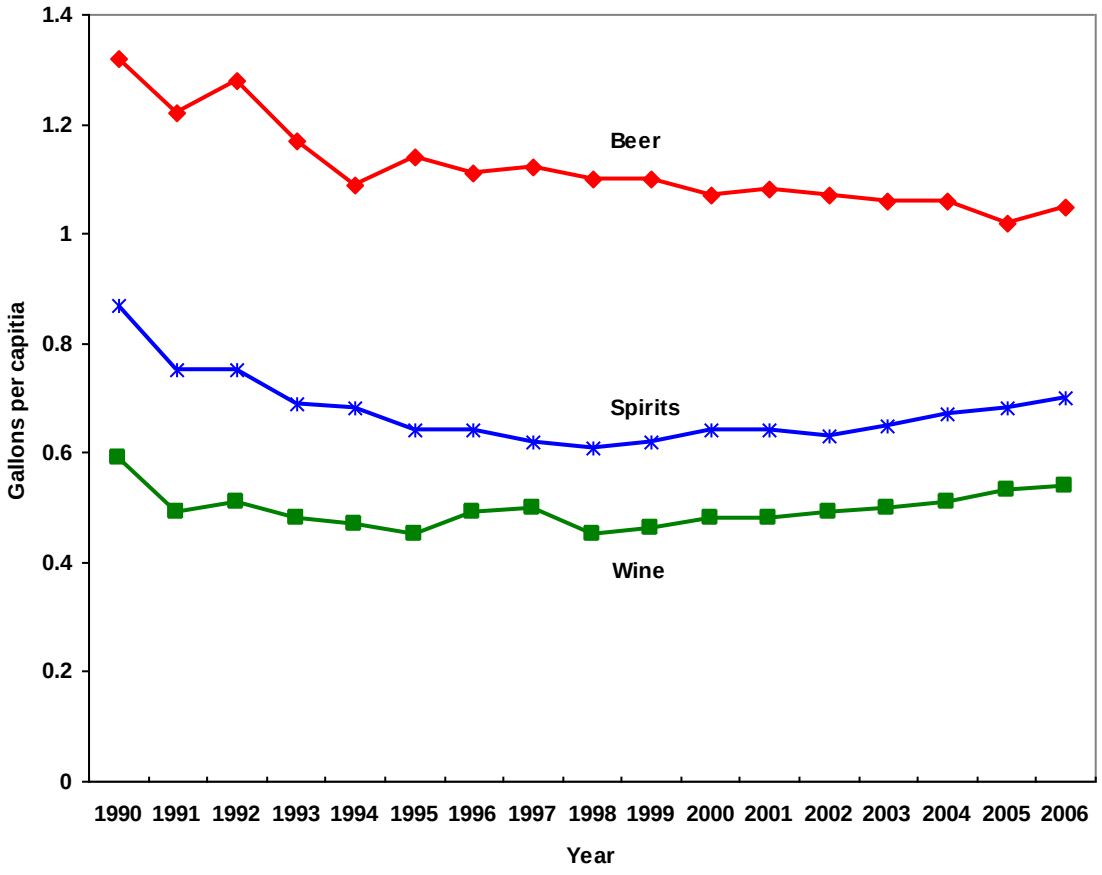
Data on sales of alcohol and tobacco products by commercial enterprises are required to be submitted to the state for tax collection purposes. Given the requirement for reporting, this information is likely to represent valid and reliable data, and provide an ongoing source for historical and trend data. As such, it represents an important source of information for ATOD assessment and planning. For example, at the county level it provides useful information on the relationship between sales and use and might assist in tracking environments and patterns of sales that can be used to better focus prevention efforts.

A. Alcohol Sales

In California, the Board of Equalization (BOE) maintains the alcohol sales and taxation data. To date these data have not been readily available or used for ATOD assessment and prevention planning. The data displayed below comes from the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Epidemiological Data System website: http://www.epidcc.samhsa.gov/.

1. National Institute on Alcohol Abuse and Alcoholism

Figure I.1 – Alcohol Sales: Per Capita Alcohol Consumption (Age 14 and Older), California, 1990-2006



Notes: Consumption estimates are based on state sales, taxations, or receipts data on gallons of ethanol.
Source: Alcohol Epidemiologic Data System, National Institute on Alcohol Abuse and Alcoholism. Retrieved from http://www.niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/AlcoholSales/.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Highlights

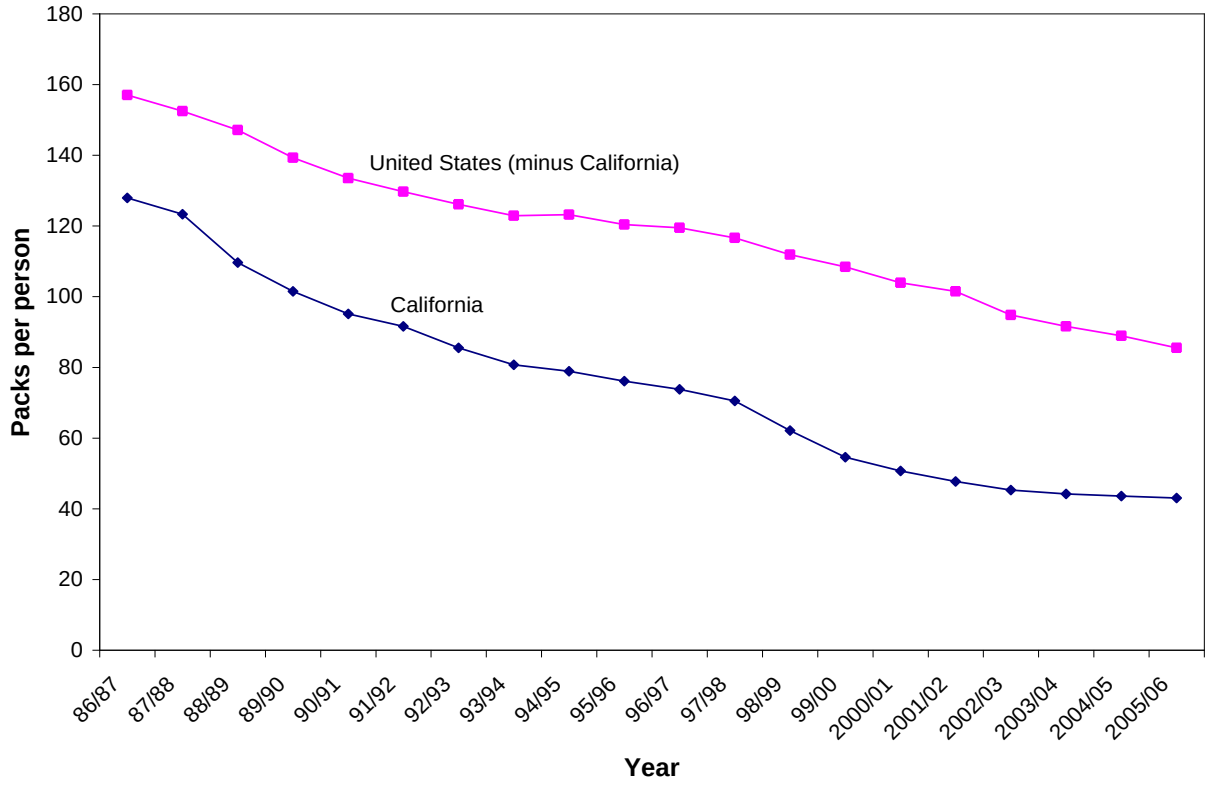
- After earlier declines, total alcohol consumption has increased slightly over the last 5 years, reaching 2.29 gallons per capita in 2006.
- Beer consumption is highest among beverage types despite a slight decline over the late decade.
- Consumption of both spirits and wine is lower than beer, but account for the recent slight increase.

B. Tobacco Sales

1. California State Board of Equalization (BOE) and United States Department of Agriculture

Despite the fact that BOE collects this data, currently there is no ongoing mechanism for public access to tobacco sales information. The data displayed were compiled by the Tobacco Control Branch, California Department of Public Health from the state BOE data and from the U.S. Department of Agriculture.

Figure I.2 - Per Capita Cigarette Pack Consumption by Adults, California and the United States, 1986-2006



Notes: Data is presented by fiscal year. United States totals are calculated minus the California totals.

Source: California Board of Equalization (packs sold) and California Department of finance (population); Tax Burden on Tobacco, United States Department of Agriculture and US Census, 1986 - 2006
Prepared by: Tobacco Control Section, California Department of Public Health (CDPH), March 2007
Adapted By: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008

Highlights

- There has been a steady drop in per capita tobacco sales to adults in both California and the nation.
- California has consistently lower per capita cigarette sales than the nation with an increasing gap since the early 1990s when California began its state-of-the-art public health prevention campaigns. California's decline appears to be leveling off since 2003.

I. Consumption of Alcohol, Tobacco, and Other Drugs

A. Youth

The youth prevalence data summarized here are divided into two sections: 1) data generated from classroom surveys about substance use by public school students; and 2) data from a population-based survey on substance use by adolescents aged 12-17. While overlapping, the methodologies and populations are not identical and thus the information generated varies by source. These data display only selected major indicators of alcohol, tobacco, and other drug use. There are more comprehensive and detailed accountings of the student and adolescent data available from the original sources.[1]

1. California Student Survey (CSS)

Substance use remains widespread among California students and, for several substances, extremely high. Although the 2007-08 findings for many substances are slightly higher than previous years, the survey authors state these findings are likely the result of changes in the way the questions were asked. These annual CSS surveys clearly indicate a very serious and ongoing public health problem with a large youth population at risk and in need of prevention and intervention programs. Together, these surveys demonstrate that for California students ATOD use begins early and increases quickly with age. Alcohol, tobacco, and marijuana continue to be the major drugs of choice among school age youth. However, the 2007-2008 survey documents that previous surveys "have significantly underestimated actual levels of high school substance use by under-assessing the level of non-medical use of "medicinal" drugs" (i.e., prescription drugs, over the counter drugs) [2].

Table II.1 – Past 30-Day Use of Tobacco, Alcohol, and Other Drugs among 7th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-08[1]
	Percentages			
TOBACCO				
Cigarettes	4.3	4.9	5.1	5.6
Smokeless Tobacco	0.8	1.6	1.8	2.8
ALCOHOL				
Alcohol Use	10.4	10.0	12.0	14.8
Binge Alcohol Use	2.9	3.7	4.6	6.4
OTHER DRUGS				
Cocaine[2]	--	--	--	--
Inhalants	2.5	3.1	4.7	5.1
Marijuana	4.0	3.9	4.7	6.6
Any Illegal Drug[3]	5.7	6.2	8.0	9.3
NO AOD[4]	86.8	87.0	84.8	82.1

[1] The 2007-08 survey expanded the number of response options for use frequency and added additional drug categories to "any drugs". The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] No question asked specifically about cocaine or methamphetamine use among 7th grade students.
[3] "Any Illegal Drug" refers to the use of cocaine, inhalants, marijuana, methamphetamines, and psychedelics.
[4] No AOD means no alcohol or other drug use, but does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

[1,2] For the California Student Survey, see http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf; California Student Tobacco Survey data, see http://www.cstats.info/; California Health Interview Survey, see http://www.askchis.org and http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=176.

Table II.2 – Lifetime Use of Tobacco, Alcohol, and Other Drugs among 7th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[1]
	Percentages			
TOBACCO				
Cigarettes (Whole)	6.9	5.8	7.5	7.1
Smokeless Tobacco	2.4	1.7	2.7	4.1
ALCOHOL[2]	21.4	16.1	17.9	24.0
OTHER DRUGS				
Cocaine[3]	2.1	2.1	2.6	--
Inhalants	6.3	6.0	7.8	11.5
Marijuana	8.5	8.3	7.9	9.4
Methamphetamines or Amphetamines[3]	1.8	2.0	2.3	--
Prescription Painkillers[4]	--	--	4.4	--
Any Illegal Drug[5]	14.3	14.1	15.9	16.9
NO AOD[6]	74.0	76.9	75.0	71.7

[1] The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] Question asks about a "full drink".
[3]The 2007-8 survey did not ask separate questions for cocaine and methamphetamines because of their low prevalence.
[4] Specific question on prescription painkiller use was only asked in the 2005-2006 survey.
[5]"Any Illegal Drug" includes "Other Drugs" listed above, plus ecstasy and psychedelics.
[6]No AOD means no alcohol or other drug use, but does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Highlights

The data from 7th grade students show:

- 82% report no alcohol or other drug use (excluding tobacco) within the past 30 days, and 72% report no lifetime use on the 2007-08 survey.
- Prevalence of alcohol use in 2007-08 is reported more than twice as often as the use of any other drug for the past 30 days (15%) and over the lifetime (24%). Over 6% report having engaged in at least one episode of binge drinking.
- Reported lifetime prevalence of alcohol rose for the first time in several years in 2007-8 but this increase may in large part be a result of changes in the way the questions were asked.
- Considering the most recent survey, marijuana is the next most commonly used substance, with nearly 7% having used marijuana within the past 30 days, and 9% reporting having ever used it.
- Tobacco and inhalants are the third and fourth most often used substances, with 6% and 5% respectively reporting having used each within the past 30 days, and 7% and nearly 12% reporting having ever used tobacco and inhalants.
- Overall lifetime use of illegal drugs is reported by 17% of 7th grade students, continuing the increase noted in the 2005-6 survey and nearly reaching the percentage reported for 9th graders. The noted methodological changes might account for this year's increase, but the two years of increase raise concerns that this might represent a true increase.
- The 2005-6 results highlighted the significant appearance of the non-medical use of prescription painkillers even among 7th graders at 4.4%.

Table II.3 – Past 30-Day Use of Tobacco, Alcohol, and Other Drugs among 9th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[1]
	Percentages			
TOBACCO				
Cigarettes	11.1	10.2	10.0	11.1
Smokeless Tobacco	1.4	1.7	2.7	5.3
ALCOHOL				
Alcohol Use	29.3	24.7	23.8	27.3
Binge Alcohol Use	13.4	11.5	11.5	15.8
OTHER DRUGS				
Cocaine	1.6	2.7	2.6	3.1
Inhalants	3.5	4.2	4.9	7.0
Marijuana	13.4	12.4	12.6	15.4
Methamphetamine or Amphetamine	1.6	2.5	2.7	3.9
Any Illegal Drug[2]	15.7	14.0	15.3	17.8
NO AOD[3]	67.4	71.3	71.7	67.6

[1] The 2007-08 survey expanded the number of response options for use frequency and added additional drug categories to "any drugs". The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] "Any Illegal Drug" refers to the use of cocaine, inhalants, marijuana, methamphetamines, and psychedelics.
[3] No AOD means no alcohol or other drug use, but does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Table II.4 – Lifetime Use of Tobacco, Alcohol, and Other Drugs among 9th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[1]
	Percentages			
TOBACCO				
Cigarettes (Whole)	20.7	18.2	16.0	20.4
Smokeless Tobacco	4.8	4.4	5.2	6.1
ALCOHOL[2]	48.2	42.0	40.9	47.4
OTHER DRUGS				
Cocaine	3.9	4.0	4.1	4.9
Inhalants	9.4	8.7	10.2	14.1
Marijuana	24.1	22.8	22.3	24.6
Methamphetamines or Amphetamines	3.4	3.5	3.5	4.9
Prescription Painkillers[3]	--	--	9.1	11.6
Any Pills or Medicine[4]	--	--	--	31.4
Any Illegal Drug[4]	30.7	27.2	30.0	31.3
NO AOD[5]	47.9	52.9	52.7	51.6

[1] The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] Question asks about a "full drink".
[3] Questions specifically about use of prescription painkillers was not asked until the 2005-2006 survey.
[4] In 2007-08, questions on use of "medicinal" drugs, including prescription and over-the-counter medicine were added.
[5]"Any Illegal Drug" includes "Other Drugs" listed above, plus ecstasy and psychedelics.
[6]No AOD means no alcohol or other drug use and does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Highlights

The data from 9th grade students show:

- Alcohol remains the major drug of use among 9th grade students, with over one in four (27%) reporting past 30 day use, with reported binge drinking in the past 30 days spiking to 16%! Nearly half of all 9th graders (47%) report having ever drunk alcohol.
- Marijuana and cigarettes are the second and third substance used most often within the past 30 days, with reported use prevalence of 15% and 11%, respectively. One quarter and one fifth of students report having ever used marijuana, and having ever smoked cigarettes, respectively.
- 7% of students have used inhalants within the past 30 days, and 14% report having used over their lifetime.
- Lifetime use of painkillers without a prescription showed an increase from 9% in the 2005-6 survey to nearly 12% in the 2007-8 survey.
- In 2007-8, questions on the use of "medicinal" drugs were added to better capture the non-medical use of prescription and over-the-counter drugs, an area under-assessed by most state and national survey until recently. Nearly one third of all 9th graders reported such use, reflecting a major under-recognized problem!

Table II.5 – Past 30-Day Use of Tobacco, Alcohol, and Other Drugs among 11th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[1]
	Percentages			
TOBACCO				
Cigarettes	18.9	14.8	15.2	17.4
Smokeless Tobacco	2.8	2.8	3.2	6.3
ALCOHOL				
Alcohol Use	40.7	37.1	35.8	41.9
Binge Alcohol Use	26.2	23.3	21.4	29.0
OTHER DRUGS				
Cocaine	4.0	4.8	3.9	4.0
Inhalants	4.0	4.6	3.8	7.1
Marijuana	23.0	19.8	19.2	23.9
Methamphetamine or Amphetamine	5.0	5.0	3.9	4.7
Any Illegal Drug[2]	24.6	22.8	22.4	26.2
NO AOD[3]	55.6	56.8	57.8	53.7

[1] The 2007-08 survey expanded the number of response options for use frequency and added additional drug categories to "any drugs". The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] "Any Illegal Drug" refers to the use of cocaine, inhalants, marijuana, methamphetamines, and psychedelics.
[3] No AOD means no alcohol or other drug use, but does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Table II.6 – Lifetime Use of Tobacco, Alcohol, and Other Drugs among 11th Graders, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[1]
	Percentages			
TOBACCO				
Cigarettes (Whole)	35.7	28.2	28.0	33.6
Smokeless Tobacco	8.6	8.0	8.3	10.1
ALCOHOL[2]	65.3	63.2	61.9	66.4
OTHER DRUGS				
Cocaine	9.2	7.6	7.3	10.4
Inhalants	12.6	8.9	9.5	15.2
Marijuana	44.0	38.7	38.2	41.6
Methamphetamines or Amphetamines	9.0	7.6	7.0	7.2
Prescription Painkillers[3]	--	--	15.1	17.6
Any Pill or Medicine[4]	--	--	--	34.8
Any Illegal Drug[5]	47.4	42.7	45.0	45.6
NO AOD[6]	31.6	33.1	32.8	31.5

[1] The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.
[2] Question asks about a "full drink".
[3] Questions specifically about use of prescription painkillers was not asked until the 2005-2006 survey.
[4] In 2007-08, questions on use of "medicinal" drugs, including prescription and over-the-counter medicine were added.
[5] "Any Illegal Drug" includes "Other Drugs" listed above, plus ecstasy and psychedelics.
[6] No AOD means no alcohol or other drug use and does not include tobacco.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Highlights

The data from 11th grade students show:

- Alcohol remains the number one substance used, with 42% of students reporting drinking and 29% binge drinking within the past 30 days in the 2007-08 survey. By 11th grade, two-thirds (66%) report having drank alcohol in their lifetime.

- Marijuana and cigarettes are the second and third most consumed substances:
  - 42% have ever smoked marijuana, with 24% using in the last 30 days.
  - 34% have smoked cigarettes at least once, and 17% are current smokers within the last 30 days.

- The regular use of other substances - inhalants, smokeless tobacco, amphetamines, and cocaine - appears to be substantially lower compared to the major youth substances. However, use of the illegal drugs may reflect a more "high risk" and "poly-drug" user who is already, or may soon be, experiencing significant drug-related problems.

- A major emerging problem warranting special attention is the finding that nearly 18% of students report having used prescription painkillers (e.g., OxyContin, Vicodin, and Percodan) without a medical reason.

- In 2007-8, questions were added on the non-medical use of "medicinal" drugs (i.e., prescription and over-the-counter drugs). Nearly 35% of all 11th graders reported such use, further highlighting this under-assessed and major emerging problem!

Table II.7 – High Risk Users[1] (HRU) and Excessive Alcohol Users[2] (EAU): Grades 7, 9, and 11, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008[3]
	Percentages			
GRADE 7				
HRU	2.8	3.2	4.3	3.0
EAU	2.9	4.4	5.5	5.6
Total EAU and/or HRU	4.4	6.2	7.4	6.4
GRADE 9				
HRU	10.4	9.3	10.9	8.3
EAU	17.1	14.3	13.7	17.5
Total EAU and/or HRU	20.0	17.4	17.2	19.2
GRADE 11				
HRU	21.3	17.3	17.3	16.8
EAU	32.4	29.9	27.4	29.2
Total EAU and/or HRU	35.7	33.6	32.2	33.4

[1] Inclusion based solely on engaging in any of the following behavior over the past six months: Cocaine use in any form (including crack); Frequent poly drug use (three or more times); Regular marijuana use (weekly or more frequent); or a pattern of use of numerous other illicit drugs besides cocaine or marijuana, or of high frequencies of use of individual drugs; and alcohol use at least once as a control.
[2] Inclusion based on reporting any of the following behaviors: Drank five drinks in a row three days in the past 30-Days; or Was very drunk or sick three or more times in lifetime; or Likes to drink to get drunk or feel the effects a lot.
[3] The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.

Source: California Student Survey, 2001-08, California Attorney General's Office, Retrieved from http://www.safestate.org/documents/CSS_12th_Compendium_Tables.pdf, February 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2009.

Highlights

- Students documented to be high-risk users are represented at significant levels at all grade levels.
- Over 6% of 7th graders, 19% of 9th graders and a third (33%) of 11th graders are either High Risk Users and/or Excessive Alcohol Users.
- No clear trend patterns are apparent over the four survey years for any of the grade levels.

Overview of CSS Findings for All Grades:

Substance use is wide spread among California students. By 11th grade, less than a third of students report having never used one or more substances (excluding tobacco) during their relatively short lifetimes. When considering all grades, the overall percentage of students who report having never used drugs reflects a generally worsening condition from 2001-02 to 2007-08.

The 2007-08 data clearly suggest that underage drinking continues to be an integrated part of California student and adult cultures, with drinking being extremely common among school-age adolescents. Across all grades, alcohol is reported to be the most commonly used substance on both 30 day and lifetime measures, and binge drinking remains a continuing and significant problem. Nearly twice as many students consistently report use of alcohol compared to any other drug across all grades, with reported lifetime alcohol use nearly tripling from 7th to 11th grade (24%, 47%, and 66%, respectively). There is also a nearly five-fold increase in binge drinking among California students from the 7th to the 11th grade (6%, 16%, and 29%, respectively).

Students' use of marijuana and tobacco are the next most consumed substances. Reported 30-day marijuana use nearly quadrupled between the 7th (7%) and 11th (24%) grades. Cigarette smoking triples. Lifetime marijuana and tobacco use also more than quadruples, from 9% to 42%, and 7% to 34%, respectively.

The reported non-medical use of prescription painkillers and over-the-counter drugs has become a significant emerging problem, an area under-assessed by most state and national survey until recently. Lifetime use of painkillers without a prescription showed a 3% increase from the 2005-06 survey to the 2007-08 survey for both 9th graders, from 9% to 12%, and 11th graders, from 15% to 18%. In 2007-8, additional questions on the use of other "medicinal" drugs were used to better capture the non-medical use of prescription and over-the-counter drugs. Nearly one third of all 9th graders and 35% of 11th graders reported such use, reflecting a major growing problem!

Together, these data demonstrate that for a significant portion of California students ATOD use begins early, and the percentage reporting substance use increases significantly in the later grades. Alcohol, tobacco, and marijuana continue to be the major drugs of choice among school age youth, with the non-medical use of prescription painkillers and over-the-counter drugs becoming a growing, significant new concern.

The authors of the CSS suggest caution in interpreting the apparent 2007-08 increases in student drug use. They point to changes in the number of response options offered students for many drug categories which produced increased reports of use compared to six month estimates that used the same responses category as previous surveys. However, results from the last two surveys do not suggest any consistent signs of decline in student drug use, and for some categories (e.g., overall illegal drug use) there is evidence of a potential increase.

2. California Student Tobacco Survey (CSTS)

The CSTS assesses smoking prevalence among students in grades 6 through 12, including daily smoking, current smoking (past 30 days), and lifetime use. Data from grades 9-12 are presented here. With a large sample size, and large number of tobacco-related questions, it provides detailed information on smoking behavior and allows for demographic breakdowns.

Table II.8 – Past 30-Day Tobacco Use Among Students in Grades 9-12, California, 2002 – 2008

	2002	2004	2006	2008
	Percentages			
GRADE				
9th	10.4	9.3	11.2	10.5
10th	14.8	13.1	14.9	13.2
11th	17.6	14.5	17.2	15.8
12th	22.9	17.1	19.7	20.7
GENDER				
Male	16.2	14.4	17.1	12.3
Female	15.7	11.9	13.7	16.8
RACE				
African American	8.2	7.2	12.7	11.7
Asian/Pacific Islander	13.6	8.4	10.7	10.5
White	19.9	15.8	18.3	17.6
ETHNICITY				
Hispanic/Latino	14.0	13.5	14.3	13.9
TOTAL	16.0	13.2	15.4	14.6

Source: California Student Tobacco Survey, 2002, 2004, 2006, and 2008 Tobacco Control Section, California Department of Public Health (CDPH).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Highlights

- The overall 30-day smoking prevalence rate for 9-12th graders in 2008 is 14.6%, with students in higher grades, females, and whites having higher than average rates.
- The percentages of current smokers in 9th and 11th grades reported in the CSTS are slightly lower than the percents reported in the CSS (10.5% versus 11.1%; 15.8% versus 17.4%, respectively) for 2008.
- No clear patterns over time or within variables are apparent, for example with higher rates in 2002 and 2006, and lower rates in 2004 and 2008.
- Although the rate for African American students is lower than average, the increase since 2002 is dramatic - a six year increase of 40% between 2002 and 2008 (from 8.2% to 11.7%)—the highest increase recorded.

3. California Health Interview Survey – CHIS (Adolescents)

The California Health Interview Survey (CHIS) provides a relatively new source of state and local data on substance use among a representative sample of California adolescents 12-17 years old (including non-students) surveyed biannually four times (2001,2003, 2005 and 2007).

CHIS uses a well-established, reliable, and scientifically valid random-digit-dial (RDD) telephone methodology to produce a representative sample of California's non-institutionalized population. While the CHIS utilizes a large and representative adult sample, the adolescent sample is relatively small (N=~4,000), similar to the BRFSS adult sample. Additionally, while CHIS is the largest statewide health survey, and one of the largest conducted in the US, it currently includes only a few ATOD questions. The AskCHIS query system is easy to use and allows users to customize their data tables to look at age, gender and race/ethnicity breakdowns. The consumption data presented in the following two tables emphasize the magnitude of consumption and the relative standing among substances.

Table II.9 –Tobacco, Alcohol, and Other Drug Use among Adolescents 12 – 17 Years of Age, California, 2003, 2005 and 2007

	2003	2005	2007
TOBACCO			
Current Smoking Status, Cigarettes[1]	5.8%	6.5%	4.8%
ALCOHOL			
Binge Alcohol Use, Past Month[2]	6.3%	7.0%	4.8%
OTHER DRUGS			
Marijuana, Past Month	5.9%	5.2%	4.6%

[1] Cigarette use means individual smokes regularly.

[2] Binge is defined as consuming five or more drinks at one sitting.

Source: California Health Interview Survey, 2001-07, UCLA Center for Health Policy Research. Retrieved from www.ASKCHIS.org March 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, March 2009.

Table II.10 –Lifetime Use of Alcohol and Other Drugs among Adolescents 12 - 17 Years of Age, California, 2003, 2005 and 2007

	2003	2005	2007
ALCOHOL			
Ever Drank	37.2%	35.5%	34.3%
OTHER DRUGS			
Marijuana, cocaine, sniffing glue, or other drugs	13.5%	13.4%	10.8%

Source: California Health Interview Survey, 2001-07, UCLA Center for Health Policy Research. Retrieved from www.ASKCHIS.org March 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

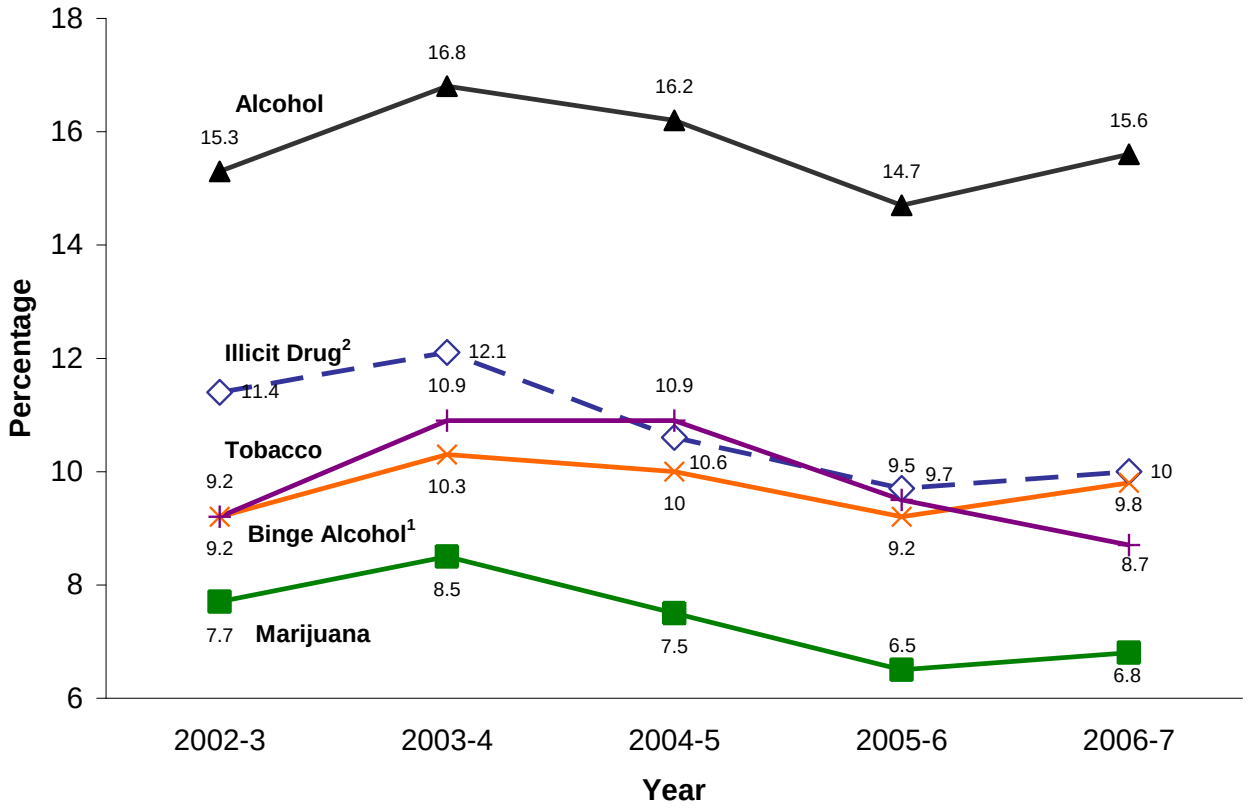
Highlights

- Because of differences in methodology and the presentation of adolescent data only in aggregate (12-17 years of age), the results are not directly comparable to the CSS or CSTS.
- More than a third of adolescents report having drank alcohol during their lifetime, and 5-7% report recent binge drinking. Lifetime alcohol use was more than three times as high as the use of other illegal substances.
- 11% of adolescents report having used substances other than cigarettes and alcohol in their lifetime.
- All substances queried showed slight declines over the three surveys.

4. National Survey of Drug Use and Health – NSDUH (Adolescents)

The NSDUH provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use among a representative sample of civilian, non-institutionalized persons aged 12 or older. Although not presented, NSDUH allows for direct state comparisons with the national sample.

Table II.11 – Selected Measures of Alcohol, Tobacco, and Other Drug Use in the Past Month, Age 12-17, California 2002-2006



[1] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30-Days.
[2] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Source: National Survey on Drug Use and Health, 2002-2007, Office of Applied Studies, Substance Abuse and Mental Health Service Administration. Retrieved June 2009 from http://www.oas.samhsa.gov/states.cfm.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Highlights

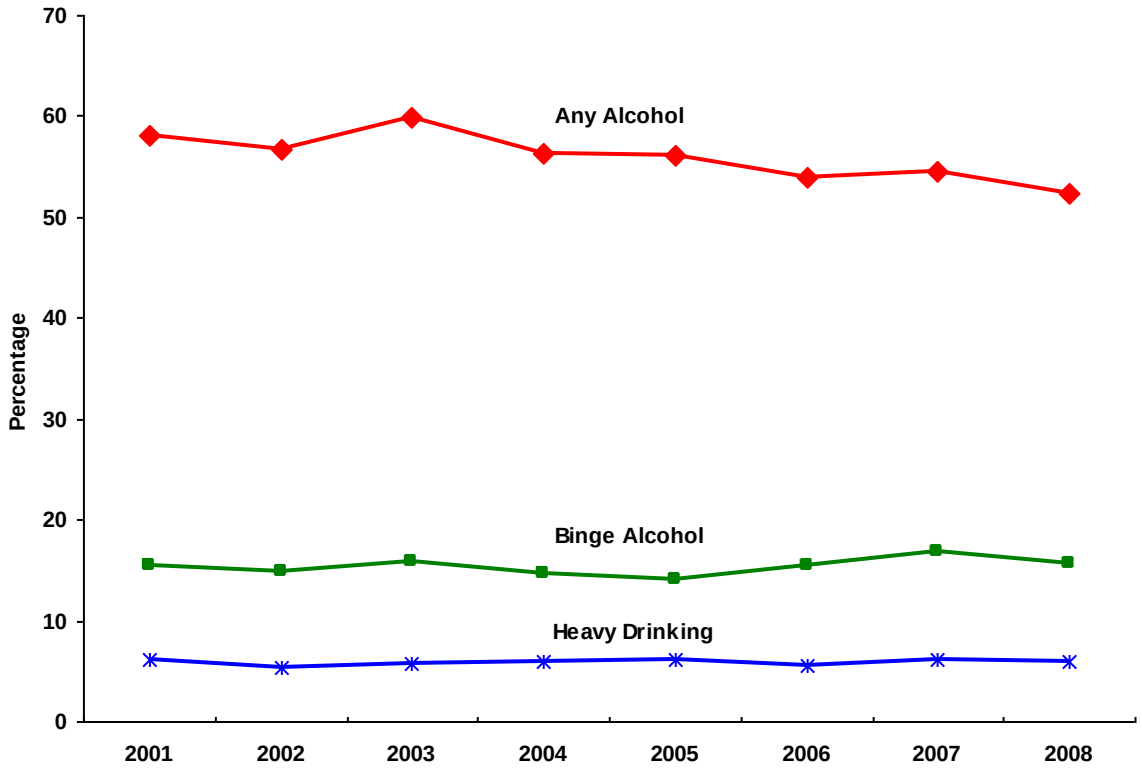
- Alcohol remains the most commonly reported substance, with about 15% of the adolescent population reporting having consumed alcohol within the past month.
- After a fairly steady decrease, the percentages of adolescents who report substance use increased slightly in 2006-7 for the three major substances: alcohol, binge drinking and marijuana.

B. Adults

1. Behavior Risk Factor Surveillance System (BRFSS)

The BRFSS is an on-going telephone health survey system tracking health conditions and risk behaviors throughout the U. S. yearly since 1984. State health departments manage the BRFSS field operations following the Centers for Disease Control and Prevention (CDC) guidelines. State level data is available at both the CDC and state web sites. BRFSS generates state-specific representative ATOD data.

Figure II.12 – Past 30-Day Alcohol Use among Adults, California, 2001-2008



Source: Behavioral Risk Factor Surveillance Survey, Centers for Disease Control and Prevention, 2001- 2008. Retrieved from http://apps.nccd.cdc.gov/brfss/, June 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Table II.13 – Selected Alcohol and Tobacco Consumption Indicators, California Compared with United States, 2007

Indicators	California	United States[1]
Binge drinking among adults aged 18+ years	16.9 %	15.8 %
Binge drinking among women of childbearing age (18-44)	13.4 %	14.6 %
Heavy drinking among adult females 18+ years	5.7 %	4 %
Heavy drinking among adult males aged 18+ years	6.5 %	6.1 %
Cigarette smoking among adults aged 18+ years	14.3 %	19.8 %

[1] Median percentage

Source: Behavioral Risk Factor Surveillance Survey, Chronic Disease Indicators: State Profile, Centers for Disease Control and Prevention, 2007. Retrieved from http://apps.nccd.cdc.gov/cdi/ March 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

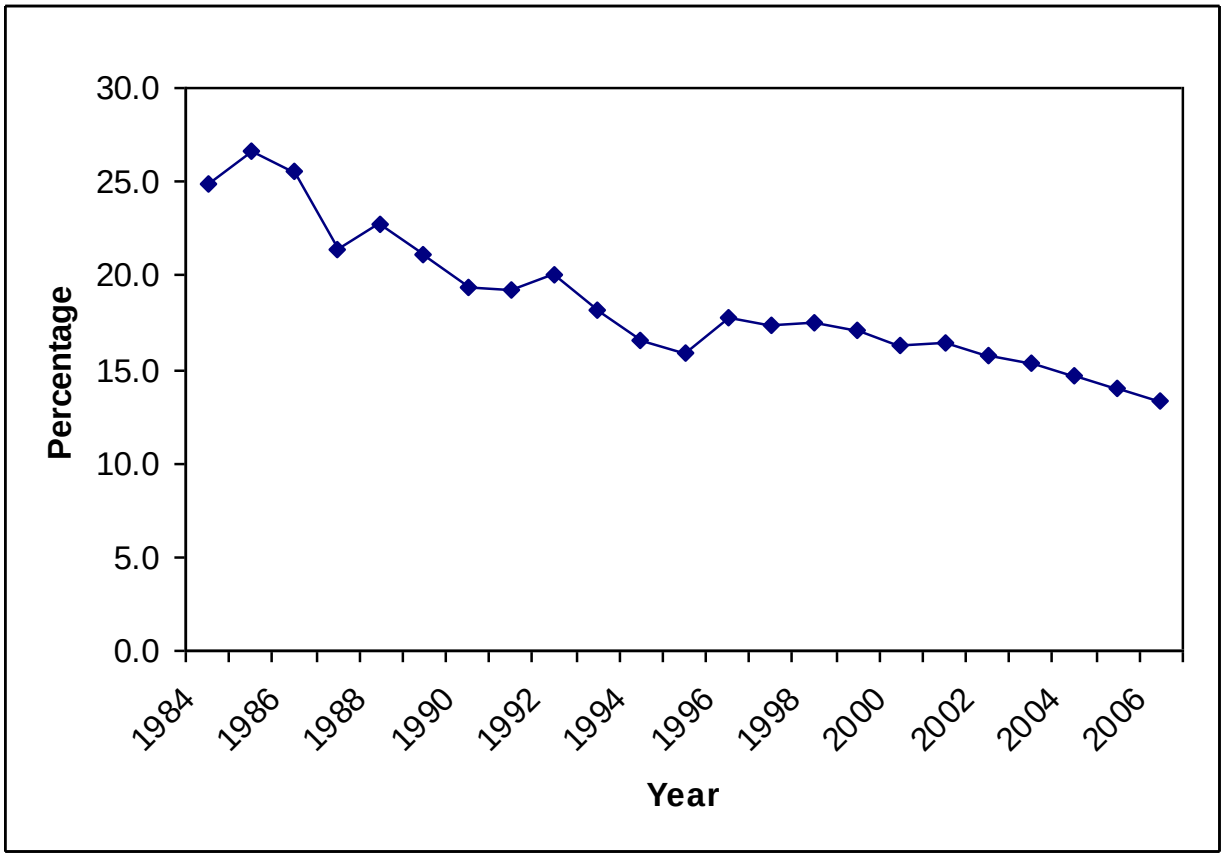
Highlights

- Among California adults (18+ years old), 54% drank alcohol in the past 30 days, a decrease since a high of 60% in 2003.
- Binge and heavy drinking continue to hold steady over time at around 15% and 6% of adults, respectively.
- Compared to the nation, California adults have a lower percentage of cigarette smoking, and lower binge drinking rates for women of childbearing age.
- California adults have higher rates of binge drinking and heavy drinking than the US median percentage.

2. California Behavioral Risk Factor Survey and California Adult Tobacco Survey

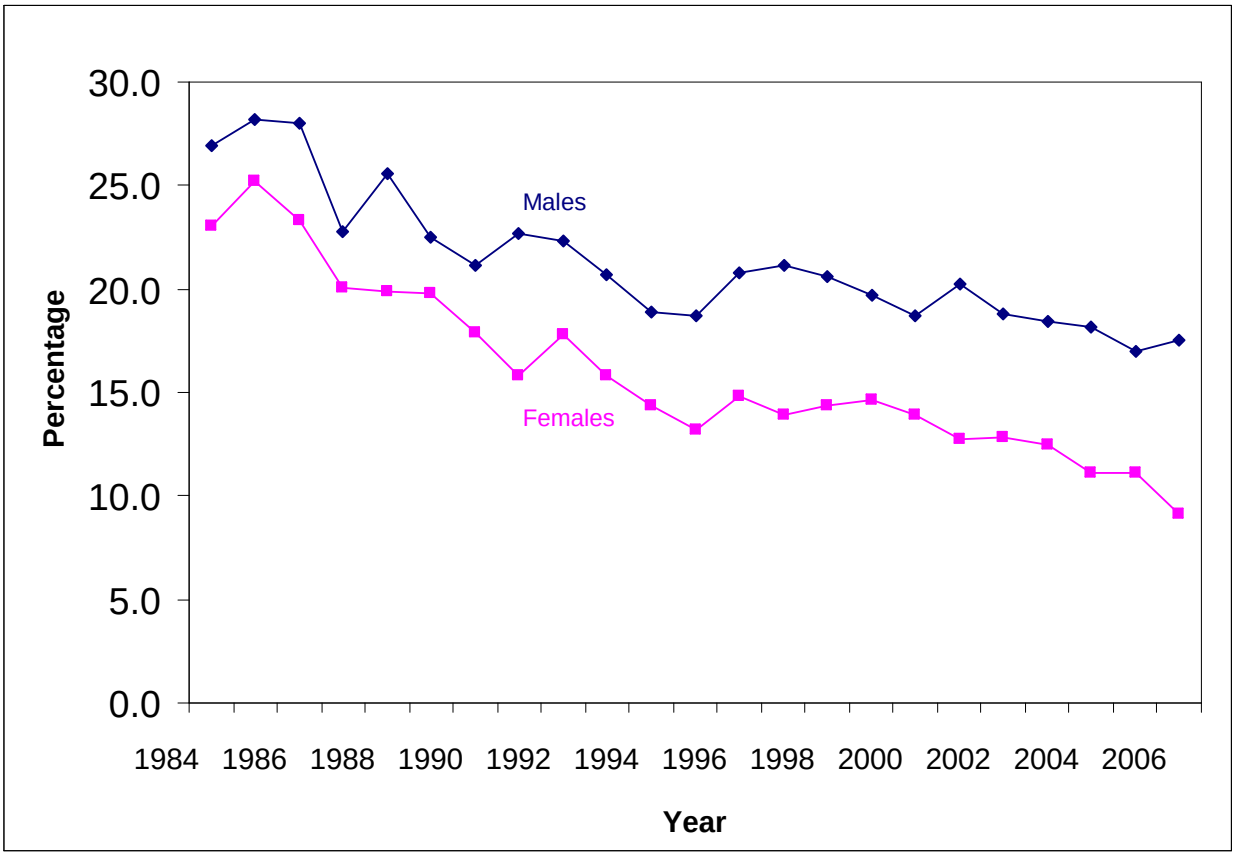
Both the California Behavioral Risk Factor Survey (BRFS) and the California Adult Tobacco Survey (CATS) are conducted by the Survey Research Group (SRG) of the California Department of Public Health's (CDPH) Cancer Surveillance Section. BRFS is part of the national Behavioral Risk Factor Surveillance System (BRFSS). The Tobacco Control Branch of CDPH has combined these data sources to produce the following three trend charts on smoking prevalence rates over a 20 year time period.

Figure II.14 – Smoking Prevalence among Adults, California, 1984-2006



Note: Change of smoking definition in 1996 that included more occasional smokers.
Source: Behavioral Risk Factor Surveillance Survey (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data are combined for 1993-2006. The data are weighted to the 2000 California population.
Prepared by: Tobacco Control Section, California Department of Public Health (CDPH), March 2007.
Adapted by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

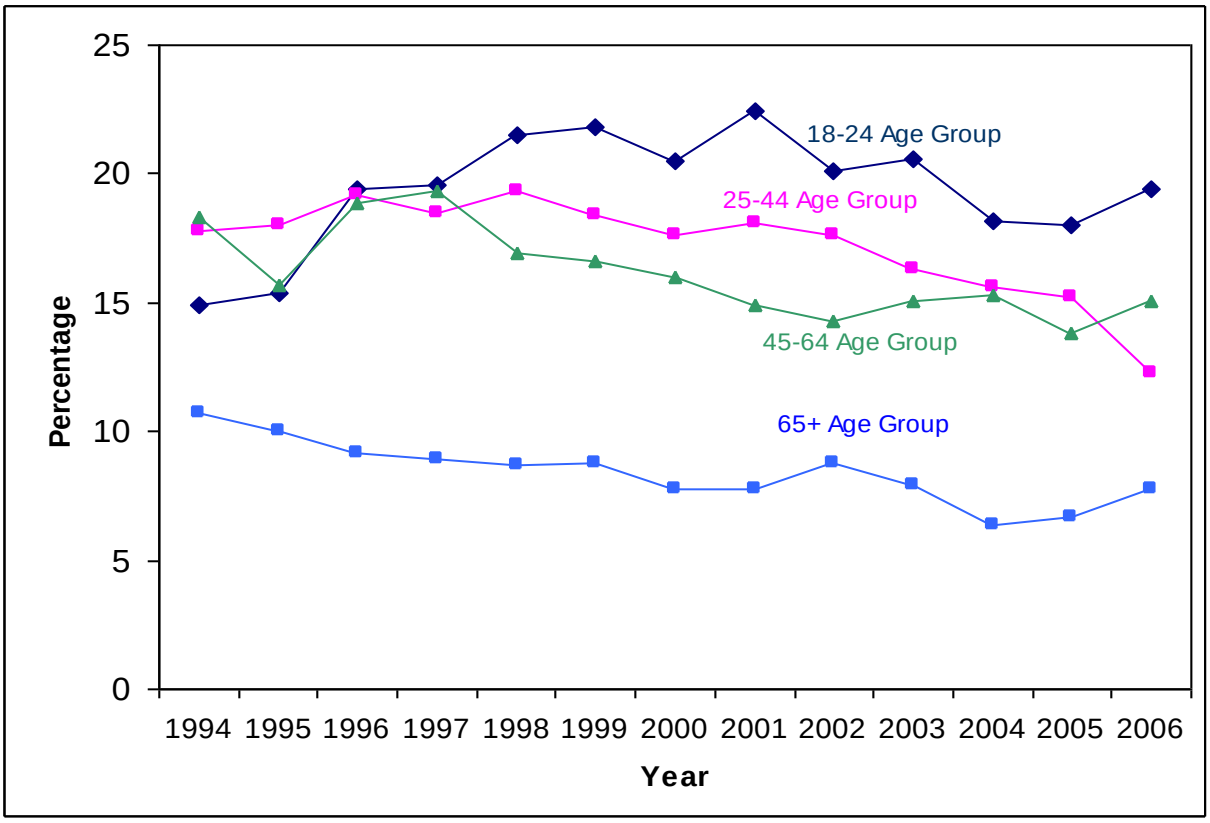
Figure II.15 – Smoking Prevalence among Adults by Gender, California, 1984-2006



Note: Change of smoking definition in 1996 that included more occasional smokers.

Source: Behavioral Risk Factor Surveillance Survey (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data are combined for 1993-2006. The data are weighted to the 2000 California population.
Prepared by: Tobacco Control Section, California Department of Public Health (CDPH), March 2007.
Adapted by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

Figure II.16 – Smoking Prevalence among Adults by Age Group, California, 1994-2006



Note: Change of smoking definition in 1996 that included more occasional smokers.

Source: Behavioral Risk Factor Surveillance Survey (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data are combined for 1993-2006. The data are weighted to the 2000 California population.
Prepared by: Tobacco Control Section, California Department of Public Health (CDPH), March 2007.
Adapted by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

Highlights

- Among California adults (18+ years old), smoking rates have been dropping consistently since 1986.
- Males smoke at consistently higher rates than females and their drop has been less steep.
- The highest rates are among the 18-24 age group.
- The steepest declines in smoking percentages since 1996 are among the 25-44 and 45-64 age groups. However, the youngest and oldest adult age groups have not shown consistent declines during the same time period.

3. California Health Interview Survey—CHIS (Adults)

The CHIS uses a well-established, reliable, and scientifically valid random-digit-dial (RDD) telephone methodology to produce a representative sample of California's non-institutionalized population. CHIS' large sample size allows for state and county-level level estimates for adults, in addition to age (within 3 year range), gender, and race/ethnicity breakdowns within county, and across counties and regions. However, the limited number and inconsistency of questions across years reduces the value of CHIS data for ATOD surveillance purposes.

Table II.17 – Tobacco and Alcohol Use among Adults, California, 2003, 2005 and 2007

	2003	2005	2007
TOBACCO			
Current Smoking Status, Cigarettes[1]	16.5%	15.2%	14.4%
ALCOHOL			
Ever Drank	57.4%	60.3%	--[3]
Binge Alcohol Use, Past Month[2]	15.1%	17.6%	--[4]

[1] Cigarette use means individual smokes regularly.
[2] Binge is defined as consuming five or more drinks at one sitting.
[3] CHIS question in 2007 for adults not available through AskCHIS.org
4 CHIS question in 2007 for adults was Binge Drinking in the Past Year – 29.7%

Source: California Health Interview Survey, 2001-07, UCLA Center for Health Policy Research. Retrieved from www.ASKCHIS.org March 2009.
Prepared by: Epidemiology and Prevention for Injury Control Branch, California Department of Public Health, March 2009.

Highlights

- CHIS produces similar estimates for cigarette smoking, lifetime drinking prevalence, and binge drinking as BRFSS.
- Cigarette smoking prevalence continued to decline over the three survey periods to less than 15% in 2007.
- About 60% of adults report having ever drunk alcohol.
- The adult binge drinking percentage increased from 15% in 2003 to nearly 18% in 2005.

4. California Tobacco Survey (CTS)

The California Tobacco Survey (CTS) provides representative statewide data from adults 18+ on cigarette smoking behavior, attitudes toward smoking, media exposure to smoking, and use of tobacco products other than cigarettes. Although only administered once every three years, this survey allows for state, regional and county-level estimates due to the large sample.

Table II.18 – Past 30-Day Use of Tobacco among Adults by Age, Gender, Race, and Ethnicity, 1999, 2002, and 2005

	1999	2002	2005
AGE			
18 – 24	19.9	18.0	14.2
25 – 44	19.6	18.1	16.9
45 – 64	17.4	16.4	13.5
65 +	9.2	7.6	7.2
GENDER			
Male	20.6	19.5	17.1
Female	14.8	13.0	11.6
RACE			
African American	19.2	19.0	19.2
Asian/Pacific Islander	13.3	12.1	10.1
White	19.1	17.3	15.3
ETHNICITY			
Hispanic/Latino	14.7	13.4	12.0
TOTAL	17.6	16.2	14.3

Source: California Tobacco Survey, Tobacco Control Section, California Department of Public Health (CDPH).
Prepared by: Epidemiology and Prevention for Injury Control Branch, CDPH, February 2008.

Highlights

- Overall, adult smoking prevalence has dropped steadily over the past three surveys among nearly all age, gender, and race-ethnicity groups. In 2005, 14.3% of Californians smoked, compared to 17.6% in 1999, nearly a 20% decrease over the six year period (continuing the trend started with the implementation of the California Tobacco Health Protection Act of 1988, also known as Proposition 99.
- Surprisingly, however, prevalence rates for African Americans have remained virtually unchanged since 1999, at 19%, and now African Americans have the highest prevalence rate among all sub-groups.
- Smoking rates among Asians/Pacific Islanders and Whites have dropped substantially from 1999 to 2005: about 24%, and 20%, respectively.
- In 2005, males (17.1%), those between 25-44 years old (16.9%), and Whites (15.3%) are also higher that the statewide average rate.

5. California Women's Health Survey (CWHS)

The California Women's Health Survey (CWHS) is an annual statewide household-based telephone survey that collects information from a sample of approximately 4,000 randomly selected adult women on a wide variety of health indicators, including health related behaviors and attitudes. The CWHS was started in 1997 and was the first California survey specifically created to ask about women's health. Regrettably, it includes very few questions about alcohol and drug use.

Table II.19 – Past 30-Day Use of Alcohol[1] among Women by Age, Race, and Ethnicity, California, 2005-2006

	2005	2006
AGE		
18 – 24	50.3%	42.6%
25 – 34	49.1%	46.7%
35 – 44	56.6%	53.7%
45 – 54	54.7%	53.2%
55 – 64	52.1%	48.0%
65 +	47.6%	44.3%
RACE		
African American	40.8%	40.6%
Asian/Other	42.0%	36.2%
White	63.8%	61.5%
ETHNICITY		
Hispanic/Latina	35.9%	31.0%
TOTAL	52.0%	48.6%

[1] Weighted prevalence estimate of women reporting any drinking in past month. Data are weighted according to the 2000 Census for California women age 18 and older.

Source: California Women's Health Surveys, 2005-2006. Special data run by Maternal, Child, Adolescent Health Program's Surveillance and Program Evaluation Section, California Department of Public Health (CDPH) received February 2008.
Prepared by: Epidemiology and Prevention for Injury Control Branch, CDPH, February 2008.

Highlights

- In 2006, 49% of women reported drinking alcohol during the past 30 days, a slight decrease from 2005.
- Whites, and those between 35-54 years of age, reported drinking more often than the statewide average. Women 18-24, and Asian/Other women, reported drinking less often than the statewide average.
- Hispanic/Latina women report drinking less than non-Hispanic/Latino women.
- All other age, race and ethnicity groups had lower than the statewide average percentages for past 30-day drinking.

Table II.20 – Current Use[1] [2] of Tobacco Among Women by Age, Race, and Ethnicity, California, 2006

	2006
Age	
18 – 24	17.5%
25 – 34	9.8%
35 – 44	12.6%
45 – 54	13.8%
55 – 64	13.4%
65 +	9.1%
Race	
African American	15.2%
Asian/Other	12.9%
White	14.2%
Ethnicity	
Hispanic/Latina	8.0%
TOTAL	12.4%

[1]Weighted prevalence estimate of women reporting any smoking in past month. Data are weighted according to the 2000 Census for California women age 18 and older.
[2]Prevalence estimates were created by combining the results of two questions: "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes everyday, some days…?"

Source: 2006 California Women's Health Survey. Special data run by Maternal, Child, Adolescent Health Program's Surveillance and Program Evaluation Section, California Department of Public Health (CDPH) received February 2008
Prepared by: Epidemiology and Prevention for Injury Control, CDPH, February 2008.

Highlights

- Similar to the 2005 results of the California Tobacco Survey, in 2006 about 12% of California women reported smoking cigarettes within the past 30 days.
- The highest percentages of smokers were reported among the youngest age groups (18-24), African Americans, and Whites, while the lowest percentages of female smokers were found among Hispanics/Latinas and the oldest age group (65+).
- The high percentages among the youngest age groups and African American women suggest an important target group for current interventions.

6. Maternal Infant Health Assessment Survey (MIHA)

The Maternal Infant Health Assessment (MIHA) is an annual, population-based self-administered survey of about 3,500 women randomly chosen who are at least 15 years old and recently gave birth to a live infant in California. MIHA asks women to report on their behaviors and experiences that occur before, during, and after pregnancy, and is modeled after the Centers for Disease Control and Prevention's Pregnancy Risk Assessment Monitoring System (PRAMS). As with the CWHS, MIHA does not include many questions about substance use.

Table II.21 – Percentage of Adult Women[1] Giving Birth Who Reported Drinking During Pregnancy by Age, Race, and Ethnicity, California, 2005-2006

	2005	2006
AGE		
18 – 19	10.8%	8.1%
20 – 34	17.5%	15.1%
35 +	20.1%	23.6%
RACE[2]		
African American	15.5%	16.3%
Asian/Pacific Islander	9.4%	14.9%
White	28.6%	28.3%
Other	28.6%	20.5%
ETHNICITY[2]		
Hispanic/Latina	10.9%	8.2%
TOTAL[2,3]	17.3%	15.8%

[1] Percentages represent the proportion of women who report drinking in either the 1st and/or 3rd trimester.
[2] The estimates for race and ethnicity include data for the small group of women who participated in the survey younger than 18 years old.
[3] Survey response data are weighted to the California population of women who gave birth in 2005 and 2006, respectively

Source: Maternal Infant Health Assessment (MIHA) Surveys, 2005 and 2006. Special data run by Maternal, Child, Adolescent Health Program's Surveillance and Program Evaluation Section, California Department of Public Health (CDPH) received February 2008.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

Highlights

- Almost 16% of women reported drinking alcohol during their pregnancy in 2006. This is a slight decrease from 2005.
- Whites reported substantially higher rates (28.3%) of drinking during pregnancy when compared to others, as did women 35 and older. Women 18-19 years old reported substantially lower levels of drinking, especially when compared to older women.
- When compared to the other race-ethnic groups, Latinas and Asian/Pacific Islander women reported the lowest rates of drinking during pregnancy, while White (non-Hispanic) women reported the highest rates.

Table II.22 – Percentage of Women Giving Birth Who Reported Smoking During Pregnancy by Age, Race, and Ethnicity, California, 2005-2006

	2005	2006
AGE		
18 – 19	13.9%	9.7%
20 – 34	10.2%	7.8%
35 +	5.3%	7.5%
RACE[2]		
African American	13.6%	9.5%
Asian/Pacific Islander	n/a	n/a
White	16.5%	12.3%
Other	20.9%	19.5%
ETHNICITY[2]		
Hispanic/Latina	4.9%	5.1%
TOTAL[2,3]	9.5%	7.9%

[1] Percentages represent the proportion of women who report smoking in either the 1st and/or 3rd trimester.
[2] The estimates for race and ethnicity include data for the small group of women who participated in the survey younger than 18 years old.
[3] Survey response data are weighted to the California population of women who gave birth in 2005 and 2006, respectively

Source: Maternal Infant Health Assessment (MIHA) Surveys, 2005 and 2006. Special data run by Maternal, Child, Adolescent Health Program's Surveillance and Program Evaluation Section, California Department of Public Health (CDPH) received February 2008.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

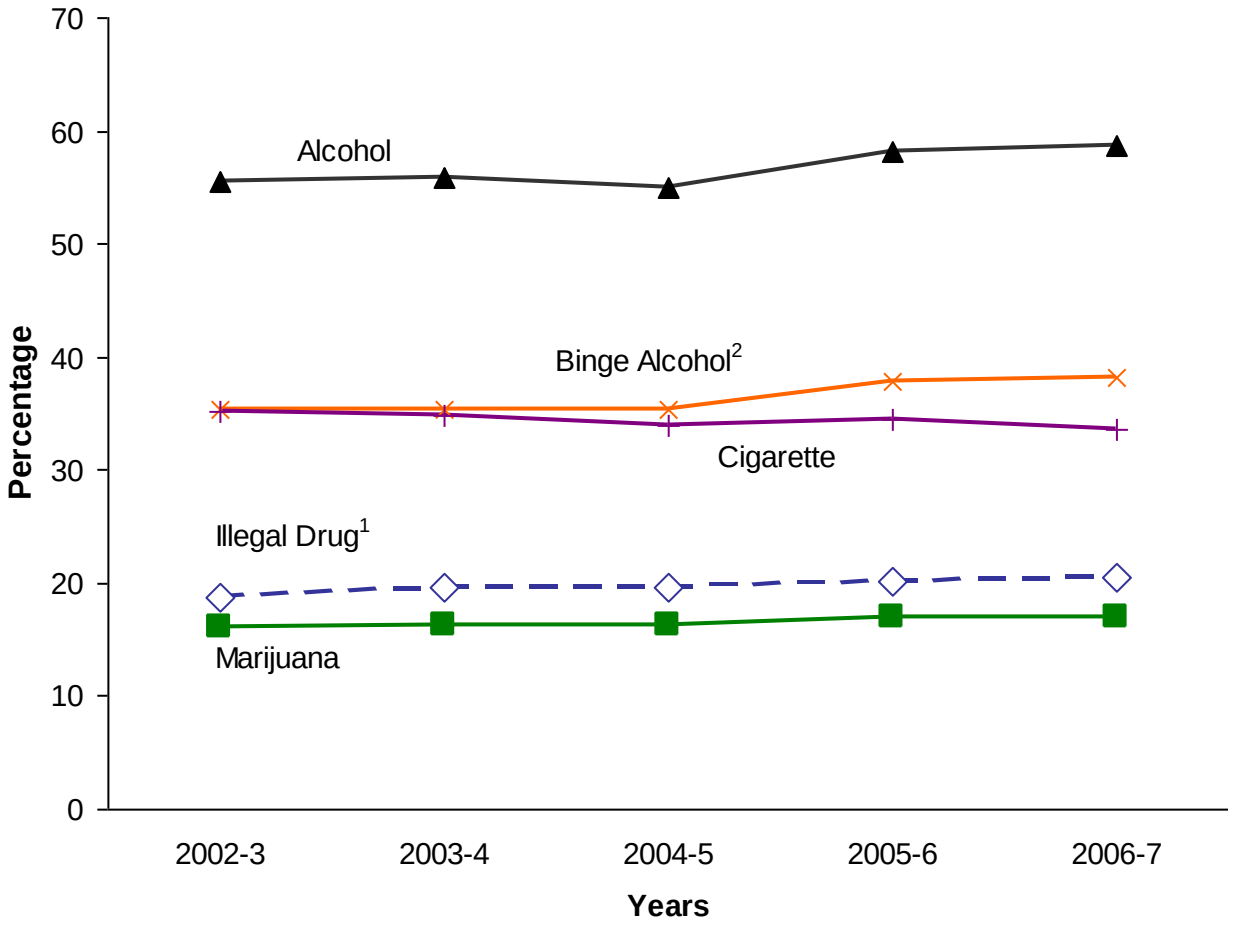
Highlights

- Nearly 8% of women reported smoking during their pregnancy in 2006. This is a slight decrease from 2005.
- The highest percentages of women smoking during pregnancy were among Other, White, and African American race groups, and 18-19 year olds. The lowest percent was for Hispanics/Latinas.
- Between 2005 and 2006 there were substantial drops in reported smoking during pregnancy among some groups of women:
    - Smoking prevalence dropped 30% in pregnant women between 18-19 years old, and 24% in pregnant women between 20-34 years old. There was a 42% increase in smoking among women 35 and older.
    - Smoking prevalence dropped 30% among African American women, and 25% among White women.

7. National Survey of Drug Use and Health (NSDUH)

National Survey on Drug Use and Health (NSDUH) data comes from an in-person, self-report survey produced by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies, and Research Triangle Institute, International (RTI). Data on 70,000 randomly selected individuals, 12 years and older, are collected annually, and the survey provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use.

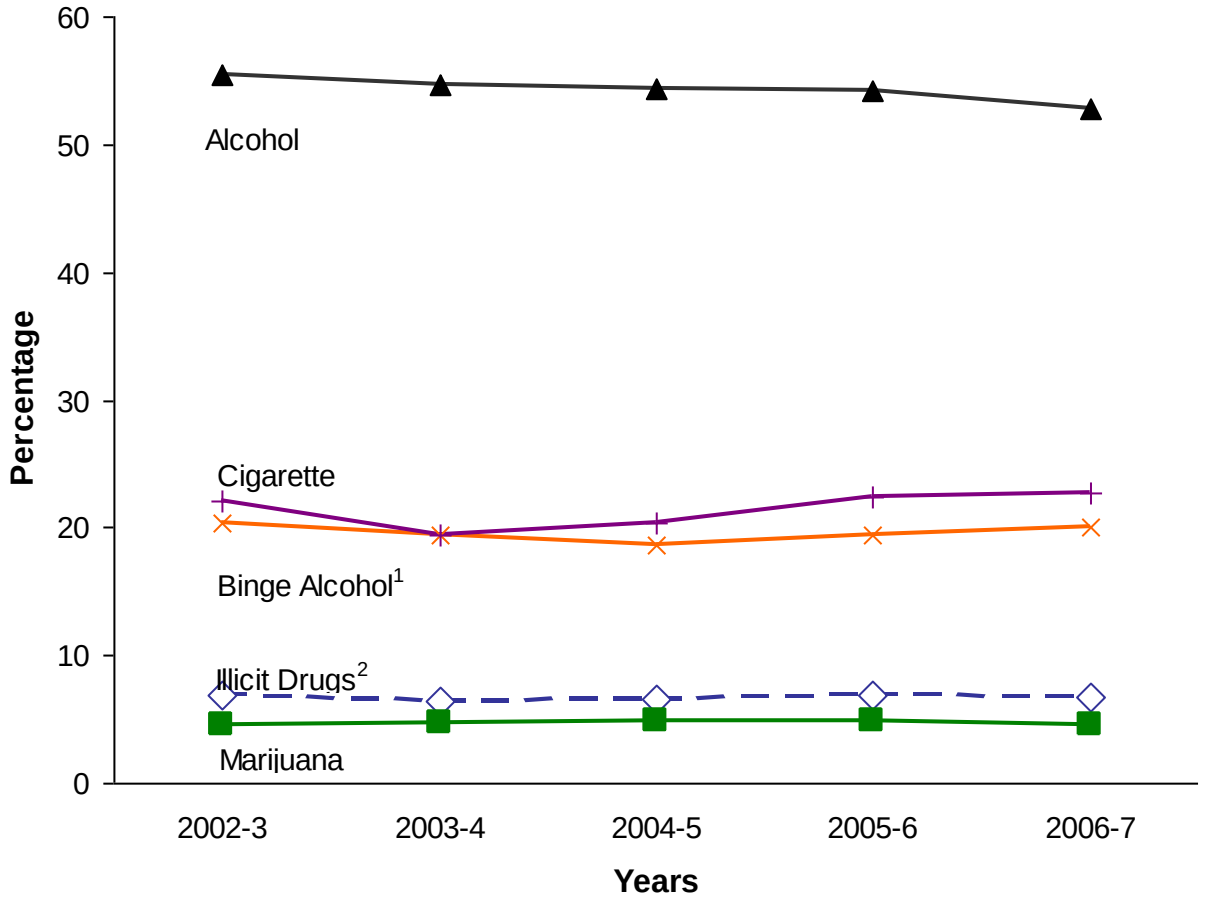
Figure II.23 – Selected Measures of Alcohol, Tobacco, and Other Drug Use in the Past Month, Age 18 to 25, California, 2002-2007



[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30-Days.

Source: National Survey on Drug Use and Health, 2002-2007, Office of Applied Studies, Substance Abuse and Mental Health Service Administration.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Figure II.24 – Selected Measures of Alcohol, Tobacco, and Other Drug Use in the Past Month, Age 26 and Over, California, 2002-2007



[1] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30-Days.
[2] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Source: National Survey on Drug Use and Health, 2002-2006, Office of Applied Studies, Substance Abuse and Mental Health Service Administration.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Highlights

- Generally, the percentage of adults who consume drugs in California over the past several years has not changed significantly.
- The top five most consumed five drugs has also remained unchanged, as has their relative standing: Californians consume alcohol more than other substances—both in terms of general consumption and in binge drinking—followed by their use of cigarettes, illicit drugs, and marijuana.
- Alcohol use in the past 30 days remains high at over 50% for both age groups (18-25 and 26+).
- While both younger and older adults drink alcohol at comparable levels, younger adults (18 to 25 years old) tend to binge drink, smoke cigarettes, use illicit drugs, and smoke marijuana at higher percentages than adults 26 and older.
- Trends in ATOD use have stayed relatively flat over the three survey periods for both age groups.

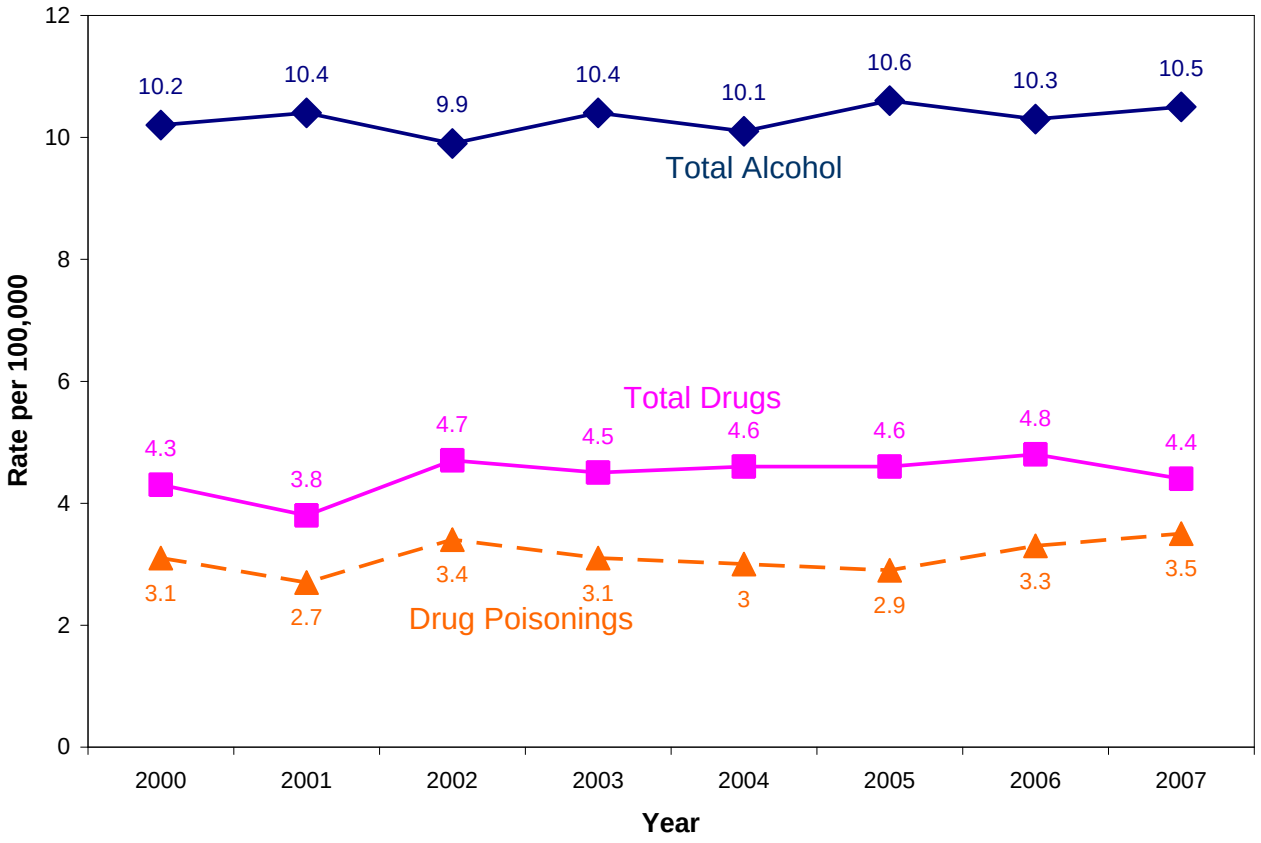
II. Consequences of Alcohol, Tobacco, and Other Drug Use

A. Health

1. California Death Statistical Master Files

Substance use has both acute health consequences, such as poisoning overdoses and substance-related risk behaviors leading to unintentional and intentional injuries, and long-term health impacts, such as chronic liver disease and lung cancer. Obviously, the most severe health consequence of ATOD use and abuse is death. The following two charts show the rates of death related to alcohol and drug use among California residents. Only those causes of death that can be 100% attributed to alcohol or drugs respectively are included, producing very conservative estimates. The data are based on the California Death Statistical Master Files that contain the official record of all deaths in California.

Figure III.1 Trends for Alcohol and Drug-related Deaths, California, 2000-2007



Notes: California residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100% attributable to alcohol or drugs, respectively.
Data Source: Death Statistical Master Files, 2000-2007; Office of Vital Statistics, California Department of Public Health (CDPH).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

Highlights

- The eight year average rate in California for alcohol-related deaths (10.3 per 100,000) is over two times greater than the average rate for drug-related deaths (4.5 per 100,000).
- Rates of alcohol- and drug-related deaths have been fairly constant over the eight-year period for California.
- Drug-related death rates in California increased in 2002 and have stayed relatively stable until 2007. Drug poisonings make up the majority of total drug-related deaths, reaching 80% of the total in 2007.

Table III.2 – Number and Rates of Alcohol and Drug-Related Deaths by Type, California, 2005-7

	2005		2006		2007	
	#	Rate	#	Rate	#	Rate
ALCOHOL						
Mental and Behavioral Disorders	1,042		993		660	
Physical Condition	2,831		2,828		3,039	
Poisonings	54		42		264	
Total	**3,928**	**10.6**	**3,863**	**10.3**	**3,966**	**10.5**
DRUG						
Mental and Behavioral Disorders	621		534		325	
Physical Condition	0		2		0	
Poisonings	1,084		1,252		1,333	
Pregnancy-related	8		7		5	
Total	**1,713**	**4.6**	**1,795**	**4.8**	**1,663**	**4.4**
TOTAL	**5,638**	**15.3**	**5,658**	**15.1**	**5,629**	**14.9**

Notes: California residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100% attributable to alcohol or drugs, respectively.
Source: Death Statistical Master and Birth Statistical Master files, 2005-7, Office of Vital Records, California Department of Public Health (CDPH); Race/Ethnic Population with Age and Sex Detail, 2000–2050, California Department of Finance, July 2007
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

Table III.3 – Number of Alcohol and Drug-related Deaths by Age, Gender, and Race/Ethnicity, California, 2007

	Alcohol	Drug	Total
AGE			
0-20 Years	14	59	73
21-29 Years	75	156	231
30-39 Years	246	267	513
40-49 Years	980	533	1,513
50-59 Years	1,384	499	1,883
60+ Years	1,267	149	1,416
GENDER			
Male	2,990	1,166	4,156
Female	976	497	1,473
RACE/ETHNICITY			
Hispanic/Latino	1,288	368	1,656
African-American	236	207	443
American Indian	52	15	67
Asian	106	19	125
Pacific Islanders	5	2	7
White	2,257	1,033	3,290
Multiple Race	16	18	34
Other/Unknown	6	1	7
TOTAL	**3,966**	**1,663**	**5,629**

Notes: California residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100% attributable to alcohol or drugs, respectively.
Source: California Death Statistical Master Files, 2005-7
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

Highlights

- Most alcohol-related deaths are due to physical conditions (such as tissue damage, hepatitis, etc.) rather than mental or behavioral disorders (late-onset psychotic disorder, delirium tremens, alcoholic dementia, etc.). The vast majority of drug-related deaths were classified as due to poisoning (e.g., opiods analgesics).
- Each year, the number and rate of alcohol-related deaths greatly exceed those of drug-related deaths. Of the 5,629 deaths in 2007 100% attributable to psychoactive substance use, 70% are due to alcohol.
- Two-thirds of decedents who died of alcohol-related causes are 50 years or older, 75% are men, and 57% are non-Hispanic Whites.
- Sixty-two percent of drug-related deaths are among decedents between 40 and 59 years old. Less than 30% of drug-related deaths are among decedents less than 40 years old. 70% are men, and 62% are non-Hispanic Whites.
- Generally, older adults are more likely to die from alcohol and drug-related causes: 59% of those who died from alcohol and drug causes were 50 years of age or older, and 85% were 40 years old or older.

2. Centers for Disease Control and Prevention (CDC) Alcohol-Related Disease Impact (ARDI)

The CDC uses Alcohol-Related Disease Impact (ARDI) software to generate estimates of Alcohol-Attributable Deaths and Years of Potential Life Lost due to alcohol consumption. The data presented on alcohol-related deaths may be underestimated due to the reliance on self-report data (BRFSS), reports of current alcohol consumption, and the impact of secondary causes of death. Five year totals are used to generate a measure of the magnitude of alcohol health consequences.

Table III.4 – Estimated Number of Annual Alcohol-Attributable Deaths Due to Medium and High Average Daily Alcohol Consumption, California, 2001-2005

	Chronic Causes	Acute Causes	Total (All Causes)
ALL AGES			
Male	3,663	3,500	**7,163**
Female	1,468	1,133	**2,601**
Subtotal	**5,131**	**4,633**	**9,764**
YOUTH (<21)			
Male	12	425	**437**
Female	5	99	**104**
Subtotal	**17**	**524**	**541**
TOTAL	**5,148**	**5,157**	**10,305**

Source: Alcohol-Attributable Deaths Report, Average for California 2001-2005; Centers for Disease Control and Prevention; Retrieved February 2008 from http://apps.nccd.cdc.gov/ardi/Homepage.aspx.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Table III.5 – Estimate of Alcohol Attributable Years of Potential Life Lost Due to Medium and High Average Daily Alcohol Consumption, Average for California, 2001-2005

	Chronic Causes	Acute Causes	Total (All Causes)
ALL AGES			
Male	83,037	130,928	**213,965**
Female	34,674	38,953	**73,627**
Subtotal	**117,711**	**169,881**	**287,592**
YOUTH (<21)			
Male	829	24,460	**25,289**
Female	423	6,415	**6,838**
Subtotal	**1,252**	**30,875**	**32,127**
TOTAL	**118,963**	**200,756**	**319,719**

Source: *Years of Potential Life Lost Report, Average for California 2001-2005*; Centers for Disease Control and Prevention. Retrieved February 2008 from http://apps.nccd.cdc.gov/ardi/Homepage.aspx.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

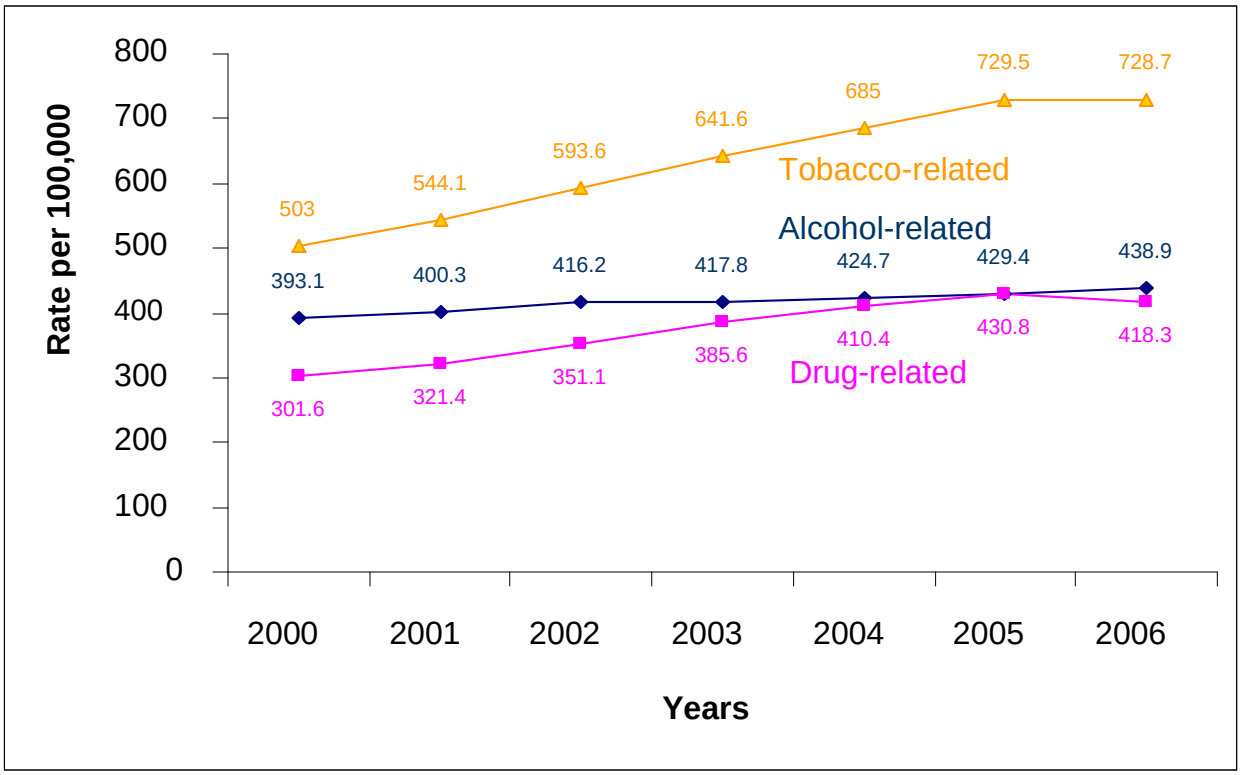
Highlights

- Over 10,000 deaths were attributed to alcohol over the five year period examined, with the vast majority of deaths occurring among adults.
- Nearly three quarters of all alcohol-attributable deaths were males.
- Adults were more likely to die from chronic causes (e.g., alcoholic liver disease, alcohol dependence; alcohol-induced stroke) than from acute causes (e.g., motor vehicle accidents, homicide, suicides).
- For those under 21 years old, the reverse was true—youth were much more likely to die from acute causes rather than chronic causes.
- The average alcohol-attributable potential years of life lost for all ages was 29.5 years per death (29.9 years per death for men, and 28.3 years per death for women).
- While there are more alcohol-attributable deaths due to chronic causes when compared to deaths due to acute causes, acute causes are associated with substantially earlier deaths and thus more years of potential life lost.
  - The average alcohol-attributable potential years of life lost for all ages due to acute causes was 36.7 years per death versus 22.9 for chronic causes.
- Those who died younger than 21 years old lost 59.4 years per death.
- Younger females fared much worse in terms of alcohol-attributable potential years of life lost (57.9 years per death for men, and 65.8 years per death for women).

3. Office of Statewide Health Planning and Development

The Office of Statewide Health Planning and Development **(**OSHPD) oversees the collection of data on hospital inpatient discharges and, more recently (2005), Emergency Department (ED) visits for administrative billing and payment purposes. OSHPD is a rich data source for identifying and tracking substance-related health consequences. Only those causes of death that can be 100% attributed to alcohol or drugs respectively are included. The first graph displays trends for alcohol-, drug-, and tobacco-related hospitalizations for California (rates per 100,000). The two other charts show the hospitalizations rates compared to ED rates for 2006.

Figure III.6 – Trends for Alcohol, Drug, and Tobacco-related Hospitalizations, California, 2000-2006



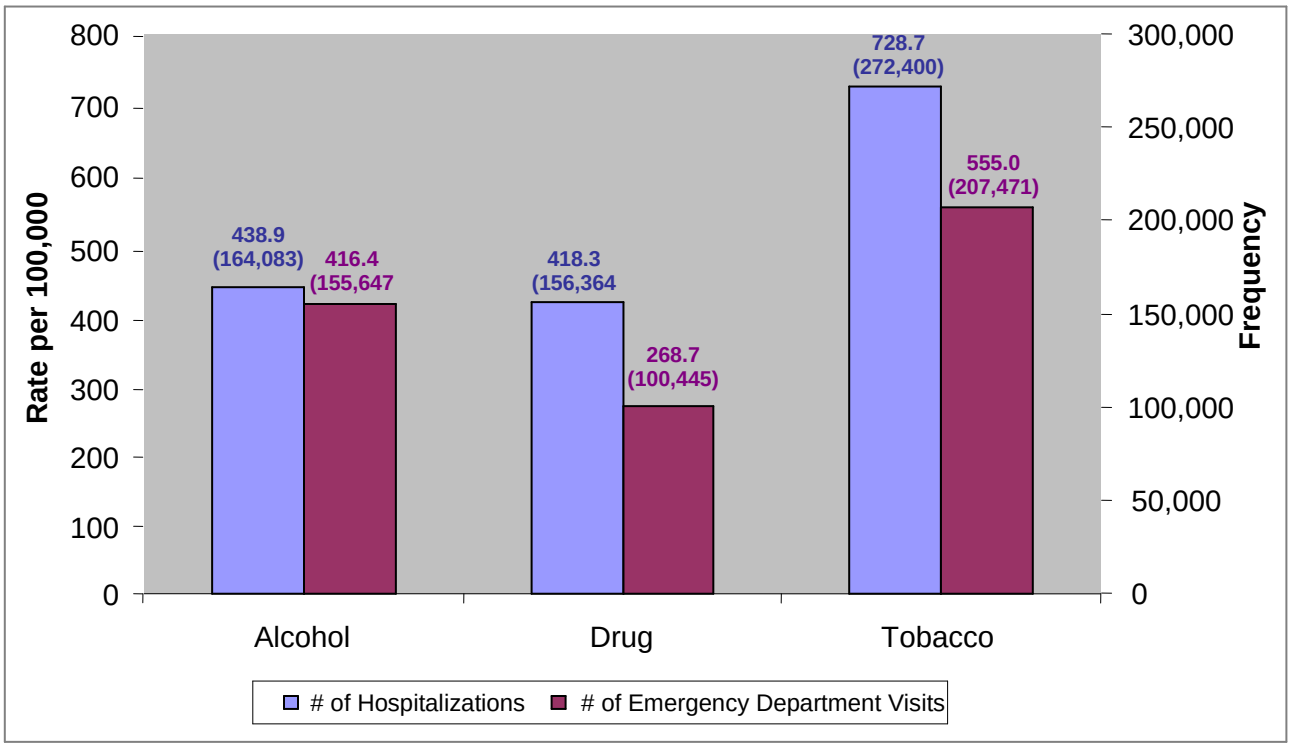
Note: California residents only; includes selected ICD-9CM codes 100% attributable to alcohol, tobacco, or other drugs found in any diagnostic fields (i.e., Principal Diagnosis and all Other Diagnoses 1-24). List of codes adapted from Epidemiology, Assessment and Program Development; Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

Source: Hospital Inpatient Discharge Data, 2000-2006, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, February 2008.

Highlights

- In California, rates for tobacco-related hospitalizations have been consistently higher than rates for alcohol-related hospitalizations or drug-related hospitalizations.
- Tobacco-related rates have risen faster than the rates for either of the other substances.
- Despite slight increases each year, alcohol-related hospitalization rates have been fairly constant over the seven-year period for California.
- Drug-related hospitalizations increased over one-third, from 302 to 418 per 100,000.

Figure III.7 - Rates (and Numbers) of Hospitalizations & Emergency Department Visits for ATOD, California, 2006



Note: California residents only; Includes selected ICD-9CM codes 100% attributable to alcohol, tobacco, or other drugs found in any diagnostic fields (i.e., Principal Diagnosis and all Other Diagnoses 1-24). List of codes adapted from Epidemiology, Assessment and Program Development; Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

Source: Patient Discharged Data and Emergency Department Data 2006, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH and Office of Applied Research and Analysis, Department of Alcohol and Drug Programs, July 2009.

Highlights

- In 2006, the rates for tobacco-related Hospitalizations (729 per 100,000) were substantially higher than the rates for alcohol-related (439 per 100,000) or drug-related (418 per 100,000) hospitalizations.
- A similar finding is apparent for Emergency Department (ED) visits - the rates for tobacco-related ED visits (555 per 100,000) exceeded alcohol-related (416 per 100,000) and drug-related (269 per 100,000) ED visits).
- Statewide, hospitalizations rates for each substance exceeded the rates for ED visits. However, the rates of alcohol-related hospitalizations (439 per 100,000) and ED visits (416 per 100,000) were fairly close.

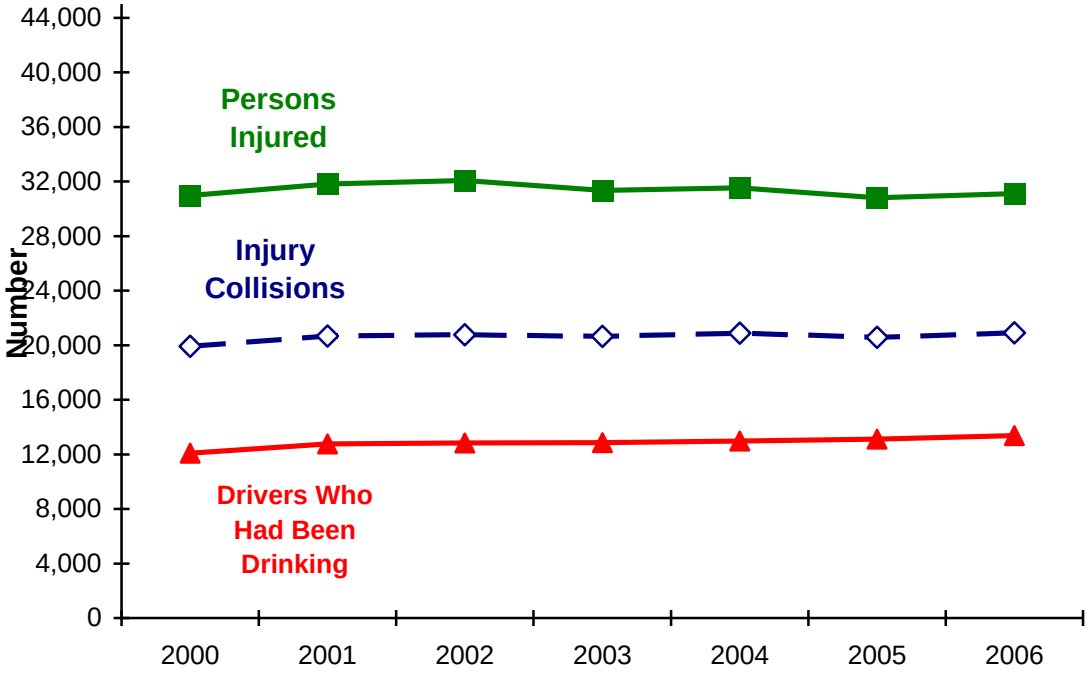
B. Traffic

There are two good sources of statewide data that document traffic-related consequences of using alcohol and other drugs: California's Statewide Integrated Traffic Records System (SWITRS) operated by the California Highway Patrol in partnership with the California Department of Motor Vehicles), and the federal Fatality Analysis Reporting System (FARS). SWITRS includes information on all motor-vehicle collisions, whereas FARS focuses on fatal collisions only. FARS also reports Blood Alcohol Levels toxicology results when available.

1. Statewide Integrated Traffic Records System (SWITRS)

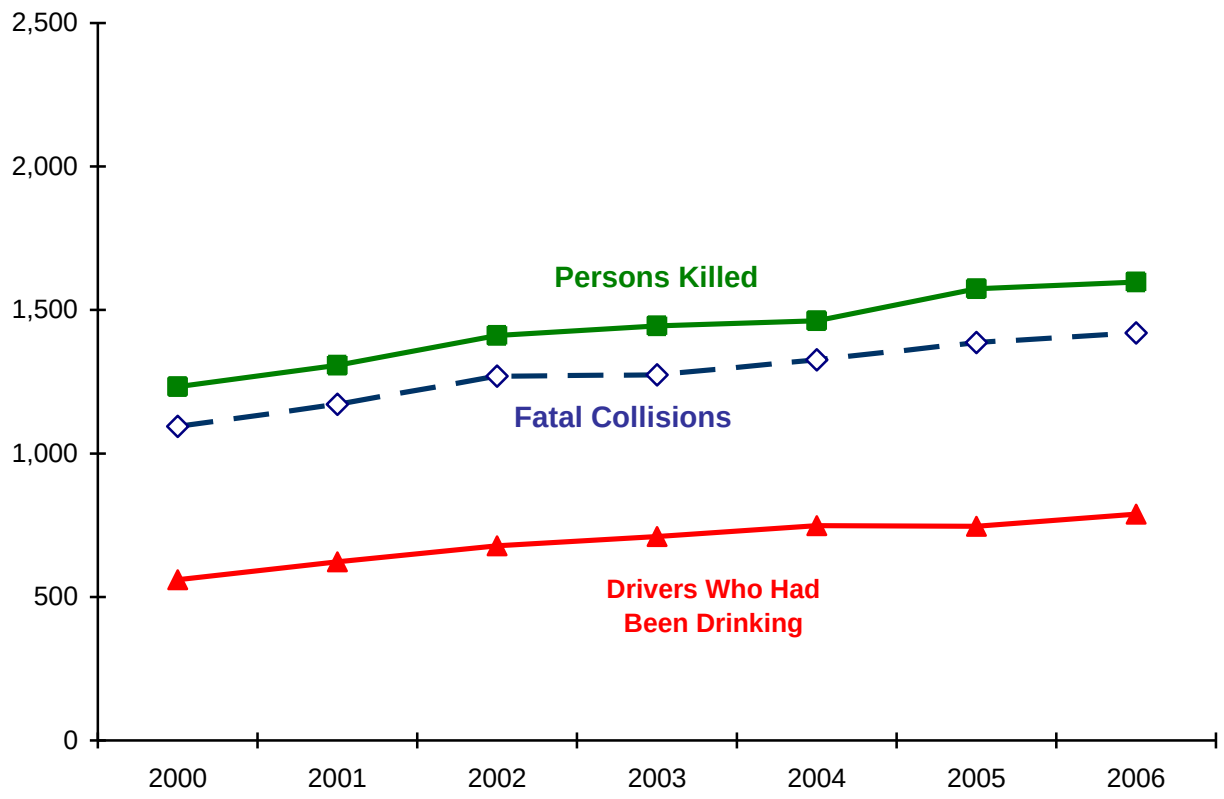
The data provided on alcohol-involved motor vehicle collisions comes from SWITRS. The database includes all property-damage and injury crashes investigated by police in all California jurisdictions.

Figure III.8 –Injury Collisions, Persons Injured, and Drivers Who Had Been Drinking in Alcohol-involved Motor Vehicle Collisions, California, 2000-2006



Source: 2006 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions; California Department of Highway Patrol. Retrieved from http://www.chp.ca.gov/switrs/xls/2006-sec5.xls March 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, March 2009, and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, May 2009.

Figure III.9 –Fatal Collisions, Persons Killed, and Drivers Who Had Been Drinking in Alcohol-involved Motor Vehicle Collisions, California, 2000-2006



Source: 2006 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions; California Department of Highway Patrol. Retrieved from http://www.chp.ca.gov/switrs/xls/2006-sec5.xls March 2009.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, March 2009, and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, May 2009.

Highlights

- In California between 2002 and 2006, there were approximately 103,762 alcohol-involved motor-vehicle collisions, resulting in 156,860 people being injured, and 7,489 persons being killed. In 2006, 1,597 people died in alcohol-related motor vehicle collisions.
- The number of injury collisions and persons injured has remained relatively flat since 2000, whereas the number of fatal collisions and persons killed has increased for each of the years of observations displayed.

2. Fatality Analysis Reporting System (FARS)

In 1975, the U.S. Department of Transportation, National Highway Traffic Safety Administration created FARS. FARS provides annual estimates of alcohol/drug involvement (of the driver) for all motor vehicle crashes on public roads that result in the death of an occupant of a vehicle or a non-motorist within 30 days of the crash. The data system allows comparisons over time and among local jurisdictions. Data are gathered from several sources (police reports, coroners, EMS, hospitals, and others) and combined to ensure corroborated and complete information coded with strong quality control.

Table III.10 – Persons Killed in Alcohol-related Crashes by Driver's Blood Alcohol Concentration and Age, California, 2006

AGE	Driver's Blood Alcohol Concentration[1] (BAC)	
	0.01 – 0.07	**0.08+**
< 16	2	5
16 - 20	55	206
21-24	51	281
25-44	98	684
45-64	69	331
> 65	16	37
Unknown	1	3
TOTAL	**292**	**1,547**

[1]Grams per deciliter
Notes: Excludes individuals for whom BAC level was 0.0% and those for whom BAC level was not ascertained.
Source: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration; Retrieved June 2009 from http://www-fars.nhtsa.dot.gov/QueryTool/QuerySection/SelectYear.aspx.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, , and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009.

Highlights

- According to FARS data, approximately 1,547 persons were killed in 2006 in alcohol-related traffic collisions where the driver's BAC equaled or exceeded .08 gm/dl. This total is slightly smaller than the estimate of 1,579 alcohol-related traffic collisions provided by California SWITRS 2006 data. However, SWITRS data does not allow the determination of driver's BAC.
- Overall, more than four times as many deaths occurred in vehicles where the driver's BAC was 0.08 and above than in vehicles where the driver's BAC was between 0.01 to 0.07 gm/dl.
- This consequence was most apparent for adults between 25-44 years old.

C. Crime

1. Monthly Arrest and Citation Register (MACR)

MACR contains information on adult and juvenile (under 18 years of age) arrests throughout the state. These tables and charts display adult felony and juvenile and misdemeanor arrests for drug offenses for Californians. Arrest data should never be used as a direct indicator of the magnitude or nature (i.e., demographic breakdown) of the AOD problem. As a "response" indicator arrests often reflect the level of resources (e.g., funding, staff/personnel) and administrative or institutional attention devoted to addressing a problem more than the underlying nature of the problem itself. However, arrests do provide an indication of the actual impact of AOD on the criminal justice system. A limited set of indicators is presented as a sample of what data are available.

Table III.11 – Adult and Juvenile Misdemeanor and Felony DUI Arrests, California, 2000-2006

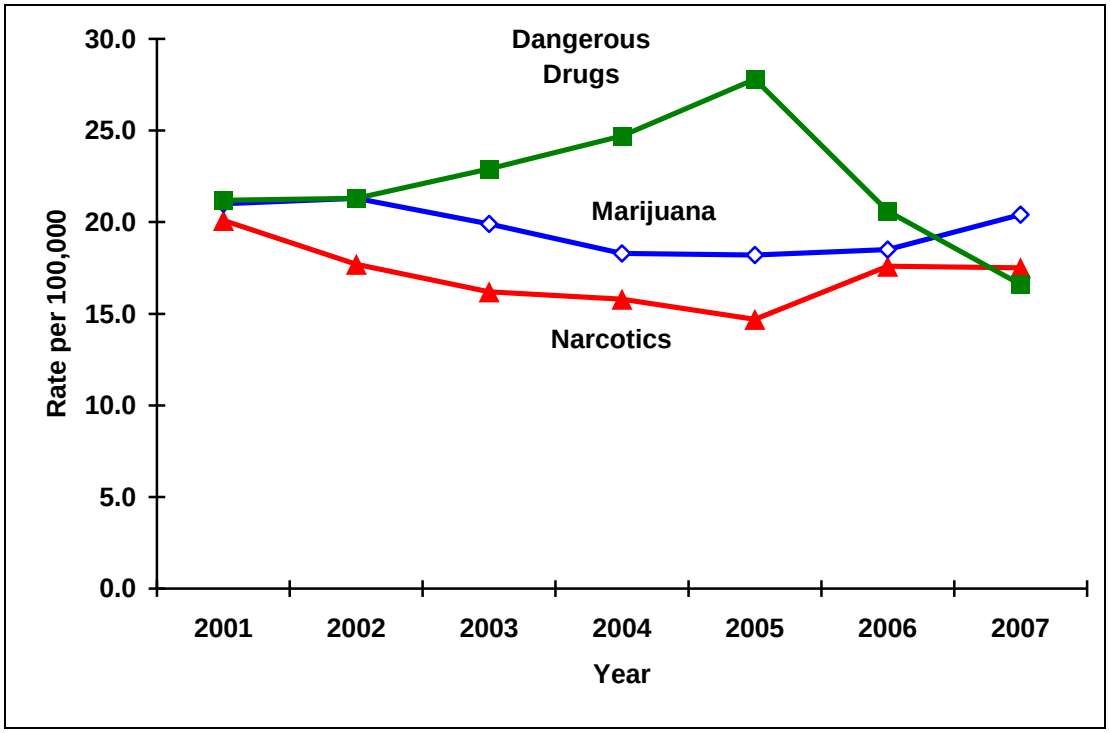
	2001	2002	2003	2004	2005	2006
Juvenile						
Misdemeanor	1,560	1,482	1,513	1,403	1,380	1,621
Felony	91	83	72	98	67	82
Adult						
Misdemeanor	171,679	172,266	178,561	175,653	175,004	191,282
Felony	5,620	5,832	5,827	5,617	5,963	6,162
Total	**178,950**	**179,663**	**185,973**	**182,771**	**182,414**	**199,147**

Note: DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, and Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2009..

Highlights

- There were nearly 200,000 DUI arrests made in 2006, an average of nearly 550 DUI arrests per day.
- Misdemeanor DUI arrests greatly outnumber felony DUI arrests for both juveniles and adults.
- Adult Misdemeanor DUI arrests increased substantially in 2006 - an increase of over 16,000 arrests.

Figure III.12 – Juvenile Felony Arrest Rates for Drug Offenses, California, 2001-2007



Notes: Narcotics include plant derivatives such as heroin, cocaine, etc. Dangerous Drugs are defined as manufactured drugs such as barbiturates, phencyclidine, methamphetamines, etc.
Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, and the Office of Applied Research and Analysis, Department of Alcohol and Drug Programs, July 2009.

Highlights

- Juvenile felony arrests for all categories are slightly lower in 2007 than they were in 2001.
- Juvenile felony arrests for dangerous drug violations increased steadily until they peaked in 2005 and have dropped substantially in 2006 and 2007.

Table III.13 – Adult Misdemeanor Drug Offense Arrests by Age and Gender, California, 2006

	MARIJUANA[1]			PUBLIC INTOXICATION[2]			LIQUOR LAWS[3]			DRIVING UNDER THE INFLUENCE[4] (DUI)		
	%[5]	N[6]	R[7]	%	N	R	%	N	R	%	N	R
AGE												
18-20	32.6	12623	765.1	9.2	9414	570.6	55.1	9121	552.8	8.6	16392	993.6
21-29	40.7	15765	348.2	29.4	30239	667.8	12.9	2139	47.2	40.9	78155	1726.1
30-39	13.9	5382	100.0	20.8	21412	397.7	10.4	1730	32.1	23.6	45091	837.5
40-49	9.1	3525	61.7	25.0	25754	451.1	11.9	1964	34.4	16.8	32175	563.6
50+	3.6	1412	13.9	15.6	16004	158.1	9.7	1612	15.9	10.2	19469	192.3
TOTAL	**100.0**	**38707**	**141.3**	**100.0**	**102823**	**375.4**	**100.0**	**16566**	**60.5**	**100.0**	**191282**	**698.3**
GENDER												
Male	88.8	34364	253.5	86.3	88718	654.6	78.4	12995	95.9	81.9	156679	1156.0
Female	11.2	4343	31.4	13.7	14105	101.9	21.6	3571	25.8	18.1	34603	250.0
TOTAL	**100.0**	**38707**	**141.3**	**100.0**	**102823**	**375.4**	**100.0**	**16566**	**60.5**	**100.0**	**191282**	**698.3**
TOTAL ARRESTS RATE		**141.3**			**375.4**			**60.5**			**698.3**	

[1] Marijuana: Possession for sale, etc.

[2] Public Intoxication: Includes the use of alcohol, drugs, or the combination of alcohol and drugs, but is predominantly alcohol.

[3] Liquor Laws Violations: "The violation of laws or ordinance prohibiting: the manufacture, sale, transporting, furnishing, possessing of intoxicating liquor."

[4] DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
[5] Percentage of total arrest per category.
[6] The number of arrests per category.
[7] Arrest rate per 100,000

Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- There were nearly 350,000 adult misdemeanor drug offense arrests in 2006.
- Most adult misdemeanor drug related arrests are for Driving Under the Influence (DUI): (698 per 100,000). Public Intoxication account for the next highest rate of misdemeanor arrests (375 per 100,000).
- In general, men account for nearly 90% of misdemeanor drug arrests.
- In 2006, adults Californians between the ages of 18 and 29 have the highest rates of arrests for each of the four misdemeanor crime categories.
  - Rates for misdemeanor marijuana arrests (765 per 100,000) and liquor law violations (553 per 100,000) are highest among those 18-20 years old.
  - Rates for misdemeanor DUI arrests (1,726 per 100,000) and public drunkenness (668/100,000) are highest among those 21-29 years old.

Table III.14 – Adult Misdemeanor Drug Offense Arrests by Race and Ethnicity, California, 2006

	MARIJUANA[1]			PUBLIC INTOXICATION[2]			LIQUOR LAWS[3]			DRIVING UNDER THE INFLUENCE[4] (DUI)		
	%[5]	N[6]	R[7]	%	N	R	%	N	R	%	N	R
RACE & ETHNICITY												
White	40.5	15667	118.4	49.7	51078	385.9	51.5	8524	64.4	40.3	77166	583.0
Hispanic/Latino	32.4	12559	148.9	36.7	37765	447.7	30.9	5120	60.7	45.7	87505	1037.5
Black	21.3	8227	498.9	8.5	8783	532.6	8.3	1371	83.1	7.0	13362	810.3
Other	5.8	2254	55.3	5.1	5197	127.6	9.4	1551	38.1	6.9	13249	325.3
TOTAL	**100.0**	**38707**	**141.3**	**100.0**	**102823**	**375.4**	**100.0**	**16566**	**60.5**	**100.0**	**191282**	**698.3**
TOTAL ARRESTS RATE		**141.3**			**375.4**			**60.5**			**698.3**	

[1] Marijuana: Possession for sale, etc.

[2] Public Intoxication: Includes the use of alcohol, drugs, or the combination of alcohol and drugs, but is predominantly alcohol.

[3] Liquor Laws Violations: "The violation of laws or ordinance prohibiting: the manufacture, sale, transporting, furnishing, possessing of intoxicating liquor."

[4] DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
[5] Percentage of total arrest per category.
[6] The number of arrests per category.
[7] Arrest rate per 100,000.

Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Rates of adult misdemeanor drug offense arrests for Marijuana, Public Intoxication, and Liquor Law violations are highest among African Americans, and DUI arrests are highest among Hispanics.

Table III.15 – Adult Felony Drug Offense Arrests by Age and Gender, California, 2006

	NARCOTICS[1]			DANGEROUS DRUGS[2]			DRIVING UNDER THE INFLUENCE[3] (DUI)		
	%[4]	N[5]	R[6]	%	N	R	%	N	R
AGE									
18-20	8.3	4,519	273.9	9.3	7,572	459.0	9.4	577	35.0
21-29	25.4	13,781	304.4	35.2	28,622	632.1	36.3	2,235	49.4
30-39	23.4	12,713	236.1	28.6	23,219	431.2	22.8	1,408	26.2
40-49	28.6	15,545	272.3	21.4	17,408	304.9	19.4	1,196	21.0
50+	14.3	7,777	76.8	5.5	4,490	44.4	12.1	746	7.4
TOTAL	**100.0**	**54,335**	**198.4**	**100.0**	**81,311**	**296.8**	**100.0**	**6,162**	**22.5**
GENDER									
Male	78.7	42,785	315.7	77.9	63,352	467.4	83.6	5,153	38.0
Female	21.3	11,550	83.5	22.1	17,959	129.8	16.4	1,009	7.3
TOTAL	**100.0**	**54,335**	**198.4**	**100.0**	**81,311**	**296.8**	**100.0**	**6,162**	**22.5**
TOTAL ARREST RATE		**198.4**			**296.8**			**22.5**	

[1]Narcotics: Plant derivatives such as heroin, cocaine, etc.

[2]Dangerous Drugs: Manufactured drugs such as barbiturates, phencyclidine, methamphetamines, etc.
[3] DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
[4]Percentage of total arrest per category.
[5]The number of arrests per category.
[6]Arrest rate per 100,000.

Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General;
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Most adult felony arrests are for dangerous drug violations: (297 per 100,000).
- In general, men account for nearly 80% of felony drug arrests.
- Adults between 21-29 have the highest arrest rates for each of the three felony crime categories
  - Rates for narcotics violations: (304 per 100,000)
  - Rates for dangerous drug violations: (632 per 100,000)
  - Rates for DUI arrests: (49 per 100,000)

Table III.16 – Adult Felony Drug Offense Arrests by Race and Ethnicity, California, 2006

	NARCOTICS[1]			DANGEROUS DRUGS[2]			DRIVING UNDER THE INFLUENCE[3] (DUI)		
	%[4]	N[5]	R[6]	%	N	R	%	N	R
RACE & ETHNICITY									
White	21.9	11,903	89.9	43.7	35,568	268.7	38.3	2,358	17.8
Hispanic	28.4	15,441	183.1	44.7	36,365	431.1	47.3	2,916	34.6
Black	46.6	25,329	1,536.1	6.5	5,325	322.9	8.1	501	30.4
Other	3.1	1,662	40.8	5.0	4,053	99.5	6.3	387	9.5
TOTAL	**100.0**	**54,335**	**198.4**	**100.0**	**81,311**	**296.8**	**100.0**	**6,162**	**22.5**
TOTAL ARREST RATE		**198.4**			**296.8**			**22.5**	

[1]Narcotics: Plant derivatives such as heroin, cocaine, etc.

[2]Dangerous Drugs: Manufactured drugs such as barbiturates, phencyclidine, methamphetamines, etc.
[3] DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
[4]Percentage of total arrest per category.
[5]The number of arrests per category.
[6]Arrest rate per 100,000.

Source: Adult and Juvenile Arrests Reported, 2006; Criminal Justice Statistics Center, California Office of the Attorney General.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- African Americans account for the majority of felony narcotics arrests.
- Hispanics/Latinos have higher per capita arrest rates for dangerous drugs and DUIs.

D. Prevention and Treatment Services

1. California Outcomes Measurement System - Prevention

Data derived from the Department of Alcohol and Drug Programs' (ADP) California Outcome Measurement System for Prevention (CalOMS—Prevention) describe the access to prevention-focused services by California youth and adults. The CalOMS-Prevention contains data on clients' demographics, utilization and access to prevention messages and activities, and providers and their prevention strategies. Cal OMS—Prevention was introduced in 2006, with implementation starting July 2006.

Table III.17 – Number of Persons Receiving Alcohol and Other Drug Prevention Services by Service Strategy, Age, and Gender, California, Fiscal Year 2006-07

	Education	Alternatives	Problem Identification and Referral	Community Based Process	Environmental	TOTAL
AGE						
5-11	50655	67855	2869	3878	457	125714
12-17	193654	219169	15144	17005	19235	464207
18 – 25	32331	36427	14285	14589	11534	109166
26 – 64	65350	47125	33562	37517	8659	192213
65+	4244	4411	1981	4891	492	16019
GENDER						
Male	161784	180261	35118	37236	19845	434244
Female	185111	198769	33466	41290	20469	479105
Other	1338	2034	195	440	87	4094
TOTAL SERVED	**348233**	**381064**	**68779**	**78966**	**40401**	**917443**

Source: California Outcomes Measurement System, 2005-06; California Alcohol and Drug Program. Special data run February 2008.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Table III.18 – Number of Persons Receiving Alcohol and Other Drug Prevention Services by Service Strategy, Race, and Ethnicity, California, Fiscal Year 2006-07

	Education	Alternatives	Problem Identification and Referral	Community Based Process	Environmental	TOTAL
RACE						
African American	32962	49325	10955	9461	3028	105731
Asian American	17128	26104	5396	4997	2300	55925
Native American/ Alaska Native	3977	11829	1221	1072	3090	21189
Native Hawaiian/Pacific Islander	2952	7412	1400	652	552	12968
White, Not Hispanic	128459	112948	22506	31955	15737	311605
Two or More Races	8517	16822	3191	7116	2523	38169
Other	3144	5119	333	501	298	9395
ETHNICITY						
Hispanic[1]/ Latino	151061	151372	23774	23212	12873	362292
TOTAL SERVED	**348200**	**380931**	**68776**	**78966**	**40401**	**917274**

[1] Hispanic/Latino ethnicity is attributed to persons who identified themselves as Hispanic/Latino regardless of racial classifications they might have chosen.
Source: California Outcomes Measurement System Prevention, 2006-07; California Department of Alcohol and Drug Programs. Special data run February 2008.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- In FY 06-07, publically-funded providers reported nearly one million Californians received some type of AOD prevention service, primarily education and alternative activities.
- Based on Cal OMS-Pv reports, relatively few people received community-based or environmental prevention services.
- Alcohol and drug prevention services appear targeted to younger audiences:
  - Over half (51%) of those who received alcohol and drug prevention services in 2006-07 were between 12 to 17 years old.
  - Only two percent who received services were 65 years and older.
- Keeping in mind that use of public services are a "response" indicator, breakdowns by race/ethnicity must be interpreted with caution.
  - Forty percent of those receiving publically-funded prevention services were Hispanic/Latino, 34% were non-Hispanic Whites, and 12% were African American.

2. California Outcomes Measurement System - Treatment

Data derived from the Department of Alcohol and Drug Programs' (ADP) California Outcome Measurement System for Treatment (Cal OMS—Treatment) describes the use of treatment services by California youth and adults. Like arrest data, treatment services data should never be used as a direct indicator of the magnitude or nature (i.e., demographic breakdown) of the AOD problem. As a "response" indicator treatment services often reflect the level of resources (e.g., funding, staff/personnel) and administrative or institutional attention devoted to addressing a problem more than the underlying nature of the problem itself. However, treatment services data do provide an indication of the actual impact of AOD on the public alcohol and other drug treatment services system.

Table III.19 – Alcohol and Other Drug Treatment Admissions by Age and Gender, California, Fiscal Year 2006-07

	Treatment Admissions (%)	N
AGE		
< 18	10.2	22,025
18 - 20	5.3	11,375
21 - 25	13.2	28,492
26 - 40	37.3	80,333
41 - 50	24.0	51,840
51+	10.0	21,502
TOTAL	**100.0**	**215,567**
GENDER		
Male	64.2	138,328
Female	35.8	77,116
Other	0.1	123
TOTAL	**100.0**	**215,567**

Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Sixty one percent of those admitted for treatment were between 26 to 50 years old.
- Nearly two-thirds (64%) of those admitted for treatment are men.

Table III.20 – Alcohol and Other Drug Treatment Admissions by Race and Ethnicity, California, Fiscal Year 2006-07

	Treatment Admissions (%)	N
RACE		
White/Caucasian	**50.3**	**108,423**
Black/African-American	**15.7**	**33,765**
American Indian and Alaska Native	**2.2**	**4,658**
Asian	**2.7**	**5,744**
Pacific Islander	**0.4**	**823**
Multi Racial	**3.3**	**7,028**
Other	**25.6**	**55,126**
TOTAL	**100.0**	**215,567**
ETHNICITY		
Not Hispanic/Latino	**66.1**	**142,416**
Hispanic/Latino	**33.9**	**73,151**
Mexican / Mexican American	27.4	59,124
Cuban	0.2	447
Puerto Rican	0.6	1,370
Other Hispanic / Latino	5.7	12,210
TOTAL	**100.0**	**215,567**

Note: In Cal OMS, race and ethnicity overlap, so that each category includes all clients.

Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Non-Hispanics represent two-thirds of treatment admissions; 50% of these individuals were White.
- Of the third of clients who were Hispanic/Latino, 81% self-identify as Mexican or Mexican American.

Table III.21 – Number of Alcohol and Other Drug Treatment Programs in 2005 by Type of Treatment Service, California, Fiscal Year 2006-07

Service Type[1]	Number of Programs[2]
Non Residential/Outpatient	
Outpatient Drug Free	1,551
Methadone Maintenance	156
Daycare Rehabilitative	609
Methadone Detoxification	141
Detoxification	20
Residential	
Inpatient Hospital Detoxification	1
Free Standing Residential Detoxification	134
Residential (30-Days or less)	145
Residential (31 days or longer)	608
Hospital Inpatient	8
TOTAL	**3,373**

[1] Treatment services may be broadly classified as either Non-Residential/Outpatient or Residential. Non-Residential/Outpatient services include the Outpatient Drug Free, Methadone Maintenance, Daycare Rehabilitative, Methadone Detoxification, and Detoxification programs. The remaining programs listed above are Residential programs.

[2] The number of certified programs changes frequently. This count is current as of 02/08.

Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Nearly three-quarters (73%) of the publically-funded AOD treatment programs in the state are non-residential.

Table III.22 – Treatment Admission Statistics from State Funded Agencies by Top Five Primary Drugs of Abuse: Age and Gender, California, Fiscal Year 2006-07

	Methamphetamine		Alcohol		Heroin		Marijuana/Hashish		Cocaine/Crack		TOTAL % (215,567)
	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	
AGE											
< 18	3	2,268	11.8	5,031	0.3	88	43.7	13,597	1.5	338	10.2
18 – 20	6	4,542	3.6	1,526	2.1	728	11.2	3,475	2.3	536	5.3
21 – 25	19.1	14,478	7.9	3,365	8.4	2,850	15.1	4,690	6.7	1,553	13.2
26 – 40	49.1	37,171	32.0	13,623	33.8	11,483	21.3	6,617	35.4	8,148	37.3
41 – 50	19.5	14,766	29.4	12,513	34.0	11,546	6.7	2,090	39.2	9,035	24.0
51+	3.3	2,491	15.3	6,508	21.5	7,294	2.1	660	14.9	3,422	10.0
Total	**100**	**75,716**	**100**	**42,566**	**100**	**33,989**	**100**	**31,129**	**100**	**23,032**	**100**
GENDER											
Male	57.7	43,700	67.4	28,684	68.8	23,399	71.4	22,223	66.6	15,346	64.2
Female	42.2	31,965	32.6	13,862	31.1	10,575	28.6	8,891	33.3	7,668	35.8
Other	0.1	51	0	20	0	15	0	15	0.1	18	0.1
Total	**100**	**75,716**	**100**	**42,566**	**100**	**33,989**	**100**	**31,129**	**100**	**23,032**	**100**
TOTAL % OF ADMISSIONS (215,567)	**35.1**		**19.7**		**15.8**		**14.4**		**10.7**		**100.0**

Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Table III.23 – Treatment Admission Statistics from State Funded Agencies by Top Five Primary Drugs of Abuse: Race, California, Fiscal Year 2006-07

	Methamphetamine		Alcohol		Heroin		Marijuana/Hashish		Cocaine/Crack		TOTAL % (215,567)
	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	
RACE											
White/Caucasian	57.5	43,526	55.9	23,803	53.7	18,269	37.2	11,595	23	5,298	50.3
Black/African-American	4.1	3,110	14	5,954	11.8	3,998	21.3	6,643	56.9	13,105	15.7
American Indian and Alaska Native (1)	2.6	2,006	2.4	1,039	2	672	1.8	561	0.9	211	2.2
Asian	3.5	2,673	2.1	892	1.3	448	3	919	2.3	539	2.7
Pacific Islander	0.5	401	0.3	147	0.2	70	0.4	136	0.2	45	0.4
Multi Racial	3.7	2,815	3	1,295	2	691	4.6	1,442	2.1	495	3.3
Other	28	21,185	22.2	9,436	29	9,841	31.6	9,833	14.5	3,339	25.6
Total	**100**	**75,716**	**100**	**42,566**	**100**	**33,989**	**100**	**31,129**	**100**	**23,032**	**100**
TOTAL % OF ADMISSIONS (215,567)	**35.1**		**19.7**		**15.8**		**14.4**		**10.7**		**100.0**

Note: In Cal OMS, race and ethnicity overlap, so that each category includes all clients.

Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Table III.24 – Treatment Admission Statistics from State Funded Agencies by Top Five Primary Drugs of Abuse: Ethnicity, California, Fiscal Year 2006-07

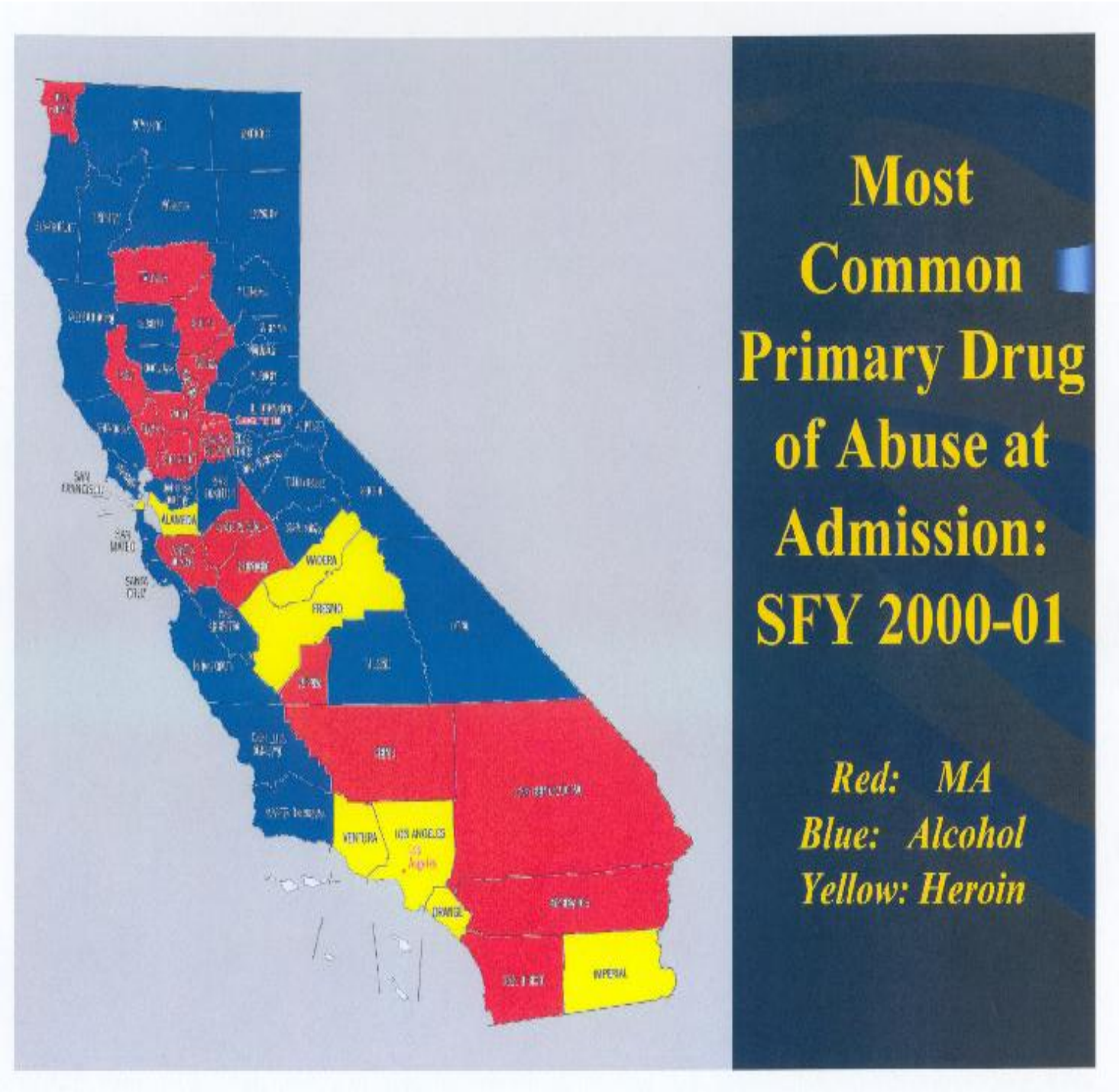
	Methamphetamine		Alcohol		Heroin		Marijuana/Hashish		Cocaine/Crack		TOTAL % (215,567)
	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	Admissions %	N	
ETHNICITY											
Hispanic/Latino	**28605**	**29.4**	**12477**	**37.3**	**12694**	**41.3**	**12858**	**19.9**	**4582**	**33.9**	**33.9**
Mexican / Mexican American	30.8	23,289	23	9,775	32.3	10,993	32.9	10,249	14.5	3,342	**27.4**
Cuban	0.2	159	0.2	73	0.2	55	0.2	64	0.4	83	**0.2**
Puerto Rican	0.7	493	0.5	214	0.7	240	0.7	211	0.7	164	**0.6**
Other Hispanic / Latino	6.2	4,664	5.7	2,415	4.1	1,406	7.5	2,334	4.3	993	**5.7**
Not Hispanic	**62.2**	**47,111**	**70.7**	**30,089**	**62.7**	**21,295**	**58.7**	**18,271**	**80.1**	**18,450**	**66.1**
Total	**100**	**75,716**	**100**	**42,566**	**100**	**33,989**	**100**	**31,129**	**100**	**23,032**	**100**
TOTAL % OF ADMISSIONS (215,567)	**35.1**		**19.7**		**15.8**		**14.4**		**10.7**		**100.0**

Note: In Cal OMS, race and ethnicity overlap, so that each category includes all clients.
Source: California Outcomes Measurement System, 2006-07; California Alcohol and Drug Program (ADP). Special data run on 12/10/07 by Cal OMS-Treatment, ADP.
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Highlights

- Five substances— methamphetamine, alcohol, heroin, marijuana/hashish, and cocaine/crack—represent the primary drugs of abuse for 96% of clients in State-funded programs.
- Thirty-five percent of treatment admissions are for methamphetamine use, followed by alcohol (20%), heroin (16%), marijuana/hashish (14%), and cocaine/crack (11%).
- Men make up the bulk of alcohol and drug treatment admissions, and comprise two thirds or more of treatment clients for four of the five primary drugs of abuse (except methamphetamine); women represent 42% of methamphetamine treatment admissions.
- Non-Hispanics account for most treatment admissions for all five substances.
  - Whites make up the majority of treatment admissions for methamphetamine, alcohol, and heroin, and marijuana/hashish.
  - African Americans, however, account for about 58% of admissions for cocaine/crack use, and 20% of marijuana/hashish use.

Map III.25 – Most Common Primary Drug of Abuse at Admission, California, 2000-2001



Source: California Alcohol and Drug Program (ADP).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

Map III.26 – Most Common Primary Drug of Abuse at Admission, California, 2004-2005

Source: California Alcohol and Drug Program (ADP).
Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

IV. Selected Risk and Protective Factors

A. Youth Risk and Protective Factors

1. National Survey of Drug Use and Health (NSDUH)

NSDUH is an in-person, self-report annual survey produced by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies, and Research Triangle Institute, International (RTI). Not only does NSDUH provide national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use, it also probes respondents about their perceptions of risk and protective factors. Selected items are presented to indicate the types of factors included in NSDUH.

Table IV.1 Perceiving Moderate/Great Risk of Harm from Having Five or More Alcoholic Drinks Once or Twice a Week, by Age Group, California, 2002-2006

Age Group	2002-03	2003-04	2004-05	2005-06
12 to 17[1]	77.7%	77.1%	78.4%	81.9%
18+	83.1%	82.8%	82.6%	81.8%

[1]Difference between the 2005–06 and 2004–05 estimates *is statistically significant at the 0.05 level*.

Table IV.2 Perception of Disapproval of Peers' Substance Use Activities Among 12- to 17-Year-Olds, California, 2002-2006

Perception of Disapproval (%)	2002-03	2003-04	2004-05	2005-06
Having 1 or 2 Alcoholic Drinks Nearly Every Day[1]	85.4	84.7	85.9	87.7
Smoking One or More Packs of Cigarettes a Day	89.9	89.1	89.2	90.1
Trying Marijuana Once or Twice[2]	80	80.6	80.8	81.7
Using Marijuana Once a Month or More[3]	81	79.1	79.8	82.2

[1,2]Difference between the 2005–06 and 2004–05 estimates *is statistically significant at the 0.05 level*.

[3]Differences between the 2003–04 and 2002–03 estimates, and between the 2004-05 and 2005-06 estimates are *statistically significant at the 0.05 level.*

Table IV.3 Family Communication About Alcohol, Tobacco, and Other Drugs During the Past 12 Months California, 2002-2006

Reporter	2002-03	2003-04	2004-05	2005-06
% Youth (12-17) Talked with Parent(s)	59.3	60	61.8	62.1
% Parent Talked to Youth	89.6	88	86.6	89.7

Note: Based on reports of youth (12-17) and their parents/legal guardians (aged 18 or older) who reported talking to either other at least once.

Table IV.4 Percentage of Youth Reporting Exposure to Prevention Messages, California, 2002-2006

Prevention Message	2002-03	2003-04	2004-05	2005-06
Yes	93	92.4	91.4	90.7

Table IV.5 Perception Regarding Workplace Policy on Random Drugs and Alcohol Testing: Percentage Reporting They Would Be More Likely to Work for an Employer Who Randomly Drug Tests, California, 2002-2006

Age Group	2002-03	2003-04	2004-05	2005-06
15 to 17	29.4	28.7	25.7	29.1
18+	39.3	38.9	38.5	38.7

Note: Estimates in Tables IV.1-5 are based on a design-based estimation approach. State estimates are based on combined data from two years of NSDUH, e.g., State estimates presented for 2004–05 are based on combined data from the 2004 and 2005 NSDUH.

Source for Tables IV.1-5: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2002, 2003, 2004, 2005, and 2006.

Highlights

- Perceptions of moderate/great harm from heavy alcohol use and disapproval of peer's substance use activities are generally high across all respondents and items (i.e. 82+%)
- There is a significant gap between youth's and parents' reported family communication on substance use, with 90% of parents but only 62% of youth reporting talking about substance use during the past 12 months
- Reported exposure to prevention messages appears very high, but no details are available about the quality and quantity of the messages.

Appendix A – Data Source Descriptions

I. Availability

1. Alcohol Epidemiologic Data System (AEDS)
2. Adult Per Capita Cigarette Pack Consumption Data

II. Consumption of Alcohol, Tobacco, or Other Drugs

3. California Student Survey (CHKS)
4. California Student Tobacco Survey (CSTS)
5. California Health Interview Survey (CHIS)
6. National Survey of Drug Use and Health (NSDUH)
7. Behavioral Risk Factor Surveillance System (BRFSS)
8. California Behavioral Risk Factor Survey (BRFS)
9. California Adult Tobacco Survey (CATS)
10. California Tobacco Survey (CTS)
11. California Women's Health Survey (CWHS)
12. Maternal Infant Health Assessment (MIHA)

III. Consequences of Alcohol, Tobacco, or Other Drug Use

13. California Death Statistical Master (DSM) Files
14. Alcohol-Related Disease Impact (ARDI) Software
15. Hospital Inpatient Discharge and Emergency Department Encounter Data
16. Statewide Integrated Traffic Records System (SWITRS)
17. Fatality Analysis Reporting System (FARS)
18. Monthly Arrest and Citation Register (MACR)
19. California Outcomes Measurement System: Prevention (Cal OMS-Pv)
20. California Outcomes Measurement System: Treatment (Cal OMS-Tx)

I. Availability

1. Alcohol Epidemiologic Data System (AEDS).

Access Point:
http://www.niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/AlcoholSales/default.htm

Description: This website provides a file that lists the "per capita alcohol consumption by State…" Data are taken from the National Institute on Alcohol Abuse and Alcoholism's Alcohol Epidemiologic Data System (AEDS). The AEDS' self-defined role is to identify, obtain, maintain, analyze, and extend alcohol-related datasets. The AEDS produces the annual Alcohol Epidemiologic Data Directory which is a current listing of (mainly national) "surveys and other relevant data suitable for epidemiological research on alcohol." Since 1977 the AEDS has served as a data repository and contains alcohol epidemiological data drawn from population-based surveys and other epidemiologic surveillance efforts. However, data sets are normally not available from AEDS directly, but rather from the organizations that produce or sponsor them.

Sources: Alcohol Epidemiologic Data System. Lakins, N.E.; LaVallee, R.A.; Williams, G.D.; and Yi, H. Surveillance Report #85: Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1970–2006. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention Research (November 2008).

Alcohol Epidemiologic Data System. Nephew, T.M., Yi, H., Williams, G.D., Stinson, F.S., and Dufour, M.C. U.S. Alcohol Epidemiologic Data Reference Manual, Vol. 1, 4th ed. U.S. Apparent Consumption of Alcoholic Beverages Based on State Sales, Taxation, or Receipt Data. Washington, DC: NIAAA. NIH Publication No. 04-5563 (June 2004).

Strengths:
- This is the largest compendium of (national) alcohol-related data sets
- Annual estimates of national and state apparent per capita alcohol consumption are available 1970.

Limitations:
- The availability of specific data sets depends on the source. For instance, there appears to be a multiple year lag in the production and/or public availability of the per capita alcohol consumption data tables

Selected Indicators:
- Per Capita alcohol consumption (age 14 and older), California, 1990-2005

2. Adult Per Capita Cigarette Pack Consumption Data

Access Point: http://ww2.cdph.ca.gov/programs/tobacco/Documents/CTCPUpdate2009.pdf (Figure 16)

Description: The per capita cigarette pack consumption data are produced by the Tobacco Control Section, California Department of Public Health based on information from several sources. The California State Board of Equalization provides historical data about the annual tax rate on cigarette packs sold. The economic consulting firm of Orzechowski and Walker provides estimates of the annual number of cigarettes pack sold in California. Data from the United States Department of Agriculture is used to provide similar data on cigarette packs sold in the US. Data from the U.S. Census and the California Department of Finance are used to produce population estimates.

Strengths:
- Annual estimates are available since Fiscal Year 1986/87
- According to the authors of The Tax Burden on Tobacco, the survey responses by thousands of cigarette retailers are used to confirm the accuracy of the cigarette pack sales figures

Limitations:

- The source of data estimates of the annual number of cigarettes sold—Orzechowski and Walker's book *The Tax Burden on Tobacco*—is funded by the tobacco industry.

Selected Indicators:

- Per capita cigarette pack consumption by adults, California and United States, 1986-2006

II. Consumption of Alcohol, Tobacco, or Other Drugs

3. California Student Survey

Access Point: 12th Biannual Survey 2007-2008 **–** An online access point to California Student Survey data is forthcoming; please contact WestED, Inc. c/o gaustin@wested.org for further information.

Description: The California Student Survey (CSS) is a biennial survey of drug, alcohol, and tobacco use and other risk factors among California students in grades 7, 9, and 11. CSS data are obtained surveying students attending a representative sample of California public and private secondary schools and classrooms. The CSS began in 1985, and since 1999 it has been integrated with the California Healthy Kids Survey (CHKS), which share many of the same questions, but administered to a different, non-representative sample of schools and classrooms. Participation of school districts, schools, and students is voluntary.

The implementation of the 2007-08 CSS was a collaborative effort among the Crime and Violence Prevention Center (CVPC) in the California Office of the Attorney General (OAG), the CA Department of Education and Alcohol and Drug Programs, and WestEd. WestEd, a private research entity, collects these data for the California OAG. The CVPC was eliminated by the OAG due to budgetary constraints and thus the CSS results are not posted on their web site as was the case in the past.

Strengths:

- CSS is best suited for observing statewide trends.
- Because it is integrated with the CHKS, it is also able to provide state norms for local data.
- CSS data are a means of accessing overall ATOD use prevalence, and the size of the population needing special attention (intervention).
- Data indicators comparable with those used in the national Youth Risk Behavior Survey

Limitations:

- Changes in question wording among survey years limit the ability to interpret trends; Caution should be exercised in determining whether differences reflect actual behavior changes.
- Based on new prescription and over-the-counter drug question on the 2007-08 CSS, previous surveys "have significantly underestimated actual levels of high school substance use by under-assessing the level of use of "medicinal" drugs."
- Since data are collected every two years, it may not be best suited in identifying rapid changes in ATOD use patterns.
- The student population may not capture use among the general adolescent population.

Selected Indicators:

- Tobacco: Past 30 day use of cigarettes and smokeless tobacco among 7th, 9th, and 11th graders
- Alcohol: Past 30 day use of alcohol and binge drinking among 7th, 9th, and 11th graders
- Other Drugs: Past 30 Day use of amphetamines, cocaine, inhalants, marijuana, and psychedelic drugs among 7th, 9th, and 11th graders
- Tobacco: Lifetime use of cigarettes and smokeless tobacco among 7th, 9th, and 11th graders
- Alcohol: Lifetime use of alcohol among 7th, 9th, and 11th graders
- Other Drugs: Lifetime use of amphetamines, cocaine, inhalants, marijuana, prescription painkillers (added in 2005-06) and psychedelic drugs among 7th, 9th, and 11th graders

4. California Student Tobacco Survey

Access Point:
http://www.cstats.info/index.cfm?fuseaction=base.selectDTNext&deID=9&deTableName=tblSBY_1&ttID=7

Description: The California Student Tobacco Survey (CSTS) is a classroom-based, self-report survey that assesses smoking prevalence for public and private school students in grades 6 through 12. The CSTS is conducted every two years. The CSTS sample design allows for surveillance of tobacco issues across 12 regions in California—the five largest counties and 5 demographically similar multi-county regions.

Strengths:
- The CSTS is designed to provide representative state level and regional data similar to the National Youth Tobacco Survey. It is the "official" source for youth tobacco use in the state.
- The large sample size of the CSTS allows for reliable estimates of youth smoking prevalence rates by grade level and by race and ethnic groups.
- It provides a crude measure of environmental tobacco smoke for California's youth. Participation in the CSTS is completely voluntary and anonymous.

Limitations:
- The typical biases inherent in self-report data.
- Data is available every other year.

Selected Indicators:
- Cigarette smoking in Past 30 Days

5. California Health Interview Survey (CHIS)

Access Point: http://www.chis.ucla.edu/main/default.asp

Description: The California Health Interview Survey (CHIS) is a population-based telephone survey of California's population conducted every other year since 2001. CHIS is the largest health survey conducted in any state and one of the largest health surveys in the nation. CHIS is based at the UCLA Center for Health Policy Research (CHPR) and is conducted in collaboration with the California Department of Public Health, the Department of Health Care Services, and the Public Health Institute. CHIS collects extensive information for all age groups on health status, health conditions, health-related behaviors, health insurance coverage, access to health care services, and other health and health related issues. Since it was first conducted in 2001, CHIS has become a valuable tool for policy makers, researchers, and health advocates needing a detailed snapshot of the health needs of California's diverse population.

The survey uses a well-established, reliable, and scientifically valid random-digit-dial (RDD) telephone methodology. Households are sampled from every county in the state, and interviews are conducted with one randomly selected adult from each household. The 2007 survey included a sub-sample of 800 households with only a cellular phone. In households with children, one adolescent and one child are also randomly selected for interviews. CHIS is administered in multiple languages and is unique in its ability to distinguish among Asian groups that are usually combined under the single category "Asian". The CHIS 2007 sample is representative of California's non-institutionalized population and is comprised of 48,791 adults, 3,622 adolescents ages 12-17 and 9,818 children ages 0-11. This large sample size provides data for the state as a whole, for individual counties with populations over 100,000, and for aggregates of smaller counties.

Strengths:
- CHIS' data for many questions is readily available to the public by registering at AskCHIS (www.askchis.org), and using the easy to use query system for creating custom data.

- CHIS' large sample size allows for state and county-level level estimates for both adults and children (0-11) in addition to age (within 3 year range), gender, and race/ethnicity breakdowns within county, and across counties and regions.
- Confidence intervals are also provided to describe the precision and stability of the prevalence estimates and allow for more accurate interpretations of estimates based on small numbers.
- Currently CHIS is occurring every two years allowing for trend analyses.
- All counties with populations over 100,000 (41) are included and the rest (17) are combined into three groups of contiguous counties.
- Selected illegal drug items are included for adolescents.

Limitations:
- The ability to sustain the survey over time is still to be determined given the tremendous cost and effort to conduct CHIS. The cost of including or adding individual items is extremely high.
- Data are collected every other year.
- Even with its large sample size, seventeen counties do not have separate county-level estimates.
- Some county-level estimates may be unstable due to small numbers. For example, the adolescent sample is relatively small (N=~3,600), smaller than the BRFSS adult sample (~10,000), and produces relatively unstable estimates for counties.
- Some items are not included in every bi-annual administration thus hindering its use to track trends.
- CHIS summary data lumps adolescents into one single age group (12-17), similar to the National Survey on Drug Use and Health, although three-year age grouping can be queried.
- Overall there have been only a few consistent alcohol and drug items over the four surveys. For example, there are no items on illegal drug use for adults.

Selected Indicators for Adolescents:
- Tobacco: Current smoking status, cigarettes
- Alcohol: Ever Drank; Binge drinking in past month
- Marijuana: Use in past month and year
- Other Drugs: Ever tried marijuana, cocaine, sniffing glue, or other drugs

Selected Indicators for Adults:
- Tobacco: Current smoking status, cigarettes
- Alcohol: Ever Drank; Binge Alcohol Use

6. National Survey of Drug Use and Health (NSDUH)

Access Point: http://www.oas.samhsa.gov/2k6state/toc.cfm

Description: The National Survey on Drug Use and Health (NSDUH) is an annual, in-person, self-report survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and produced by SAMHSA's Office of Applied Studies, and Research Triangle Institute, International (RTI). The survey provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use. A face-to-face questionnaire is administered to a representative, randomly selected sample of civilian, non-institutionalized persons aged 12 or older at their place of residence. Youth aged 12 to 17, and adults aged 18 to 24, are oversampled. Previously (before 2002) this survey was called the National Household Survey on Drug Abuse (NHSDA). The administration of the NSDUH is federally mandated. State level estimates have been possible since 1999. The NSDUH interview consists of a core section that remains the same from year to year and that establish substance use prevalence trends, and supplemental sections that can be revised, dropped, or added from year to year.

The primary objectives of the NSDUH are to
- collect timely data on the magnitude and patterns of alcohol, tobacco, and illegal substance use and abuse
- track trends in the use of drugs
- assess the consequences of substance use and abuse; and

- identify those groups at high risk for substance use and abuse.

Strengths:
- NSDUH is the federal government's official (primary) source of information about substance use at the national level.
- Data on 70,000 randomly selected individuals, 12 years and older, are collected annually. It is the largest of its kind.
- Novel data analyses are possible because of the sample size. For instance, data on parents and children in the same household are available, allowing for a measure of awareness by parents of their child's drug use.

Limitations:
- The data do not describe segments of the population that may be particularly susceptible to problems with ATOD use: the military, prison populations, and the homeless.
- Depending on the substance assessed, small sample sizes and small prevalence sometimes leads to the need to combine data across years.
- In validity checks, there is a measurable difference (15%) between self-report for tobacco use and the results of urine tests for youth and young adults.

Selected Indicators:
- Selected measures of alcohol, tobacco, and other drugs in the past month, ages 12 to 17, 2002-2007
- Selected measures of alcohol, tobacco, and other drugs in the past month, ages 18 to 25, 2002-2007
- Selected measures of alcohol, tobacco, and other drugs in the past month, age 26 and over, 2002-2007

7. Behavioral Risk Factor Surveillance System (BRFSS)

Access Point: http://apps.nccd.cdc.gov/brfss/ and http://www.cdc.gov/brfss/

Description: The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and the states and territories of the United States. The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the U. S. yearly since 1984. The BRFSS is a state-based system of health surveys that generate information about health risk behaviors, clinical preventive practices, and health care access and use primarily related to chronic diseases and injury. The annual questionnaire has three parts: 1) core component asked by all states; 2) optional modules states may elect to use; and 3) state-added questions. The computer assisted telephone interview method of survey data collection is well established, reliable, scientifically valid, and cost-effective.

State health departments manage the BRFSS field operations following CDC guidelines. The emphasis of the survey is on health-related behaviors in the California adult population with a specific focus on behaviors related to disease and injury. The survey is part of surveillance efforts conducted by the California Department of Public Health and the Public Health Institute in cooperation with CDC. The annual sample size for the survey is approximately 5,000 interviews. Starting in 2008 the sample size will be double for some items, with two tracks of interviews.

Strengths:
- Uses a probability random sample of households with telephones (one adult per household) in the state, and a well-established national standard survey design.
- Collects uniform state-specific data regularly over time in the adult population on preventive health practices and risk behaviors that are linked to chronic disease, injuries, and preventable infectious diseases.
- Both part of the national BRFSS and uses many questions designed to be comparability with other national surveys.

- First time use of small area estimation methods to produce county and regional level estimates on single questionnaire items.

Limitations:
- No data on those less than 18 years old.
- Limited core questions on alcohol and tobacco, with no questions on illegal drug usage; optional questions may not be repeated in future iterations.
- County-level estimates not available for all counties (i.e., only regional estimates available for smaller counties). County estimates may not be as precise as state-level estimates (i.e., larger confidence intervals).

Selected Indicators:
- Past 30-day alcohol use among adults, California, 2001-2006
- Selected alcohol and tobacco consumption indicators, California compared with the United States, 2005

8. California Behavioral Risk Factor Survey (BRFS)

Access Point: http://www.surveyresearchgroup.org/sub.php?page=projects_behavioral

Description: The California Behavioral Risk Factor Survey (BRFS) is an ongoing collaborative effort of the California Department of Health Services, the Public Health Institute and the Centers for Disease Control and Prevention. The survey is conducted by the Survey Research Group (SRG) of the California Department of Health Services' (CDHS) Cancer Surveillance Section (CSS). BRFS is part of the (national) Behavioral Risk Factor Surveillance System (BRFSS)—the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the U. S. yearly since 1984. The annual questionnaire has three parts: 1) core component asked by all states; 2) optional modules states may elect to use; and 3) state-added questions.

The emphasis of the survey is on health-related behaviors in the California adult population with a specific focus on behaviors related to disease and injury. The survey is part of surveillance efforts conducted by the California Department of Public Health and the Public Health Institute in cooperation with CDC. The annual sample size for the survey is approximately 5,500 interviews. Starting in 2008 the sample size will be double for some items, with two tracks of interviews.

Strengths:
- Uses a probability random sample of households with telephones (one adult per household) in the state, and a well-established national standard survey design.
- Collects uniform state-specific data regularly over time in the adult population on preventive health practices and risk behaviors that are linked to chronic disease, injuries, and preventable infectious diseases.
- Both part of the national BRFSS and uses many questions designed to be comparability with other national surveys.
- First time use of small area estimation methods to produce county and regional level estimates on single questionnaire items.

Limitations:
- No data on those less than 18 years old.
- Limited core questions on alcohol and tobacco, with no questions on illegal drug usage; optional questions may not be repeated in future iterations.
- County-level estimates not available for all counties (i.e., only regional estimates available for smaller counties). County estimates may not be as precise as state-level estimates (i.e., larger confidence intervals).

Selected Indicators:
- Smoking prevalence among adults, California
- Smoking prevalence among adults by gender, California
- Smoking prevalence among adults by age group, California

9. California Adult Tobacco Survey

Access Point: http://www.surveyresearchgroup.org/sub.php?page=projects_adult_tobacco

Description: The California Adult Tobacco Survey (CATS) is an ongoing monthly telephone survey that collects information on a wide variety of tobacco-related behaviors and attitudes from a random sample of adults. Topics addressed include past and current cigarette smoking, and attitude and beliefs about tobacco use. The survey began in February of 1993. The CATS is administered by the Survey Research Group, which is co-located with the Cancer Surveillance Section of the California Department of Health Services. The annual sample size for CATS is approximately 5,500; results are combined with BRFSS data (reaching 10,000) to provide official state prevalence estimates.

Strengths:
- The CATS is an ongoing survey; data are collected monthly.
- CATS has a respectable history of being used to track the attitudes and beliefs of Californians concerning tobacco-related legislation
- Trend data are available beginning in 1993
- Typically, questions used in the CATS have been taken from previously conducted national or statewide surveys to ensure comparability

Limitations:
- Due to the sample size, the data has to be weighted for age, race, and gender.
- The CATS only interviews adults 18 and above
- Because it is a telephone interview, those without telephones are not included.
- The CATS is best suited for providing state prevalence estimates; regional and county breakdowns are not appropriate
- There is some evidence suggesting that tobacco specific surveys may undercount smoking prevalence for some respondents (i.e., women who occasionally smoke).

Selected Indicators:
- Smoking prevalence among adults, California
- Smoking prevalence among adults by gender, California
- Smoking prevalence among adults by age group, California

10. California Tobacco Survey

Access Point:
http://www.cstats.info/index.cfm?fuseaction=base.selectDTNext&deID=8&deTableName=tblSBA_1&ttID=7

Description: The California Tobacco Survey (CTS), funded by the California Tobacco Control Program of the California Department of Public Health, has been conducted every three years since 1990 by the Cancer Prevention and Control Program of the University of California, San Diego. The CTS is a large-scale random-digit-dial telephone survey that includes a screener survey, an adult extended survey, and a youth survey. The sampling strategy includes stratification by 18 regions in California, with sample sizes that allow for the calculation of regional and some individual county estimates. To allow for year-to-year comparisons of the estimates, all years of survey data were weighted to the 1990 California population by age, gender, and race/ethnicity. Each region has been separately weighted to the California population in 1990 to facilitate inter-region comparisons. 'Ever smokers' are defined as the percentage of adults (persons aged 18 and over) who report ever having smoked 100 cigarettes in their entire life. 'Daily smokers' are defined as the percentage of adults who report ever having smoked 100 cigarettes in their

entire life and who report now smoking every day. Since 1999, current smokers have been defined as the percentage of adults who report ever having smoked 100 cigarettes in their entire life and who report now smoking either every day or some days.

Strengths:
- Representative statewide data is collected on cigarette smoking behavior, attitudes toward smoking, media exposure to smoking, and use of tobacco products other than cigarettes.
- Trend data is available since the early 1990s.

Limitations:
- Since the data are only collected every three years, year-to-year change in smoking prevalence is not measureable.
- Due to sample size limitations, not all information is available for every county. Some estimates are in fact regional estimates.

Selected Indicators:
- Past 30-day use of tobacco among adults by age, gender, race, and ethnicity, 1999, 2002, 2005

11. California Women's Health Survey

Access Point: http://ww2.cdph.ca.gov/data/surveys/Pages/CWHS.aspx
http://www.surveyresearchgroup.org/sub.php?page=data_ca_2

Description: The California Women's Health Survey (CWHS) is an annual statewide household-based telephone survey that collects information from a sample of approximately 4,000 randomly selected adult women (18 years of age and older) on a wide variety of health indicators, and health related behaviors and attitudes. The survey uses a random-digit-dialing research design to produce its probability sample, and includes core demographic questions, health care access, health insurance, and specific women's health questions. It began in March 1997 as a collaborative effort between the California Department of Health Services (Department of Public Health), the California Department of Mental Health, the California Department of Alcohol and Drug Programs, California Medical Review, Inc. (CMRI), the California Department of Social Services, and the Public Health Institute.

The Survey Research Group (SRG) of the Public Health Institute administers the CWHS. SRG specializes in conducting scientific health-related telephone surveys of the California population.

Strengths:
- The survey is conducted in English and Spanish.
- The sample size permits comparisons among age, race, and ethnic groups.
- It is the first California survey focusing on women's health and was created as a response to the lack of California-specific data on women's health status, behaviors, and attitudes.

Limitations:
- The sample size is too small for regional or county estimates; statewide estimates are possible through weighting.
- Only women living in households with telephones, and who can be understood, are included in the sample.
- There is no validation of self-report data.
- The release of the annual data is after the first quarter of the following year.

Selected Indicators:
- Past 30-day use of alcohol among woman by age, race, and ethnicity
- Current use of tobacco among woman by age, race, and ethnicity

12. Maternal Infant Health Assessment Survey

Access Point:
http://ww2.cdph.ca.gov/data/surveys/Pages/MaternalandInfantHealthAssessment(MIHA)survey.aspx

Description: The Maternal Infant Health Assessment (MIHA) is a survey of a random sample of women drawn from birth certificate data that have been stratified by region of residence, maternal race/ethnicity, and maternal education and who deliver live infants in California. First conducted in 1999. MIHA is an annual, population-based self-administered survey of about 3,500 women who are at least 15 years old and recently gave birth to a live infant in California. MIHA asks women to report on their behaviors and experiences that occur before, during, and after pregnancy. MIHA uses a mail questionnaire (English and Spanish), sent eight to ten weeks post-partum, with follow-up mailings and telephone follow-up to non-responders. Random stratified, based on race/ethnicity (African Americans are over-sampled), education level, and region within California. MIHA is a collaborative project between DHS', Maternal, Child and Adolescent Health Branch (MCAH) and researchers in the Department of Family and Community Medicine at the University of California, San Francisco.

Strengths:
- MIHA is the largest survey of recently delivered mothers.
- MIHA is modeled after PRAMS,
- The response rate is over 70 percent.
- Some questions change from year to year to address emerging issues.
- When compared using statewide birth certificate data, the MIHA sample appears very similar to the statewide population of eligible mothers.

Limitations:
- Studies have shown that self-administered mail surveys find different rates than telephone surveys (e.g., CWHS).
- Specific estimates of drinking and smoking during the second trimester are unavailable.
- The small sample requires the use of weighting to produce statewide estimates.

Selected Indicators:
- Percentage of adult women giving birth who reported drinking during pregnancy by age, race, and ethnicity, 2005-2006.
- Percentage of adult women giving birth who reported smoking during pregnancy by age, race, and ethnicity, 2005-2006.

III. Consequences of Alcohol, Tobacco, or Other Drug Use

13. California Death Statistical Master Files

Access Point: http://www.applications.dhs.ca.gov/vsq/default.asp
http://www.cdph.ca.gov/data/dataresources/Pages/default.aspx
County Health Officers may be sources of these data as well.

Description: The California Department of Public Health's Center for Health Statistics' Office of Vital Records (OVR) maintains electronic Statistical Master Files of live births, deaths, and fetal deaths. The Death Statistical Master Files are compiled from the information reported on official death certificates, including detailed demographic information related to the decedent, as well as medical data related to the vital event.

Vital Statistics (birth, death, and fetal death) data files are released in a variety of versions, with and without personal identifiers, in order to provide maximum protection to the confidentiality of the individuals named on the certificates. Users may need to obtain approvals from the California Health and Human Services Agency's Committee for the Protection of Human Subjects and/or the California Department of

Public Health Vital Statistics Advisory Committee in order to use death files for research purposes. Once the files are obtained, users must follow strict guidelines to protect the confidentiality of the data.

A Vital Statistics Query System has been developed to provide an interactive Internet interface to obtain tabular summaries and statistical reports from California's birth and death vital statistics databases. However, available online data is usually several years behind the most recently released files.

Strengths:
Death Statistical Master File contains the official record of all deaths in California. The underlying cause of death is coded using the International Classification of Disease using ICD-9 (up to 1998) and ICD-10 (1999 forward) coding system that allows classification of deaths into detailed categories for analyses, including alcohol and drug related causes. Although there are limitations, these data are generally accurate enough to provide good surveillance data for tracking the magnitude and trends for specific causes of death.

Limitations:
- Use of death files for surveillance and research purposes require special care.
- Although efforts are made to ensure vital statistics are as accurate as possible, there are many potential sources of error in these data, including unreported deaths, erroneous demographic and clinical data on the certificates, inaccurate death certificates diagnoses, and variation and errors in the assignment of ICD codes.
- Analyses require the use of a statistical database package (e.g., SAS or SPSS).
- Only the underlying cause of death code is provided in the death file. The Multiple Cause of Death file has the full list of causes identified from the death certificate.
- There is currently about a two year lag in the availability of California Death Statistical Master File data.

Selected Indicators
- Rates for Alcohol-related Deaths
- Rates for Drug-related Deaths

14. Alcohol-Related Disease Impact (ARDI)

Access Point: http://apps.nccd.cdc.gov/ardi/HomePage.aspx

Description: Alcohol-Related Disease Impact (ARDI) software generates estimates of Alcohol-Attributable Deaths and Years of Potential Life Lost due to alcohol consumption. To do this, ARDI either calculates or uses pre-determined estimates of Alcohol-Attributable Fractions (AAFs)—that is, the proportion of deaths from various causes that are due to alcohol. These AAFs are then multiplied by the number of deaths caused by a specific condition (e.g., liver cancer) to obtain the number of alcohol-attributable deaths. The ARDI software uses both 100% attributable and direct and indirect estimates to determine AAFs. Alcohol-related deaths may be underestimated due to the reliance on self-report data (BRFSS), reports of current alcohol consumption, and the impact of secondary causes of death.

Strengths:
- The CDC web site is easy to use to produce state and national AADs and YPLLs.
- Provides a powerful tool for demonstrating the magnitude of the health impacts created by alcohol consumption.
- Allows for comparisons with other “attributable” causes (e.g., tobacco) of deaths and year of life lost.
- Serves as a baseline for calculating economic costs related to alcohol.
- State level estimates are available.

Limitations:
- In determining AAFs, alcohol-related deaths may be underestimated due to the reliance on self-report data (BRFSS), underreporting of current alcohol consumption, and the impact of secondary causes of death.
- ARDI uses only national estimates for AAFs; there are no state-level estimates.
- ARDI only produces a few demographic breakdowns of AADs or estimates of YPLLs.
- Calculation of AAFs are based on available research and may not account for all relevant factors (e.g., former drinkers may not be included).

Selected Indicators:
- Estimated number of annual alcohol-attributable deaths due to medium and high average daily alcohol consumption, 2001-2005.
- Estimated number of annual alcohol-attributable years of potential life lost due to medium and high average daily alcohol consumption, 2001-2005.

15. Hospital Inpatient Discharge and Emergency Department Encounter Data

Access Point: http://www.oshpd.ca.gov/HID/DataFlow/HospMain.html
http://www.oshpd.ca.gov/HID/DataFlow/HospQuery.html
http://www.oshpd.ca.gov/HID/HIRC/index.html

Description: The Office of Statewide Health Planning and Development **(**OSHPD) oversees California's data collection system for tracking hospital inpatient, ambulatory surgery, and emergency department encounters and discharges for administrative billing and payment purposes. Since 2002, facilities report their data via the Medical Information Reporting for California System (MIRCal). The reported data include patient demographic information, such as age, sex, county of residence, and race/ethnicity, diagnostic information, treatment information, disposition, and expected source of payment. An inpatient discharge record is submitted each time a patient is admitted and released from a licensed non-federal hospital in California. An outpatient encounter record is submitted each time a patient is treated in a licensed emergency department or ambulatory surgery center in California. All illnesses, injuries, and diagnostic procedures are captured based on the ICD-9 coding system. The emergency department (ED) data became available beginning January 2005.

The data in this report were derived from special analyses of the state and county data provided by OSHPD. Special permission to access and utilize the data is often needed.

Strengths:
- As the official record of hospitalizations and Emergency Department visits for the state of California, all verifiable patient encounters are documented through OHSPD.
- Rich source of state, county, and local hospital data with demographic and diagnostic information.

Limitations:
- The quality of hospital inpatient and emergency department data depends upon the medical record coding and reporting practices of reporting facilities.
- There is a significant lag in availability of the patient discharge database.

Selected Indicators:
- Rates of Alcohol-related Hospitalizations
- Rates of Drug-related Hospitalizations
- Rates of Tobacco-related Hospitalizations

- Rates of Alcohol-related Hospitalizations and Emergency Department Visits
- Rates of Drug-related Hospitalizations and Emergency Department Visits
- Rates of Tobacco-related Hospitalizations and Emergency Department Visits

16. Statewide Integrated Traffic Records System (SWITRS)

Access Point: www.chp.ca.gov/switrs Annual tabular reports for years 2000 to most recent

Description: SWITRS is operated by the California Highway Patrol with the California Department of Motor Vehicles. It is a database of all property-damage and injury crashes investigated by police in all California jurisdictions. Operators (of vehicles and motorized cycles), pedestrians, and bicyclists are classified according to whether they "had been drinking", and whether or not they were thereby impaired. "Impairment" is determined by judgment of the investigating officer and does not require having a blood alcohol concentration (BAC) beyond the legal limit. However, if the legal BAC is exceeded, the person is automatically determined to be impaired. BAC limits are more stringent for young and commercial-vehicle operators.

Strengths:
- SWITRS includes virtually all injury and damage crashes on California public roads.
- The data system is stable and standard enough to allow comparisons over time and among local jurisdictions.
- The annual report is generally available within six months after the end of the year and devotes 16 tables to alcohol-related crashes, including injuries to unimpaired persons who were victims of a crash caused by an intoxicated person.
- Rates can be calculated by population, number of licensed drivers, number of vehicle registrations, and vehicle miles traveled.

Limitations:
- Only incidents involving traffic on a public road are included. Thus most crashes in driveways, parking lots, shopping malls, and workplaces are missed.
- Some proportion of crashes where police are never summoned do not get reported.
- SWITRS does not collect information on race/ethnicity or other personal characteristics beyond age and gender.
- Actual BAC levels are not available in SWITRS reports. Drugs can be a cause of impairment, alone or in combination with alcohol, but drug impairment is not reported separately from alcohol impairment.

Selected Indicators:
- Injury collisions, persons injured & drivers who had been drinking in alcohol-involved motor vehicle crashes
- Fatal collisions, persons injured & drivers who had been drinking in alcohol-involved motor vehicle crashes

17. Fatality Analysis Reporting System (FARS)

Access Point:
http://www-fars.nhtsa.dot.gov/QueryTool/QuerySection/SelectYear.aspx

Description: In 1975, the U.S. Department of Transportation, National Highway Traffic Safety Administration created FARS. FARS is a census of all motor vehicle crashes that result in the death of an occupant of a vehicle or a non-motorist within 30 days of the crash. The crash must involve a motor vehicle travelling on a traffic way customarily open to the public. FARS covers all 50 U.S. states, the District of Columbia, and Puerto Rico. FARS provides detailed data on vehicles, traffic conditions, roadways, and drivers. Information on alcohol/drug involvement and safety restraint use, and annual estimates of alcohol involvement for all fatal traffic crashes. FARS Alcohol files are created that contain recorded driver and non-occupant BAC (blood alcohol content), as well as overall crash alcohol imputed estimates for cases with no reported BAC. Data are available at national, state and county levels. Data on fatal motor vehicle traffic crashes are gathered from the state's own source documents, and are coded on standard FARS forms.

Strengths:

- The data system is stable and standard enough to allow comparisons over time and among local jurisdictions. Data are gathered from several sources (police reports, coroners, EMS, hospitals, and others) and combined to ensure corroborated and complete information coded with strong quality control.
- The FARS Query System provides interactive public access to fatality data through a web interface. Complete raw data files are also available for detailed analysis.
- Crash reports generally have poor reporting of BAC. FARS imputes BAC to cases with no reporting information, giving estimates for all crashes

Limitations:

- Only incidents involving traffic on a public road are included. Thus fatal crashes on private roads and parking lots and crashes off road are missed.
- Only driver BAC is recorded or imputed. Alcohol-related deaths to others involved (passengers, pedestrians, etc.) are not documented.

Selected Indicators:

- Persons killed in alcohol-related crashes by driver's BAC and age, 2006.

18. Monthly Arrest and Citation Register

Access Point: http://ag.ca.gov/cjsc/datatabs.php .

Description: Monthly Arrest and Citation Register (MACR) is maintained by the Criminal Justice Statistics Center for the California Office of the Attorney General which serves as the main data depository of crime and law enforcement reports submitted by local law enforcement throughout the state. It contains information on adult and juvenile arrests, probation status, and other law enforcement activities. Specifically, the use of MACR data provides easy access to alcohol-related and illicit drug offense arrests.

Strengths:

- By including criminal justice data, we are able see an important part of the social, economic, and personal costs associated with involvement with alcohol and other drugs.
- Reflects the actual impact on the criminal justice system regardless of the reason (i.e., magnitude of the actual underlying problem or simply allocation of resources).
- Typically tabled arrest data are available online within 18 months of the end of the reporting year.

Limitations:

- Arrest data are "response" indicators based on the enforcement of laws. They are often heavily influenced by and may reflect the level of resources (e.g., funding, staff/personnel) or administrative or institutional attention devoted to addressing a problem more than the underlying magnitude of the problem itself (PIRE Guidelines, February 2008).

Selected Indicators:

- Alcohol and Drug-related Adult Felony Arrests
- Adult Felony Narcotic Arrests
- Adult Felony Dangerous Drug Arrests
- Adult Felony DUI Arrests
- Alcohol and Drug-related Adult Misdemeanor Arrests
- Adult Misdemeanor Arrests for Marijuana
- Adult Misdemeanor Arrests for Public Drunkenness
- Adult Misdemeanor Arrests for Liquor Law Violations
- Adult Misdemeanor Arrests for DUI

19. California Outcomes Measurement System: Prevention (Cal OMS-Pv)

Access Point: State and county-level data are available through the Cal OMS online-query system. Special permission to access and utilize the data is required for non-county authorized staff.

Description: Cal OMS-Pv is a statewide, web-based data collection system operated by KIT Solutions, Inc. for the California Department of Alcohol and Drug Programs. It is focused on measuring performance outcomes related to prevention efforts. Counties and providers of prevention-related activities and other related agencies submit information to the Cal OMS-Pv database.

Strengths:
- Available data on 1) clients' utilization and access to prevention messages and activities; 2) providers and their prevention strategies; and 3) demographics related to prevention outreach services.
- Available data on service providers' ATOD prevention priorities and clients' perceived needs.

Limitations:
- Reflects publicly funded prevention programs only.
- Reflects the 'counts' of services; it does not describe the quality of those services.
- Service strategy counts are self-classified; providers determine how to categorize their program content.

Selected Indicators:
- Number of persons receiving service strategies

20. California Outcomes Measurement System: Treatment (Cal OMS-Tx)

Access Point: State and county-level data are available by special request to the California Department of Alcohol and Drug Programs' Cal OMS-Tx. Standard and ad hoc reports are available.

Description: Cal OMS-Tx focuses on documenting the delivery of alcohol and drug treatment services. Counties and Direct Providers, with technical assistance from ADP, submit information about admissions to and discharges from publically funded treatment programs. Records are submitted monthly as electronic data files. Once the data arrives, Cal OMS-Tx edits and maintains the data and formulates needed reports about substance abuse treatment activities occurring in the state.

Strengths:
- Treatment data is useful in helping to identify AOD trends and risks
- The client treatment database is updated continuously (as records come in); data reports are easily produced.
- In addition to clients' treatment history, clients' current and prior AOD use, psychosocial factors, life circumstances (criminal history, employment), and demographics are also included.

Limitations:
- The 'quality' of the data—it's accuracy and utility—depends on the completeness and timeliness of the information given by counties and treatment providers.
- The frequent change in treatment providers—both their numbers, and their status (e.g., the types of services they offer)—affects the accuracy of the data; there may be rapid changes in counts.

Selected Indicators:
- Number of persons admitted for AOD treatment by selected demographic characteristics
- Number of AOD treatment programs by Treatment Service Type
- Number and percentage of persons admitted for AOD treatment by selected demographic characteristics for the Top Five Primary Drugs of Abuse.