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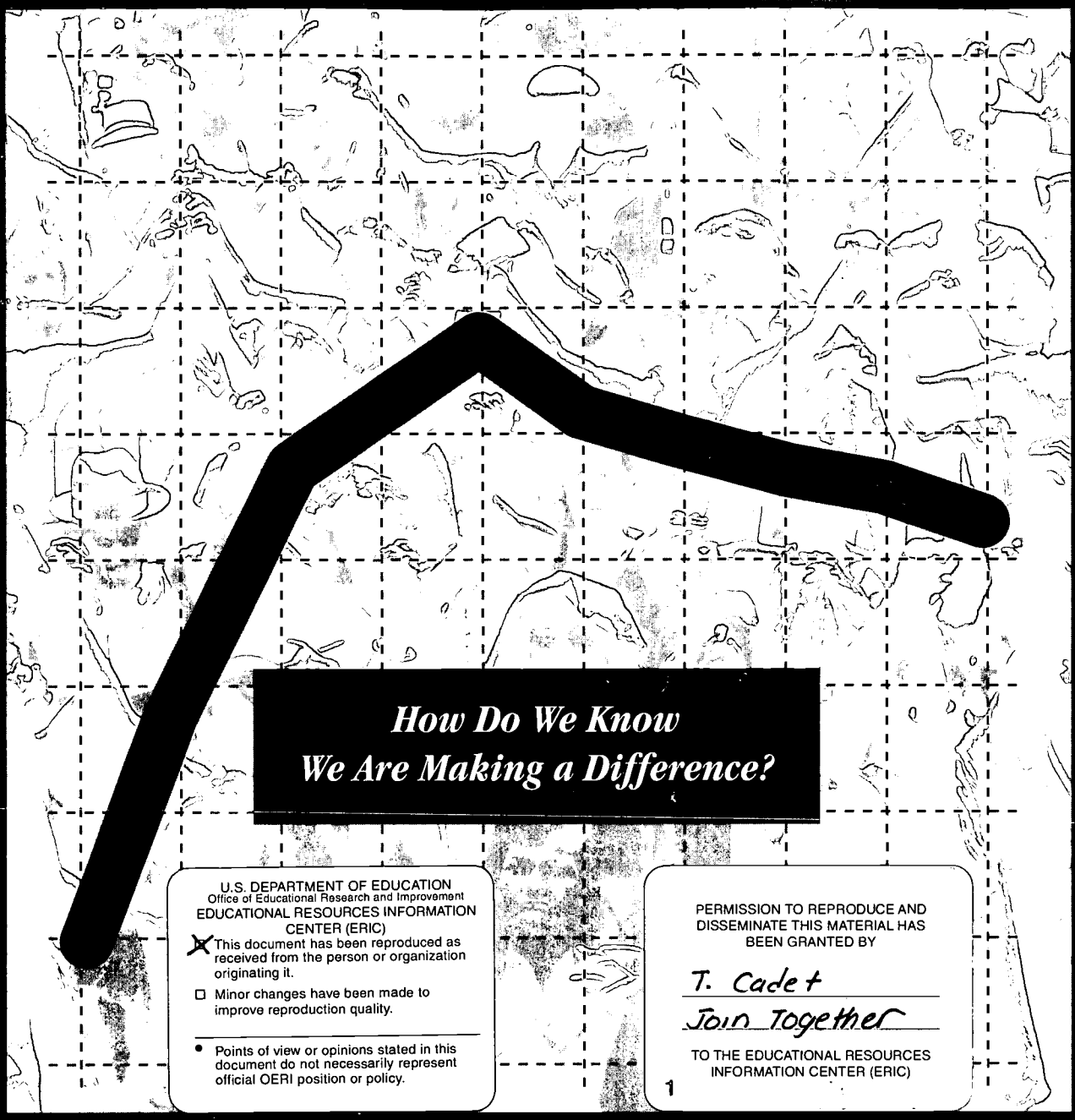
ABSTRACT

This handbook is written to help community coalitions and other groups fighting substance abuse develop indicators that describe the scope and nature of local substance abuse problems. These indicators can be powerful tools in efforts to combat substance abuse. They provide a picture of the local impact of substance abuse problems and make it possible to monitor change in the occurrence of abuse and the level of efforts to prevent, treat, or reduce it. Twenty substance abuse indicators are described that can be monitored at the local level. Chapter 1 introduces the concept of indicators and explores their uses. Chapter 2 describes one approach to the process, and chapter 3 provides basic information on the menu of 20 indicators. Some important use and interpretation issues are outlined in the fourth chapter. Chapter 5 contains state and local directories and data references specified throughout the handbook. Two of the indicators are directly related to education. The first is the existence of primary and secondary school educational programs on tobacco, alcohol, and other drugs in both public and private schools. The second is a record of student disciplinary actions, including suspensions, related to the possession, use, or sale of alcohol, illicit drug, and tobacco. Lists of state alcohol and drug agencies and related state and federal agencies include contact organizations for drug-free schools programs. (SLD)



A Community Substance Abuse Indicators Handbook

Prepared by
Join Together, Boston University School, of Public Health, Boston University *and*
Institute for Health Policy, Heller School, Brandeis University
1997

$10.00
per copy

Introduction

When Ed Koch was Mayor of New York he always asked people "How am I doing?" That is the question we all need to ask about our work against illicit drugs, excessive alcohol and tobacco. The simple truth is, if we do not ask, we will not know.

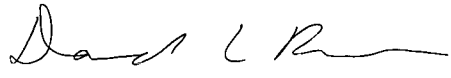
Join Together and Brandeis University are publishing this handbook to help communities monitor their own progress. The content is based on a Join Together workshop that brought community based leaders and academic experts together to discuss this issue.

We think communities will be most successful when they specify the harms they are trying to reduce, implement programs directly related to those harms, and then identify and monitor indicators related to their goals. These measures need to be part of the ongoing program. The results need to be shared with the public.

If a community's highest priority is to do something about underage drinking, the specific programs it adopts — whether in education, enforcement, public awareness or policy change — ought to be related to that problem. Similarly, the indicators it chooses to collect ought to measure underage drinking or its consequences, such as teenage motor vehicle accidents and deaths.

The indicators in this handbook relate to many of the possible goals in communities. Therefore, some will be more useful than others in your community. The starting point for using any of these indicators should be your own community's goals and targets. Once these are clearly articulated, it will be relatively easy to decide which specific indicators will help you monitor progress. Of course, there are many other indicators that you can choose that we have not included in this handbook. Our goal has been to create a useful handbook, not an encyclopedia.

A word of caution is in order. Communities are complex social institutions. Substance abuse involves a complex set of problems. We should be careful not to place too much emphasis on one activity or one indicator. Our strategies to fight substance abuse must recognize the rich complexity of our communities. We must commit ourselves to measuring and publicly reporting our progress, knowing that we will be reporting on a part of what is happening in our communities.



David L. Rosenbloom
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How Do We Know We
Are Making A Difference?

A Community Substance Abuse Indicators Handbook

Prepared by

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1997

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Using Indicators: Benefits and Investments

Introduction

This handbook is written to assist community coalitions and other groups fighting substance abuse. It is presented as a guide to help communities develop indicators that describe the scope and nature of local substance abuse problems. These indicators can be powerful tools in local efforts to reduce substance abuse.

Every coalition has a strategy to reduce harm from substance abuse. Many coalitions and community groups are already using indicator data as part of that strategy. Many other groups would use indicator data if they knew how to go about it. That is precisely the purpose of this handbook — to help you learn how to use indicator data as one strategy in combatting these problems.

We use the term "substance abuse indicator" to mean information which is usually already collected by an organization and used for some monitoring purpose. In some cases however, local data may need to be collected. Community coalitions can use these data to fit their information gathering needs and to inform the community about substance abuse trends.

Why are indicator data useful? They paint a broad picture of the local impact of substance abuse problems. They compare current conditions to those of the past. They also describe and monitor change in:

- **the number of people who use and abuse substances, or who have access to substances,**
- **the level of community harm associated with substance use problems, and**
- **the level of community effort to prevent, treat or reduce the harm from substance abuse.**

Collecting these data at regular intervals will help your community know if it is making a difference in reducing substance abuse problems.

What Are The Benefits?

The benefits of indicator data include direct and indirect payoffs to the coalitions that use them. Some payoffs come from the study process, others from the study findings. The study process itself can build group cohesiveness. Coalition members may come together from many different backgrounds with a common purpose.

A successful indicator project can be used to demonstrate the coalition's competence in identifying local substance abuse problems. The indicators will provide valuable information for deciding upon local action. Indicator data can be used to monitor community change and to compare the level of local problems and local initiatives in similar communities. Thus, the effort is an investment in future collaborations.

What Investments Are Required?

When using indicator data, new surveys or data systems are generally not necessary. Instead, you will invest your resources into retrieving appropriate information from available data sources. Indicator data retrieval requires persistence and perseverance. It does not generally require the level of statistical sophistication necessary to conduct local surveys or to build new surveillance programs.

Embarking on an indicator project requires coalition building skills and commitment from the community group. The steps required to do an indicator study involve identifying, retrieving, and interpreting existing indicator data.

Using This Handbook

The 20 substance abuse indicators described in this handbook include those which can be retrieved at the community level. The data sources are well defined and the interpretation of substance abuse problems is relatively clear. We have described the strengths and limitations of each indicator, and outlined specific steps a community would follow to retrieve the data.

This handbook is designed to be a guide.

Chapter 2 describes one way to approach the process, and also states the necessary time, effort, and commitment involved.

Chapter 3 provides basic information on a menu of 20 substance abuse indicators. It guides community leaders to the best data sources to start such a study.

Chapter 4 outlines some important use and interpretation issues. Once you have reviewed the indicator choices and know which ones fit your interests, it is important to consider these issues before you begin.

Chapter 5 contains state and local directories and data references specified throughout this handbook.

The focus is on alcohol and other drug problems; some topics reference tobacco indicator data as well. We call it a menu of indicator data, because not all indicators can be used by all communities. Use the menu to explore the possible choices. While we feel these indicators are among the best, it is not an exhaustive list. Your community may be able to retrieve other valuable local or existing national indicator information.

Topics Beyond the Scope of Indicator Monitoring

There are many aspects of community substance abuse problems, such as the number of billboard advertisements, for which there are no readily available indicators. (See sidebar.) These topics require special study because the data are not routinely available. We investigated many topics that could not be included here because we found no systematic data collection or existing standard measures. Among the missing topics are: public awareness, community-building, community policing efforts and neighborhood watch groups, purity of illegal street drugs and the number of billboards advertising alcohol or cigarette products. Your group may identify a local data source or decide to tackle a special study of one of these important issues. (See Community Focus.) Such a study may bring big results.

Another important area of community interest – community resilience – goes beyond the scope of this handbook but may be important to your community. There is a growing focus among prevention programs in emphasizing recognition of protective and risk factors. (See Community Focus on the next page.)

Using National Objectives To Set the Context

The Healthy People Year 2000 public health objectives, established to monitor the nation's progress in addressing health status, is another tool for community use.

Dozens of Year 2000 objectives relate to substance use and abuse. This handbook spotlights these objectives so that community leaders and groups can use them as benchmarks to assess local substance abuse problems. They are noted with this Healthy People 2000 icon throughout the handbook.

Chicago

After a three year battle with the city of Chicago, a coalition of organizations announced the removal of "illegal billboards" by the city's zoning department. In 1990, the Coalition Against Billboard Advertising of Alcohol and Tobacco (CABAAT) conducted a ward by ward study in a number of African American communities. The results revealed that more than 2,500 billboard advertisements were erected in Hispanic and African American neighborhoods. The coalition learned that billboards could not be constructed within 75 feet of residential or commercial businesses. The coalition noted that 579 alcohol and tobacco advertisement billboards were illegal because of zoning violations and construction without valid city permits.

SOURCE: *Chicago Defender*, February 20, 1993, p. 1.

Oregon

The Oregon Together! project is based on the Risk-Focused Prevention Model developed by Dr. J. David Hawkins and Dr. Richard Catalano of the Social Development Research Group in Seattle, Washington. Oregon Together! will be tracking risk/protective factors for each Oregon county. The indicators include measures of housing transitions and mobility, low neighborhood attachment, community disorganization, economic deprivation, family risk history, family conflict, academic failure, school attendance, and many other dimensions.

SOURCE: Judy Cushing, a 1994 Join Together Fellow, and the assistant coordinator for Oregon Together!

Using Technical Assistance and Finding Outside Experts

It is important to utilize the specialized skills and experience of members within your community. This handbook may be sufficient to get you started if you have coalition members experienced in pulling together these kinds of data. Ideally, your community can draw upon local consultants, research firms, planning councils, colleges or others devoted to prevention, education and treatment.

In addition, you may want to seek help from experts outside of your local areas, as well. Some communities have been successful in developing local indicators with technical assistance from outside experts.

Getting Started and Seeing It Through: A Process With a Payoff

In this chapter, we describe the "how to" of working with community indicators. The eight steps recommended here imply an underlying premise: that the set of indicators are yours — the coalition's — not the evaluator's and not your funding agency's. The ownership of this process and product is very important. If it is clear to you, the eight steps described here will go well and you will have a product with incredible payoff. Some of these payoffs are:

Getting people past denial — The breadth of indicator information you find will create a greater awareness of the alcohol and other drug problems in your community.

Providing a common information base — No longer will there be as many different versions of the problem as there are voices at the table. While there will always be different versions of what the data mean, these indicators will provide a common starting point from which the coalition can think and plan.

Collaborating — Working together toward common goals is what coalitions are all about. This process is the essence of collaboration, and it yields a useful and informative product.

Here are the eight steps we recommend:

1. **Convene a working group**
2. **Brainstorm an initial list of indicators**
3. **Round out the field of indicators**
4. **Find the available data**
5. **Develop a "short list" of indicators**
6. **Develop a reporting format**
7. **Finalize the set of indicators**
8. **Make strategic use of your report**

Convene a Working Group

It is important that the "right" people are brought together to launch this effort. Diversity in committee representation is critical. The strength of community coalitions is that they bring together key leaders or grassroots activists from many sectors to address the common concerns that substance abuse represents. This process of developing a package of community indicators must mirror that strength. As your own coalition includes representatives from law enforcement, the schools, local government, justice, the media and human service providers, these fields must also be represented around this table.

The working group may be as small as four or five, or as large as 12 to 15 persons. Subgroups of two or three individuals will be needed for specific assignments.

In most communities, representatives from law enforcement, human service, treatment and the public schools are particularly critical in this process. Typically, they have access to important data and information. Doors to these data systems will open much more quickly if these key representatives are involved from the beginning.

In the planning stages of this process, it is helpful if members selected for this working group are in leadership positions in their organizations, or at least have ready access to their leaders. If questions or concerns about access to or appropriateness of information arise, time can be saved if the people with answers to these questions are already at the table.

What do you do with this group once you have it assembled? Begin with a discussion about why you are taking on this project. The power of these indicators as a communication device cannot be overstated. Also, be clear from the outset about the intended audience for the product. Our belief is that the audience for this effort is the community itself, and the local media. It is not an exercise for researchers. Clarifying the audience will dictate many details of the final product. Lastly, be clear that the members of this group (or their designees)

Community Focus

Syracuse, New York

In Syracuse, New York, the director and evaluator of the coalition assembled their group by first identifying agencies in the county that would likely have data on substance abuse concerns. Some agency leaders were already members of the coalition, but many were not. Representatives included administrators from mental health agencies, business, treatment centers, law enforcement and schools. The evaluator contacted them personally, identified the coalition and its work, and discussed her interest in gathering information from their agency. Virtually all were cooperative. She then followed up with written information about the task at hand, the timeline, and a guarantee that the process would consume no more than three meetings. Initially, they brainstormed a list of over 40 indicators. The agency representatives provided useful leads about where to look for more pertinent information.

Assisted by student interns from the local university, the coalition evaluator gathered the data, summarized it and produced sample displays. Within a year, the coalition produced its first Community Substance Abuse Indicator Report for Syracuse/Onondaga County. The product has not only captured the interest of the community; the process has expanded the membership of the coalition. Many of the agencies who participated in this project joined the coalition and continue to play key roles in its work.

For more information, contact:

Marilyn P. Morey, Partnership Director
and Eileen Ziobrowski, Project Evaluator
(315) 435-5712
City of Syracuse/County of Onondaga
Drug and Alcohol Abuse Commission
102 East Jefferson Street
Syracuse, NY 13202-2585

are going to do the work. They will plan, design, collect data and design the reporting approach. The product will be theirs.

Clarity in these early stages will reap many benefits for later work. New members will likely be brought into the process at various stages, but if this core understanding and commitment exists, the process can steer clear of the blind alleys and dead ends that inevitably present themselves in later stages of the effort.

Brainstorm an Initial List of Indicators

Once the working group is assembled, generate a starter list of indicator information. It will be useful to have someone with evaluation or research expertise contributing to, but not dictating, the discussion. In general, it is the local expertise around the table that will provide the best guidance for "what's important" in describing the breadth and depth of the substance abuse problem in their community.

At this stage in the process all ideas have equal weight. Your discussion facilitator should reinforce this. He or she does not need to be a research expert, but ought to be someone who is clear about what the coalition is trying to do. The facilitator must do whatever is necessary (e.g., "warmup" activities) to make it comfortable for all to contribute their ideas. These individuals are the experts.

The process can begin by posing simple questions, such as: "What makes you think we have a substance abuse problem in this community?" or "What was the last conversation you had about drug use?" Open-ended questions like this will get people thinking about things like the workmen's compensation article they read in the newspaper, or the stories they have heard about drug dealing on streetcorners, or a movie they saw that portrayed children experimenting with drugs.

Write these ideas down as quickly as they are generated. At this point, they should not be screened or judged. You will get to that later. The intent here is to identify as much broad information as possible.

The evaluator/researcher can play a helpful role in this process. He or she can help "operationalize" the ideas into measurable terms. For example, suppose that a response to the "What makes you think..." question is something like "This problem with crack babies is really hitting our schools now. We don't know what to do with them." This is a valid response to the question, and one that may lead to an important indicator of the substance abuse problem in the community, but one that is not, by itself, a statistical indicator.

A few questions from the evaluator ("**E**") can help clarify the working group member's ("**M**") interest:

E: Why do you say this is a problem?

M: The first grade teachers at my son's school say they have never had so many kids with learning problems. They think it stems from fetal alcohol syndrome or the mother's drug use while pregnant.

E: So, shall we look at the increasing number of kids in special education in first grade?

M: No, there are lots of other reasons for needing special education that have nothing to do with drugs.

E: Maybe the schools have more specific categories that will separate reasons for learning problems due to mothers' alcohol or drug use while pregnant.

M: I don't think we can tell all that well. Besides, there are lots of different reasons for learning problems.

E: How about going back to the source? Maybe the hospitals keep track of whether babies have any trace of drugs or alcohol in their systems when they are born.

M: Or maybe doctors treating pregnant women determine whether or not they are using drugs while they are pregnant.

This kind of dialogue — usually involving many of the members of the work group — begins to funnel the attention down to a more measurable expression of the problem, and generally points to a place to start finding data.

Many other ideas for possible indicators of interest are contained in this handbook, along with technical guidance that will help access and interpret the information once you get it. But remember, the authors of this handbook are not the experts for your community. We are not here to tell you what is important to you. The experts are right at the table working with you.

Community Focus

Thurston County, Washington

In Thurston County, Washington, a committee of coalition staff got together to brainstorm a list of possible indicators of substance abuse and violence in their community. After much discussion with staff, a list of more than 30 indicators emerged. They included:

- **Percent of students who have tried alcohol**
- **Prevalence of binge drinking**
- **Age of first use of alcohol; marijuana**
- **Percent of students who have used marijuana in the past 30 days**
- **Percent of students who have been in a physical fight in past 30 days**

Sorting these indicators into categories revealed that nearly 25 of the indicators were from a recent survey of adolescent health behaviors conducted in all seven school districts in the county. The survey had been a huge effort, and coalition members were understandably focused on their results. But this representation seemed imbalanced, and conveyed a subtle message that substance abuse was a problem only for the youth — not the adults — of the community.

Studying their list in this way generated some discussion around some other possibilities that represented more of the harm associated with alcohol or drug use.

Several more indicators were added, including:

- **Number of drug-related arrests in the county**
- **Number of arrests for interpersonal violence**
- **Number of traffic deaths involving alcohol**
- **Number of domestic violence-related calls to the crisis hotline**

The coalition director and her staff used this information to stimulate discussion with 29 different community groups around the severity of the substance abuse and violence problem in their community. From these data and discussions, the community generated a compendium of 30 different prevention/intervention strategies, and termed it their Community Youth Agenda. The full portrayal included the community indicators that best represented the problem, the strategy recommended by these community groups, and the outcomes they hoped would result from effective use of the strategy.

For more information, contact:

Earlyse Swift, Partnership Director
(206) 493-2230
and Roy Gabriel, Evaluator (503) 223-8248
Thurston TOGETHER!
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Lacey, WA 98503-0290

Getting to an initial list of indicators is the task of one or two meetings. The goal of your first meeting(s) should be to come up with an initial list of indicators. This will allow you to send people away after a job well done, with no specific assignments other than to perhaps think a little more about the way they are defining the problem. This will set the stage nicely for the next step in the process.

Round out the Field of Indicators

Once the initial "brainstorming" list is put together, and perhaps a little distance from this task has occurred, it may be time to return to the list to look at it a bit more critically. This step will help to identify any gaps in the list, and may lead to adding some other possibilities. A classification scheme for the initial list of indicators can now be introduced. The categories listed as tabs in this handbook (Availability/Environment, Use, Prevention/Treatment, Enforcement/ Regulation, and Harm) are one example of a classification scheme. The use of "risk factors" from the substance abuse literature (School Factors, Community Factors, Family Factors, Peer/Individual Factors, etc.) is another classification scheme. Guidance from a prevention specialist will be very helpful if either of these classification systems are used.

Another way to classify the indicators already on the list is simply by the sector of the community from which they come: the medical community, law enforcement, the schools, traffic safety, etc. By sorting the indicators into categories such as these, the breadth of representation can be seen more easily. It is helpful to represent a broad spectrum of the community in the collection of indicators. The pervasiveness of the effects of substance abuse is one of the most powerful messages these indicators can deliver.

Find the Available Data

Now the detective work begins. You have refined your list of indicators so that it is well organized and has the breadth and depth you're looking for.

Divide the working group into small teams of two or three people and divide up the data collection work to be done. If you have chosen the working group members wisely, many of them will have "leads" for where to look for the data on certain indicators. But, typically, this will be only the beginning. Expect to make several telephone calls before you get to the individual who can provide the data or information you need. But take heart! Often, when you find the appropriate person, he or she is thrilled to discuss every aspect of the data with you, and will gladly send you whatever you need.

Remember, collecting the available data does not require training in statistics or research methods. It takes clarity about what you are looking for and why; and lots of persistence and hard work.

The DeKalb Prevention Alliance
Atlanta, Georgia

This group had identified a variety of indicators for its community-wide needs assessment. Among these were a number of crime statistics, including the prevalence of drug-related crime. Much of this information was available from the county Public Safety Department by census tract, and could be plotted so that particular communities within the county could be targeted for more intensive prevention/intervention efforts. Through the assistance of the Geographical Information Systems (GIS) Applications Laboratory of Georgia Tech, maps were produced that displayed trends in these indicators by census tract. By identifying the areas in which the greatest increases in drug violations occurred, the neighborhood-based activities of the coalition could be more targeted. Working collaboratively with the GIS lab, the coalition evaluator began the development of mapping other substance abuse-related indicators in the same census tract-based way.

For more information, contact:
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Atlanta, GA 30307
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Indicator Contact Log

Indicator Name

Date Person Contacted

Organization Telephone No.

Summary of Discussion

Next Steps

Remember that the individuals in the working group are volunteers, and this "tracking down the data" will likely take weeks and months of work. The volunteers will develop their detective skills as they work through the agency systems to get to the source of the data needed. We have found it helpful to document our trail of contacts for each indicator we are pursuing. For this purpose, we suggest using a simple "Indicator Contact Log," like the one at the left. It helps in several ways. First, as this hunt will have inevitable interruptions, it reminds us whom we have called already and how we have found the person we are about to call. Second, we can use this history in our discussions with the people we are about to call. ("I talked to Mr. Norman of the ABC agency last week, and he suggested that you may be closer to the information and that I give you a call.") And, finally, the log supplies us with the contact information for future surveys.

It may be worthwhile to meet a month or so after the data search has begun to share "war stories" or "success stories" about the experience. Working group members may get new ideas from the experiences of their colleagues.

One final word of optimism to keep you and your team going through this activity. Finding the key data source is always hardest the first time you try producing this set of community indicators. If you decide to update your collection in another year or two — and most coalitions do — this entire process (but especially this data collection activity) will take only a fraction of the time. Once the data sources have been identified and access to the information obtained, it is often manageable for a single individual to gather the data on all indicators in subsequent years.

Develop a "Short List" of Indicators

Once the available data are gathered, reconvene the working group to review the available information, debrief (commiserate) on the process of obtaining it, and set about the crucial task of deciding which indicators to include in the final set. The experience of gathering the data — and hearing about all of its limitations — will empower the working group with lots of ideas and issues to consider. From this discussion, you can screen each indicator for inclusion using a generated set of criteria.

Here are a few criteria we recommend:

Validity - Two validity considerations —
1) How well does the information measure what it's supposed to measure?
2) How well does it measure the indicator of interest? For example, data on the number of people receiving treatment for alcohol or drug abuse may be a very accurate count of

those service recipients. But it will not reflect the actual indicator of interest — the number of people in the community who abuse alcohol and drugs to such an extent that they need treatment. Often, the count of treatment recipients is more a measure of the capacity of the treatment centers, not the need in the community. (While this is true, we would suggest that there is much more to be gained than lost by using these less than perfect measures of the "true" indicators.

Reliability - How consistently is this indicator measured from year to year or neighborhood to neighborhood? Does it depend upon who is doing the counting? Generally, data obtained from standard reporting systems, such as arrest data from the Uniform Crime Reporting System, have strict definitions and reporting conventions to ensure their consistency. In contrast, procedures to document recent use of drugs or alcohol in mothers giving birth are often reported inconsistently from hospital to hospital.

Relevance - Does the indicator measure what the coalition or the work group believes to be a relevant and important aspect of the substance abuse problem in the community? No matter how valid or reliable the measurement is, if the indicator is not viewed as important, there is little sense in including it in the final list. The decision as to what is relevant can involve much discussion. Work group members will have their own views. Prevention research may suggest important predicting factors, when conventional wisdom fails to see the connection. And, finally, relevance may be viewed as relative to the other indicators in the final list. For example, while the number of businesses with Employee Assistance Programs (EAPs) may not be seen as critically important in itself, it may be the only indicator relating specifically to the workplace, and thus adds supplemental value to the others on the list.

Availability - Is the information routinely available year to year, and at the level it is needed? Also consider whether the information is available at the geographic level desired (city, county or neighborhood), or whether additional data analysis is required. The extent of the effort required is relevant to which indicators to include. Also, data collection systems can change in subsequent years. If these are anticipated, it may be worth reconsidering use of this indicator.

Taken together, these criteria may seem stringent. A parting word is in order. Generally, people closest to these data collection systems are their harshest critics. They are often more conversant in what the indicators don't measure than what they do.

As mentioned earlier, none of the indicator data will be perfect. The criteria we have suggested above are useful considerations to ensure the highest quality information possible. But don't let the limitations of the information discourage you. The strength of the message communicated by these indicators is in the full collection, not in any one indicator. Yes, each may have its flaws and imperfections, but the collective message is usually undeniable. While critics can charge that students don't tell the truth when they respond to surveys of their alcohol and drug use, or that arrest statistics say more about law enforcement priorities than they do about the severity of the current problem, it is difficult to disown the collective message when it includes an array such as traffic fatalities due to alcohol, overdose deaths, hospital emergency room visits, people receiving alcohol or drug treatment services, and births of drug-affected babies.

Develop a Reporting Format

The format you select for communicating the indicator information must be simple and direct. Charts and graphs, which present a clear picture of the main point, are preferred over narrative detail that illuminates the subtle characteristics and trends in the data. Aim for a publication that is short enough to be read easily in one sitting at the time it is received, and attractive enough that the reader will want to take a few minutes and look through it. If your product goes on the "to read" pile, you have probably lost the opportunity.

The challenge in keeping it simple is that the members of your work group will now be experts in the definitions and idiosyncrasies of the reporting systems they have investigated. Their own interest or a sense of ethics in reporting may compel them to want to include the limitations and technical underpinnings of each indicator. Our

Community Focus

Kenosha, Wisconsin

The Concerned Citizens Coalition of Kenosha, Wisconsin, arrived at a final list of indicators by rating the indicators developed by the coalition. Their initial "brainstorming" list included over 40 indicators. By having all coalition members rate each indicator on a scale of 1 ("extremely important") to 4 ("oppose inclusion"), they reduced the list to 13. Attempts to gather information on these indicators eliminated some and suggested a few others, and soon another rating exercise was needed. At this point, the list consisted of 18 indicators in three general areas: law enforcement, medical, and social.

Coalition members were asked to keep three questions in mind as they approached the new rating task:

- **Would this indicator help divide the community into those that are healthy and those that are at risk?**
- **Would this indicator be easily understood by the community?**
- **Would the coalition's efforts be expected to have an impact on this indicator?**

With these criteria in mind, each coalition member was given 100 points to distribute among the indicators within each area (the most important receiving the most points). By tallying these ratings across all coalition members, the work group was able to determine which indicators were most important within each area.

For more information, contact:

Ann Schmitter and Patrick Linnane
(414) 224-0404

Planning Council for Health and Human Services
Concerned Citizens Coalition
1442 N. Farwell Ave., Suite 300
Milwaukee, WI 53202-2913

advice is to not succumb to this temptation. Keep any technical information as brief as possible, or put it in an appendix so as not to obscure the message you are trying to deliver.

Displaying indicator data clearly and accurately may take some additional resources. Graphics software for personal computers is increasingly common, and some members of the work group may have access to good programs. Volunteers from business may be particularly experienced and helpful in this effort. Some of the agencies that provided you with the indicator data may have some suggestions about inexpensive display mechanisms for this purpose. Vary the types of displays you use: bar graphs, line graphs and pie charts will provide a nice mix of displays in the collection.

Finalize the Set of Indicators

Your "short list" of indicators, all of which are displayed by now, may still not be your final set. Looking at the displays as a collection will clarify some of the criteria discussed earlier: validity, reliability, relevance and availability. Stay with these criteria as you finalize the set.

Make Strategic Use of Your Report

Making your Efforts Count

Compiling indicator data is a very important step in documenting the impact that alcohol, illicit drugs, and tobacco have on your community. Yet, using the data to map out a strategy for change is a second, and equally important, step. The data that you collect should be used to bring concerned leaders together to fine tune your strategy to address the problems revealed by the data. For example, if your indicator data uncover a growing problem with underage drinking,

Community Focus

Portland, Oregon

The Regional Drug Initiative (RDI) of Portland, Oregon, has produced an annual collection of substance abuse indicators, termed the Drug Impact Index, since 1990. In deciding on a reporting format, RDI decided to produce a booklet of 12 indicators shown in chart form with minimal narrative. Advice from RDI:

- **Emphaze "white space" in each indicator display. Pictures are far better than words.**
- **Clearly display the indicator title (Annual number of births of drug-affected babies) and the source of data (Children's Services Division).**
- **Use "Brief Remarks" to state simply what the graph is showing. Even though they are simple, the displays do not speak for themselves.**
- **Use "Technical Note" to deal with any technicalities that may impact valid interpretation of the data.**
- **Include state-level data along with county-level to add to the interpretation of trends over time. In these displays, county-level data are shown within statewide data.**
- **Add a "for further information, please call..." for those readers who want to delve more deeply into a particular indicator area.**

RDI disseminates copies of the Drug Impact Index each year to an extensive mailing list of professionals and community members throughout the county. They also respond to requests for copies and information about how to use the index from other coalitions across the country.

For more information, contact:

Carol Stone, Partnership Director
Regional Drug Initiative
522 SW Fifth Ave., Suite 1310
Portland, OR 97204

your strategy might aim at locating and closing off the various ways youth are obtaining alcohol. Any community strategy to reduce substance use will most likely involve working with the media, other community organizations, coalitions and policy makers.

The media outlets, community groups and public policy avenues will be different in each community. Here are some general guidelines for making your efforts count.

Adjusting Your Strategy

Meet with members of your work group to be clear about the message in the data before it is made public. What issues does it reveal? Are these problems widely known and accepted in the community? Will this report be met with shock, denial or indifference? Brainstorm possible solutions to issues. What would be an ideal positive outcome from this report? How will you get there? Who else do you need at the table? How can you enlist their support?

Answers to these questions should become part of your written strategy.

Working with the Media

Enlisting public opinion and encouraging citizen action is an important part of your strategy. Therefore, you will want to work with your local media — including television stations, newspapers, cable and radio stations — to get your findings out. They will be receptive to your pitch for two reasons: substance abuse is generally recognized as an important local issue and most reporters like reporting stories with strong data.

Schedule a press conference or hold briefings with individual reporters and producers who might be interested in this topic. Select a time and place that is most convenient for reporters. The best time for press conferences is usually 10 am or 2 pm. Mondays and Saturdays are generally the slowest news days, giving you a better chance to get coverage.

Develop a list of local reporters and editors who may be interested in your story. If you don't have a current list, borrow one from another local substance abuse organization.

Send out media advisories to select news directors, reporters and editors one week in advance of your press event, outlining the very basic facts. A sample media advisory is on the next page.

Also, **follow-up the media advisory** with phone calls to make sure the media contacts received it. Reporters get volumes of paper each day. Make yours stand out.

A few other tips in working with the media:

Appoint an articulate spokesperson. Designate a second person to answer technical questions. Anticipate "left field" or devil's advocate questions from reporters.

Prepare a brief press release about your findings to have available at the press conference or individual briefings. Send the release to any reporters and producers who were not able to attend.

Regardless of your media strategy, your group must be clear about the message.

Keep it simple. Craft three main points to be reflected in your remarks and in the press release, that you want to get across to the public about your findings.

You should also **include action steps** that people can take to help find a solution to the problems highlighted in the data.

Working with Key Leaders

Identify important groups, such as business and legislative leaders, who can have an impact on the issues your findings highlight. Schedule briefings with these groups, prior to releasing the data to the public, and announce their involvement in an action plan at the same time. Be aware that some groups may not be interested until the issue is in the media spotlight. With these groups, you are more likely to get their ear and a commitment in briefings directly following the media release.

For example, if your data reveal a sharp increase in alcohol outlet licenses, you may want to meet with city officials about zoning changes or promote responsible server training. If your data show an increase in substance abuse-related domestic violence arrests, you may want to use this information to bring together the police, local legislators and treatment professionals to devise a multi-faceted solution.

SAMPLE MEDIA ADVISORY

New Orleans Joins Together to Reduce Drugs and Violence

WHAT: Mayor Marc Morial will convene a day-long event to help develop the city's first community partnership coalition to reduce substance abuse and violence in New Orleans.

The day will kick-off with a CEO breakfast for business leaders in the community. Following the breakfast, representatives from the treatment community, education, criminal justice, housing, health and religious groups will come together for an "Exchange" of ideas to help formulate a community-wide coalition.

WHO: Experts in the substance abuse field from Massachusetts, Texas and New York will share what works in their communities.

The Exchange will be hosted by New Orleans Target Cities, a federally-funded substance abuse treatment and enhancement initiative, working in collaboration with the Mayor's Office.

New Orleans — and Target Cities — is one of 17 cities nationwide selected to host such an Exchange by Join Together, a national resource helping communities fight substance abuse.

WHEN: Monday, May 15

The business breakfast from 7:45 a.m. to 8:45 a.m.

The Exchange from 9 a.m. to 3:45 p.m.

WHERE: Holiday Inn downtown on Loyola Ave.

WHY: Because substance abuse and violence is a growing problem in New Orleans, as well as in other communities across the country.

Studies show that over 50 percent of violent criminals had been drinking at the time of their offense. And more than 1.7 million people are the victims of alcohol-related crimes in the United States each year. In addition, a majority of the most violent criminals in this country are heroin users.

For more information about this event, contact: name, phone.

Your indicator report can be a tremendous convening force for your community if it is used strategically and distributed to the key leaders who can get involved in the solutions.

Epilogue: Survival Tips

The full gamut of this process can easily take a year. Your detective work will occasionally lead you down blind alleys, bump into dead ends and have you considering a career change. Here are a few "survival tips" to keep in mind as you go through these steps:

Keep it simple. Remember your audience and your purpose, which is communicating to your community the breadth and depth of substance abuse problems.

Don't get distracted by "interesting" trends within these data. Yes, there are probably interesting age-group differences, or gender comparisons among these data. But pursuing these can fragment the message and delay the product. Save it for an interesting technical issue report.

Stick to your criteria. As you encounter new possibilities for indicators, screen these possibilities back against your criteria for inclusion (e.g., validity, reliability, relevance and availability). It will help keep you on track.

The authors of this handbook, and the entire Join Together and Brandeis staff, wish you well on this journey. We are encouraged by the success stories from coalitions around the country that have ventured through this process. They can tell you of the payoffs of their efforts.

We hope that all of this feels a little more approachable than it may have before. Remember, this is not a one-person job. With the assistance of all of the experts you have brought together in your coalition, you can put a collection like this together that will be of enormous help in your coalition effort.

Indicators of Community Substance Abuse Problems and Resources

The following 20 indicators are classified in five primary topic areas: Availability/Environment; Use; Prevention/Treatment Activities; Enforcement/ Regulation Activities; and Harm. They are described in this chapter:

Indicator Profiles	Indicator Measures
Availability/Environment	
1. Alcohol Outlets	Sites with licenses
2. Tobacco-Free School Environments	Presence of written policy/sanctions/enforcement
Use	
3. Cigarette Sales Locations	Sales locations and cigarette vending machines
4. Self-Reported Substance Use	Percent with alcohol use past 30 days Percent with other drug use past 30 days Percent with tobacco use past 30 days
5. Alcohol Consumption	Ethanol gallons sold
6. Drug Use Among Arrestees	Percent arrestees/detainees testing positive
7. Household Spending on Alcohol and Tobacco	Dollars spent on alcoholic beverages Dollars spent on tobacco products
Prevention/Treatment Activities	
8. School-based Substance Abuse Education	Presence of written prevention curricula
9. Self-Help Meetings	AA/NA open meetings
10. People in Treatment	People enrolled in specialty programs
Enforcement/Regulation Activities	
11. Substance Use Arrests	DUI Other alcohol Drug possession Illicit drug manufacturing or sale
12. Alcohol and Tobacco Excise Taxes	Beer, wine or spirits tax rate(s) Cigarette tax rate
13. Student Disciplinary Actions	Alcohol or drug-related sanctions Tobacco-related sanctions
Harm	
14. Substance Use-Related Hospital Cases	Alcohol-related cases Drug-related cases Tobacco-related cases Substance abuse-affected newborns
15. Child Abuse Reports	Reports to child welfare agencies
16. Drug-Related AIDS Cases	New AIDS cases reported
17. Substance Use-Related Deaths	Alcohol-related deaths Drug-related deaths Tobacco-related deaths
18. Tuberculosis Incidence	New cases with positive cultures
affic Fatalities	Single-vehicle nighttime fatal crashes
nergency Room Episodes	Substance use-related emergency room episodes

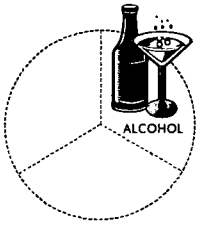
Throughout Chapter 3 the following icons are used to show which substances the indicators refer to.

Data Found in Reporting System Communities Only

Refers to data that are only available for the listed communities which participate in this particular reporting or surveillance system.

Data Reliable for Large Communities Only

Refers to events that are being tracked which occur so infrequently that the specific indicator is not meaningful for smaller-sized communities.



1. Alcohol Outlets:

The number of sites or locations with licenses to sell alcoholic beverages.

Indicator Description

The number of current licenses for alcohol outlets issued in a community is one indicator of alcohol availability in that community. Liquor licenses are issued by governments to several different types of establishments: package stores, restaurants, bars and clubs, etc. An increase in the number of licenses within a community over time may be interpreted as evidence that the availability of alcoholic beverages has increased.

What to Measure

The number of active alcohol outlet licenses in the community.

Because states use different mechanisms to license and control liquor outlets, the types of alcoholic beverages may include only spirits. Some licenses issued may be specific to spirits and wine, or beer. In control states, the location of state retail stores rather than licenses would be measured.

Other related measures include the number of new licenses issued and the number of licenses revoked during a year or other time period. Use a rate to compare across communities. The number of licenses could be expressed as the rate of licenses per capita. The number of licenses per square mile measures alcohol availability in terms of the density of outlets in the community.

Where to Find Local Data

State liquor commissioners or Alcohol Beverage Control Commissions may publish directories or be able to provide lists of active licenses located within each town. In some states, there is a regular compilation and reporting on the number of liquor licenses (Chapter 5, ABC Commissions). Two commercial references, the Distilled Spirits Council and Jobson's, are available in libraries or for purchase. The Distilled Spirits Council of the United States publishes a summary of State laws and regulations with detail on taxation, advertisement, hours of sale, etc.

Distilled Spirits Council of the United States, Inc.
1250 Eye Street, NW, Suite 900
Washington, DC 20005
(202) 628-3544

Example Rates

The Massachusetts Department of Public Health analyzed alcohol outlet density for communities of different population sizes. The following chart of per capita outlet density rates shows that the number of licenses issued may be related to community size.

Little Rock, Arkansas

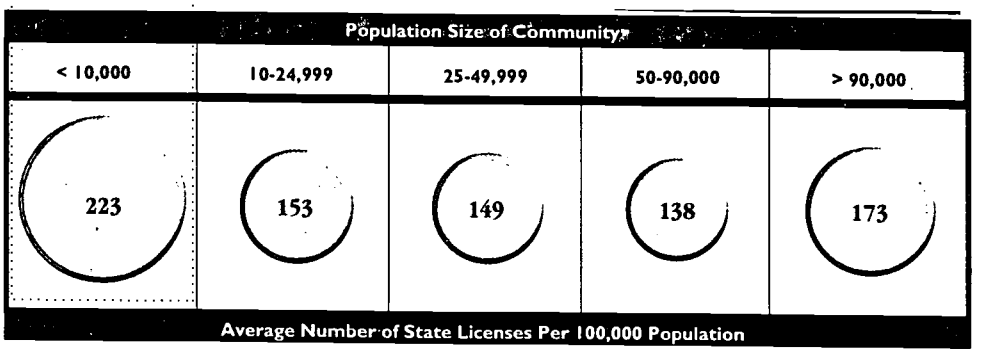
The Little Rock Fighting Back program discovered a dramatic increase in the number of alcoholic beverage retailers between 1989 and 1993. The rate of outlet licenses grew from 1 per 646 city residents to 1 per 395 city residents. This information helped the coalition increase awareness that the demand for alcohol was increasing.

CONTACT:
Rick Colclasure,
Interim Director
500 West Markham Street
Room 20W
Little Rock, AR 72201
(501) 399-3420

SOURCE: Little Rock Fighting Back. Midcourse Assessment. Little Rock Fighting Back, May 1994.

Average Number of State Licenses Per 100,000 Population

The smallest communities appear to have the greatest rate of alcohol outlets per population.



SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, *Indicators of Substance Use in Massachusetts, 1985-1992*, September 1994.

How to Interpret

There is merit in tracking the number of alcohol outlets but it is difficult to carefully interpret trends. It is only an indirect measure of alcohol sold. For example, one large store may sell more alcohol than several small stores combined. Furthermore, retail stores sell to residents of several communities, but in this measure they are counted only for the community where they are located.

It is also important to consider that the serving practices of on-premise liquor outlets are important and are not measured with this indicator. For example, the sale of alcohol to underage groups is of particular policy interest, but cannot be captured with this measure. While some retail establishments are less compliant with restrictions on underage sales than others, each establishment is counted equally.

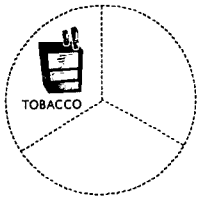
Further Reading

Distilled Spirits Council of the United States, Inc. *Public Revenues from Alcohol Beverages: 1993*. Washington, DC: Distilled Spirits Council of the United States, Inc., December 1994.

Distilled Spirits Council of the United States, Inc. *Summary of State Laws and Regulations Relating to Distilled Spirits, 28th Edition*. Washington, DC: Distilled Spirits Council of the United States, Inc., 1993.

Holder, HD and Wagenaar, AC. Mandated server training and reduced alcohol-involved traffic crashes: a time series analysis of the Oregon experience. *Accid Anal Prev*, 1994; 26(1): 89-97.

Jobson's Licensed Beverage Marketing and Merchandising Fact Book. New York: Jobson Publishers, 1993.



2 Tobacco-Free School Environments:

Written policy established by the school board prohibiting tobacco use in school buildings, on school grounds or at school activities.

Indicator Description

School systems can influence youth in choosing not to initiate tobacco use. In addition to formal school curriculum, educational facilities that are smoke-free for employees as well as for youth, can provide good models for non-smoking environments. Tobacco-free school environments reinforce student knowledge of the health hazards of tobacco use and often discourage students from starting to use tobacco. The establishment of district-wide tobacco-free school policies is a measure of efforts to both restrict tobacco use among youth and provide protective environments within school and school buildings.

What to Measure

The presence of a written policy and its specific features indicates an effort to establish a tobacco-free school environment.

The features of a comprehensive written policy include:

- total restrictions on smoking by all students, staff and visitors,
- how the policy is implemented and enforced, and
- inclusion of all school property and school-sponsored events.

For example, the form of the prohibitions may include restrictions on youth only or on both youth and adult school personnel. They may involve partial or total bans, targeting school grounds and/or all school functions.

Where to Find Local Data

A community must contact the local school district to obtain a copy of all written and implemented policies.

We are unaware of any uniform data collection efforts to routinely track these types of school board policies. However, there is a national survey of school district non-smoking policies sponsored by the National School Boards Association in collaboration with the American Cancer Society, the American Heart Association and the American Lung Association.

Example Rates

A survey commissioned by the National School Boards Association found that 40 percent of school districts had policies in effect banning tobacco use by students and adults in 1991-1992, compared to only 17 percent in 1988-1989. Further, the survey found that 56 percent of districts prohibit smoking in school buildings; 52 percent ban smoking on school grounds; and 49 percent ban smoking at off-campus school functions.

HEALTHY PEOPLE 2000

The U.S. Department of Health and Human Services has set as a protection objective to establish tobacco-free environments and include tobacco prevention curricula in all schools as part of a quality health education program.

How to Interpret

The primary limitation to using tobacco-free school environments as an indicator is that the data are not uniformly reported. This means that community groups would need to collect the data themselves. In addition, once it is determined that a tobacco-free school policy exists, it is unlikely that there will be change in the measure over time, so continued monitoring may be less relevant. Even so, your community may be interested in seeing if tobacco-free policies are established and in examining the features of the policy. Moreover, the importance of the indicator is underscored by its inclusion as a national public health objective.

The U.S. Department of Health and Human Services has an objective to establish tobacco-free environments in all elementary, middle and high schools by the year 2000. The following is a sample tobacco-free school policy.

Elkhart, Wisconsin
Community Schools Tobacco Policy

It is the purpose of this policy to create an environment that will serve to promote good health among employees, students and visitors. The Elkhart Community Schools recognizes smoking and passive smoke as a health hazard. This policy will be effective beginning August 1, 1991.

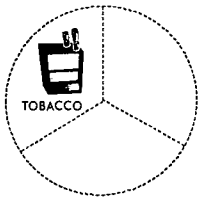
1. **Smoking is prohibited in any Elkhart Community Schools building or vehicle or on school property.**
   a. **in a non-school vehicle;**
   b. **when outside while attending a school event.**
2. **It is the responsibility of all persons to implement this policy. With sensitivity and diplomacy, any person who observes another in violation of this policy is to inform that person of the policy.**
   a. **All employees have direct responsibility for implementing this policy with students and visitors.**
   b. **Administrators have direct responsibility for implementing this policy with staff.**
3. **Any employees, students or visitors who repeatedly violates this policy will be subject to disciplinary or legal action.**

SOURCE: National School Boards Association. *Smoke-Free Schools: A Progress Report, 1989*. Alexandria, VA: National School Boards Association, 1989. National School Boards Association. Tel: (703) 838-6722.

Further Reading

National Cancer Institute. Strategies to Control Tobacco Use in the United States: A Blue Print for Public Health Action in the 1990s. *Smoking and Tobacco Control Monographs*. U.S. Department of Health and Human Services. NIH Publication No. 92-3316. October 1991.

National School Boards Association. *Smoke-Free Schools: A Progress Report, 1989*. Alexandria, VA: National School Boards Association, 1989.



3. Cigarette Sales Locations:

The number of sales outlets and cigarette vending machines.

Use

Gloucester, Massachusetts

After learning that many kids under age 18 smoke and that vending machines are a popular source of cigarettes for teens, four 6th grade girls collected 570 signatures and made a formal presentation to Gloucester City Council in August 1993 to ban cigarette vending machines. The girls wanted to prevent young kids from having access to cigarettes. They also hoped to persuade those who already smoke to quit, and prevent others from starting. Cigarette vending machines are now banned from all public places except bars, taverns and private clubs; and they must be located within sight of the bartender and have a lock installed on them to prevent access by minors. Still the four Gloucester girls believe all cigarette machines should be banned in Gloucester.

For more information, contact the Gloucester Prevention Network, (508) 281-0311.

Indicator Description

The availability of cigarettes and other tobacco products is widespread and cigarette advertising is prominent. This easy access and promotion leads to smoking initiation among youth and adolescents. To monitor availability, a community can measure the number of stores, gas stations, vending machines and other retail outlets where cigarettes can be purchased.

What to Measure

The number of locations where cigarettes or other tobacco products can be purchased.

Typical sales locations include convenience stores and other small stores, gas stations, supermarkets, and vending machines. A community might focus on sales locations readily accessible to youth, such as unmonitored vending machines.

Where to Find Local Data

You may have to rely upon your own information gathering and several different sources to find information. Not all states license or regulate the sale of tobacco products. In those states that do, a community may call the state tobacco licensing bureau to learn the addresses of distributors with licenses. We learned, however, that lists of licenses are particularly difficult to obtain, and are simply not available in some locations.

However, other approaches can be used. One approach would involve identifying from phone books or the Chamber of Commerce the location of small stores, convenience shops and supermarkets. Depending upon local regulations, presumably all or nearly all of these locations would sell cigarette products.

To focus on youth sales, a community group might identify all locations where cigarette vending machines are placed in difficult to monitor places, by visiting such locations.

Federal legislation requires states to find ways to monitor sales of cigarettes to persons under 18 and enforce laws against such sales. This legislation, not yet written into rules, will result in increased enforcement activities and possibly more useful local indicator information as well.

Example Rates

We discovered no routine reports on the number of cigarette sales locations. Thus, example rates of the proposed measure do not exist. However, information is available on where smokers buy their cigarettes.

A California survey of cigarette smoking behaviors showed that small stores were the most common place of cigarette purchases for adolescents. Purchases from vending machines were an important source for the youngest adolescents. Adolescents report they have little difficulty purchasing cigarettes at stores and no difficulty obtaining cigarettes from vending machines.

Source of Cigarettes Purchased by California Adolescent Smokers by Region, 1990-1991

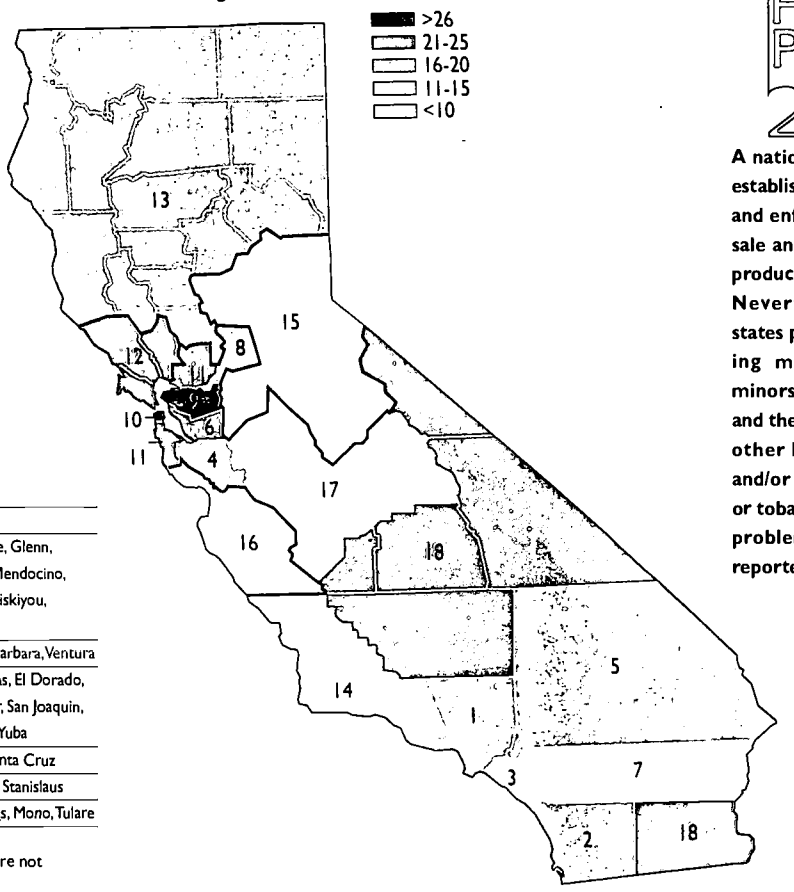
Percent of Teen Smokers who have Purchased Cigarettes from Vending Machines or Small Stores

Region	Vending Machines %	Small Stores %	Counties
1	17	13	Los Angeles
2	18	6	San Diego
3	15	12	Orange
4	19	14	Santa Clara
5	19	10	San Bernadino
6	21	5	Alameda
7	12	9	Riverside
8	19	8	Sacramento
9	33	19	Contra Costa
10	32	36	San Francisco
11	22	37	San Mateo, Solano
12	22	6	Marin, Napa, Sonoma
13	17	11	Butte, Colusa, Del Norte, Glenn, Humbolt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity, Yolo
14	7	4	San Luis Obispo, Santa Barbara, Ventura
15	9	15	Alpine, Amador, Calaveras, El Dorado, Mariposa, Nevada, Placer, San Joaquin, Sierra, Sutter, Tuolumne, Yuba
16	5	1	Monterey, San Benito, Santa Cruz
17	9	3	Fresno, Madera, Merced, Stanislaus
18	21	11	Imperial, Inyo, Kern, Kings, Mono, Tulare

NOTE: Vending machine and small store categories are not mutually exclusive.

SOURCE: Burns, D. and Pierce, J.P. Tobacco Use in California 1990-1991. Sacramento, CA: California Department of Health Services, 1992. p. 112A.

Percent of Teens Using Vending Machines in Region



HEALTHY PEOPLE 2000

A national benchmark has been established for all states to enact and enforce laws prohibiting the sale and distribution of tobacco products to youth under age 19. Nevertheless, in 1990 only 6 states prohibited cigarette vending machines accessible to minors. While forty-four states and the District of Columbia had other laws regulating the sale and/or distribution of cigarettes or tobacco to minors, a common problem is that these laws are reportedly rarely enforced.

How to Interpret

Cigarettes and other tobacco products are widely available in all areas; there is no uniform regulation of tobacco purchase across states and no easily identifiable information on sales locations. However, the location measure is important. Changes in this or other measures of cigarette availability can help assess how successful a community has been in reducing access of cigarettes to youth and can be used to describe the dimensions of local access.

The greatest limitation of this measure is the difficulty in finding systematic information sources. There is great value, however, in paying attention to the availability of a substance which contributes nationally to hundreds of thousands of preventable deaths each year.

Further Reading

Burns, D. and Pierce, J.P. *Tobacco Use in California 1990-1991*. Sacramento, CA: California Department of Health Services, 1992.

U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.

Giovino, GA, Schooley, MW, Zhu, BP, et al. Surveillance for selected tobacco-use behaviors - United States, 1900-1994. In: *CDC Surveillance Summaries, MMWR*, 1994; 43 (No. SS-3).

4. Self-Reported Substance Use:

The percent of people who report substance use in the past month. Typical measures are the percent of people who report any days with heavy alcohol use, any days with illicit drug use or any days with tobacco use in the past month.

Data Found in Reporting System Communities Only

Use

Indicator Description

Some communities and school districts periodically conduct surveys of residents and students. These surveys sometimes contain questions on tobacco use, alcohol use or other drug use. Surveys also commonly ask about attitudes towards substance use. The community group may be able to retrieve direct indicators of substance use behaviors and attitudes if the community or school district has participated in such a survey.

Types of Use Questions Found on Local Surveys

During the past 30 days, on how many days did you smoke cigarettes?

On the days you smoked, how many cigarettes did you smoke per day?

On how many days did you smoke on school property?

Did you use chewing tobacco, such as Redman, Levi Garrett, or Beechnut, or snuff, such as Skoal, Skoal Bandits, or Copenhagen?

Did you use chewing tobacco or snuff on school property?

On how many days did you have at least one drink of alcohol?

On how many days did you have 5 or more drinks of alcohol in a row, within a couple of hours?

On how many days did you have at least one drink of alcohol on school property?

How many times have you used marijuana?

How many times have you used marijuana on school property?

How many times did you use any form of cocaine, including powder, crack, or free-base?

Adapted from the survey instrument used for the 1993 Youth Risk Behavior Surveillance System.

What to Measure

The percent of adults and youth who report substance use during the past month.

You may also be able to retrieve information on substance use in the past year and during a person's lifetime, as well as the age of first use.

Where to Find Local Data

Local surveys may have been conducted by local or state health agencies, local schools or community interest groups. It may take some detective work to identify the appropriate contacts.

The school district and local schools will have officials who know which groups have already collected survey information from pupils. Be aware, however, that schools may be hesitant to share the results from surveys with these kinds of sensitive questions. The local and state health departments will know about surveys they have sponsored. (See Chapter 5, Directory of State Health Departments.)

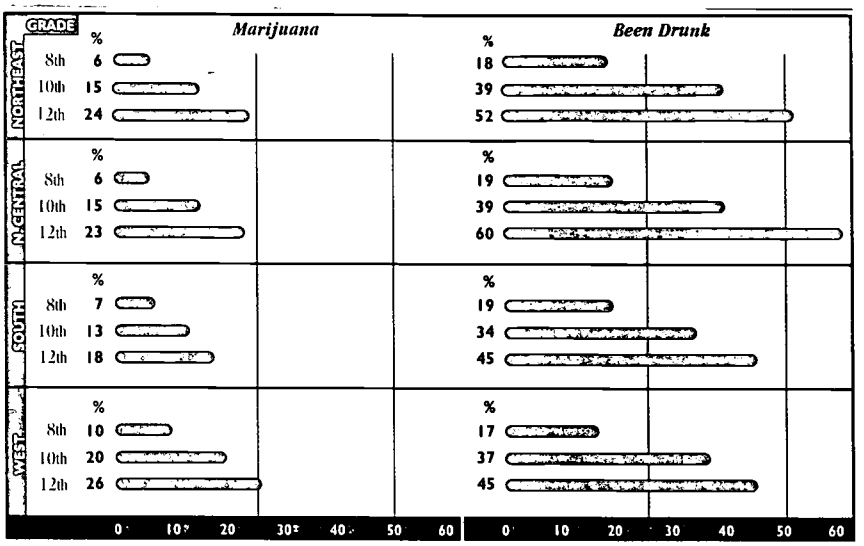
Because self-report surveys are expensive to administer, you may discover that no local survey has been conducted in your area. Local groups interested in administering a self-report survey for their community should work with public health and education agencies.

Example Rates

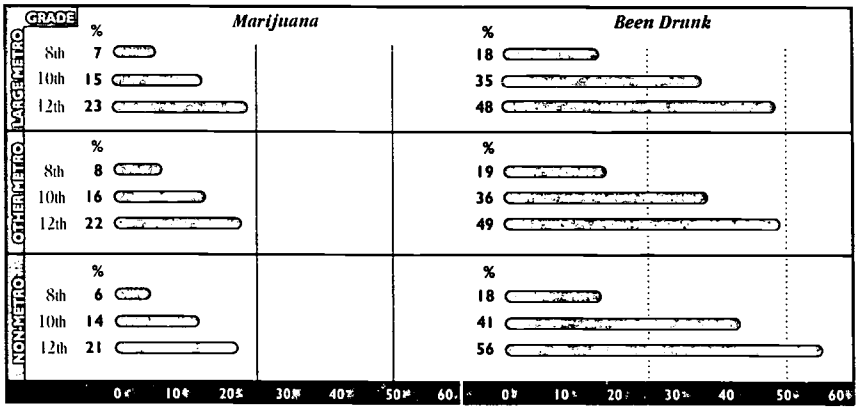
Use rates among youths are relatively consistent across regions and by metropolitan size. Heavy drinking is most prevalent in non-metropolitan areas.

Past Year Marijuana Use and Heavy Drinking by Eighth, Tenth, and Twelfth Graders, 1992

Region



Population Size



"Been Drunk" refers to "drink enough to feel high."

Large Metro: *the twelve largest Standard Metropolitan Statistical Areas (SMSA) as of the 1970 Census.*
Other Metro: *other SMSAs, counties or groups of contiguous counties which contain at least one city of 50,000 inhabitants or more.*
Non-Metro: *all areas not designated as SMSAs or (MSAs).*

SOURCE: Johnston, L.D., O'Malley, P.M., and Bachman, J.G. *Notional Survey Results on Drug Use* from *Monitoring the Future Study*, 1975-1992. Volume I Secondary School Students. University of Michigan, Institute for Social Research. Report prepared for the National Institute on Drug Abuse. U.S. Department of Health and Human Services. NIH Publication No. 93-3597. 1993.

Technical Note:

The YRBSS

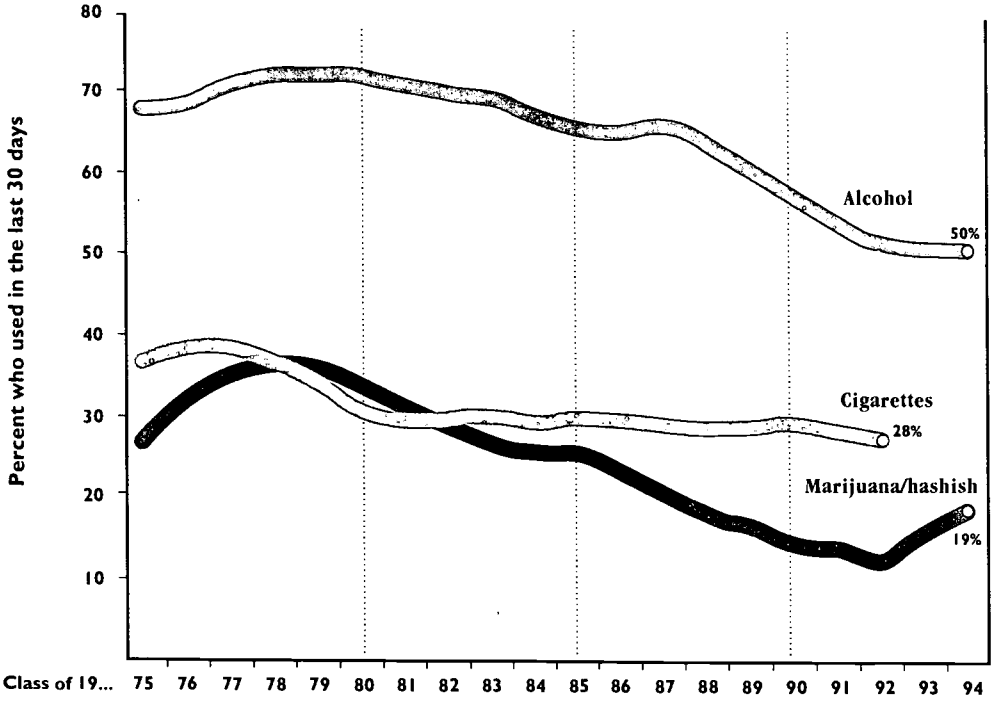
The National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, within the Centers for Disease Control and Prevention, maintains the Youth Risk Behavior Surveillance System (YRBSS). The system tracks health-related behaviors among youth. Included are data on lifetime and current alcohol, illicit drug and tobacco use. State and local participation has increased since the start-up of the system in 1989. In 1993, 18 local sites and 43 states participated. Findings from the YRBSS are reported in *Morbidity and Mortality Weekly Report*. Data requests should be directed to local education agencies reporting to the YRBSS (see Additional Resources, list of YRBSS local education agencies).

Did You Know?

A note on heavy drinking

A community might want to focus on the percent of people who have reported on days of heavy drinking in the past month. There are different ways to define heavy drinking. A common survey question is to ask about how many days in the past month someone had 5 or more drinks of alcohol either in a row or within a couple of hours. These surveys usually define a drink as one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail or one shot of liquor.

Trends in Past Month Use of Alcohol,Cigarettes and Marijuana/Hashish by Twelfth Graders



NOTE: Cigarette data for classes of 1993 and 1994 are not released; Alcohol data for class of 1994 are based on a slightly revised version of the question.

SOURCES: Class of 1975-1992 data from Johnston, L.D., O'Malley, P.M., and Bachman, J.G. National Survey Results on Drug Use from Monitoring the Future Study, 1975-1992. Volume I Secondary School Students. University of Michigan, Institute for Social Research. Report prepared for the National Institute on Drug Abuse, U.S. Department of Health and Human Services. NIH Publication No. 93-3597. 1993, Class of 1993-1994 from Press Release. December 12, 1994. Table 4.

How to Interpret

It may be useful to compare results from local self-report surveys with the established national surveys, such as the Monitoring the Future Survey (above) or health goals and objectives to be reached by the Year 2000. It is also useful to compare results from the school or community over time with state averages. Take care, however, to ensure the same types of people were surveyed when making comparisons (particularly the same age groups).

It is possible that the information from a self-report survey will give an underestimate of the true level of community use. This could happen if survey respondents were not truthful or if the people most likely to use substances are not included in the survey.

Percent of Persons Age 12 and Over in Six Communities Reporting Use of Illicit Drugs, Alcohol and Cigarettes in the Past Month: 1991

	Any Illicit Drug Use	Alcohol	Cigarettes
Chicago	5.7	54.6	23.9
Denver	7.7	53.2	26.7
Los Angeles	8.3	53.2	23.6
Miami	5.4	50.3	21.7
New York	6.8	50.3	25.7
Washington D.C.	5.7	55.9	23.1

SOURCE: Substance Abuse and Mental Health Services Administration. *National Household Survey on Drug Abuse: Main Findings, 1991*. DHHS Publication No. (SMA) 93-1980. Rockville, MD. May 1993.

The level of truthfulness among respondents is usually of some concern, particularly when reporting on disapproved behaviors. Also, people responding to questions may simply underestimate how much they actually drink. Among high risk adolescent and adult populations, studies have found that self-reported drug use is generally less frequent than the level of use detected with urine or hair testing. In general, studies have found that to obtain truthful behaviors, respondents must perceive the survey as important and know that the survey has procedures to protect their privacy and allow for anonymous participation.

Some populations are not captured in surveys administered to adults at home or children in classrooms. For example, household sampling does not include populations such as homeless people or people receiving inpatient alcohol or drug treatment. School classroom sampling could miss youth populations who do not regularly attend school, and is less likely to capture youth who are frequently absent. These youth and adults are often those at greatest risk for substance use.

HEALTHY PEOPLE 2000

National objectives for children and youth regarding substance use by the Year 2000.

- **To reduce initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20.**
- **To reduce the proportion of high school seniors and college students engaging in recent occasions of heavy drinking of alcoholic beverages to no more than 28 percent of high school seniors and 32 percent of college students.**

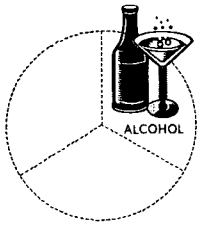
Further Reading

Centers for Disease Control and Prevention. Tobacco, Alcohol and Other Drug Use Among High School Students - United States, 1991. *Morbidity and Mortality Weekly Report*, 1992; 41(37): 698-703.

Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance, 1986-1990. *Morbidity and Mortality Weekly Report*, 1991; 40(SS-4): 1-23.

Bell, R.M.; Ellickson, P.L.; and Harrison, E.R. Do Drug Prevention Effects Persist into High School? How Project ALERT Did with Ninth Graders. *Preventive Medicine*, 1993; 22:463-483.

Johnston, L.; O'Malley, P.; and Bachman, J.G. *National Survey Results on Drug Use from the Monitoring the Future Study*, 1975-1992. DHHS Publication No. (NIH 93-3597). Rockville, MD: National Institute on Drug Abuse, 1993.



5. Alcohol Consumption:

The volume of alcohol sold or distributed per person in a geographic area.

Data Found in Reporting System Communities Only

Use

Maryland

"One of the biggest contributors to underage drinking is adults supplying the alcohol," according to a coordinator for the Maryland Underage Drinking Prevention Coalition, a grass-roots offshoot of the Governor's Drug and Alcohol Abuse Commission.

A growing number of local governments are attempting to curb underage beer consumption by monitoring beer-keg sales.

State liquor store officials say keg registration sharply cuts down on keg parties. Maine liquor officials estimate that the number of keg parties fell by 80% after its keg-registration law passed. Sales of alcohol in kegs declined by half.

SOURCE: *Wall Street Journal*, April 11, 1994.

A national health promotion and disease prevention objective is to reduce alcohol consumption by people aged 14 and older to an annual average of no more than 2 gallons of ethanol per person by the year 2000. (Baseline: 2.54 gallons of ethanol per person in 1987.)

Indicator Description

Per capita alcohol consumption is the most commonly estimated indicator of alcohol use. It is gathered and reported annually by the Alcohol Epidemiologic Data System (AEDS), a surveillance system established by the National Institute on Alcoholism and Alcohol Abuse (NIAAA). Consumption using this measure is based upon the volume sold and thus is not affected by the self-reporting biases which affect survey data from respondents. Some systems can track beer, wine and spirits sales separately. The national surveillance system reports state level estimates, but does not report community level estimates.

What to Measure

Alcohol use is defined by this indicator as the "apparent per capita ethanol consumption."

The AEDS receives routine reports on beverage sales and/or tax receipts for many states. In some states, alcohol beverage commissions maintain these records.

The preferred measure is per capita gallons of ethanol (pure alcohol) consumed annually in a location based upon the population age 14 and older. Sales or tax receipts data are used to estimate the volume of ethanol. For some states, only shipment data from major beverage industry sources are available to estimate the volume of ethanol consumed.

In addition to reporting gallons per total population over age 14, a second consumption measure is gallons consumed per drinker in the population (excluding abstainers). To calculate this, a community needs an estimate of the proportion of people that drink in the state or community. The proportion of the adult drinking population varies tremendously across communities and states (see How To Interpret).

Also, rather than tracking the total consumption, a community could track consumption based upon beer, wine, or spirits sales alone if the state maintains these records.

Where to Find Local Data

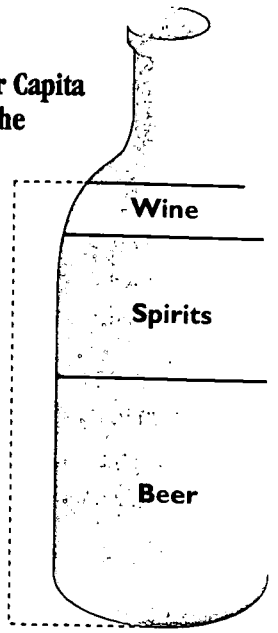
AEDS obtains alcoholic beverage sales data from every state and the District of Columbia since 1977. The AEDS receives these data from state tax departments or liquor control boards in most states. Local groups should contact the appropriate state agency to learn if the agency calculates per capita consumption for any subgeographic areas (See Additional Resources, list of alcohol beverage commissions). The AEDS receives its data in different forms depending on the state: state-wide, county level or special tax districts. Depending on where you live, it may be possible to access these local level data.

Example Rates

Apparent per capita consumption varies dramatically by state, ranging from a low of 1.36 gallons of ethanol in Utah to 4.36 gallons of ethanol in Nevada.

The range in gallons per drinker among states participating in the Behavioral Risk Factor Surveillance System is 3.72 (in Connecticut and Minnesota) to 9.05 (in the District of Columbia).

1991 Apparent Per Capita Consumption for the United States



SOURCE: Williams, G.D.; Clem, D.A.; Dufour, M.C.. NIAAA, 1993.

How to Interpret

There are two major concerns about interpreting this type of information on drinking volume. First, the alcohol volume sold is computed using the entire population, which includes non-drinkers. Thus, the interpretation of the use measure is not comparable across communities or time periods that have different rates of drinkers and non-drinkers. The percentage of people who abstain from all alcohol consumption varies tremendously across areas. For example, in Wisconsin only one-third of adults do not drink, while in Tennessee about three-quarters of people report they do not drink.

A second interpretation challenge is that these data do not reveal who is purchasing and consuming the alcohol. These factors may influence the validity of the measure for some communities. In particular, this measure is influenced by the number of non-residents who purchase alcohol within the community. Thus, areas with large sales to other communities and areas with a high volume of tourism or restaurants (such as Las Vegas and the District of Columbia) will have inflated alcohol use rates. This measure may not be an appropriate alcohol use measure for those communities. Conversely, if the community prohibits the sale of alcohol on- or off-premises, the measure will not report accurately the level of drinking among local residents since their purchase of alcohol may occur in neighboring communities.

This measure is not useful for understanding drinking among population subgroups, such as youth, binge drinkers and other target groups, nor does this measure identify the number of problem drinkers.

Because this indicator is based on volume measures, it is not a measure of individual use. Other methods of measuring alcohol consumption include self-report questionnaires or interviews, and collateral reports from spouses or dependents as a means of corroborating a person's own report of drinking.

Nevertheless, the per capita alcohol consumption measure is a reliable and valid indicator that is also widely used at the state and national levels and is appropriate to use when available for a local community.

Did You Know?

The way in which students are drinking has changed. Students today drink more alcohol, more often, and for the sole purpose of getting drunk. In fact, one in three college students drinks for the sole purpose of getting drunk, and over one-third of college women reported drinking to get drunk in 1993, more than three times the response in 1977.

SOURCE: Adapted by CESAR from Rethinking Rites of Passage: Substance Abuse on America's Campuses. A report by the Commission on Substance Abuse at Colleges and Universities, June 1994. Center on Addiction and Substance Abuse at Columbia University.

Further Reading

Williams, G.D.; Clem, D.A.; Dufour, M.C. *Apparent per Capita Alcahol Consumptian: Natianal, State, and Regianal Trends, 1977-1991*. NIAAA, Division of Biometry and Epidemiology, Alcohol Epidemiologic Data System. Surveillance Report #27, November 1993.

6. Drug Use Among Arrestees:

The percentage of arrestees who test positive for drug use at the time of arrest.

Data Found in Reporting System Communities Only

Use

Washington D.C.

Data from the District of Columbia Pretrial Services Agency show that in December 1994, 59% of all juvenile arrestees tested positive for drug use, a large increase from the 43% positive rate of December 1993. Arrestees aged 13 to 15 had greater increases in positive rates over this time period than arrestees aged 16 to 18.

SOURCE: Center for Substance Abuse Research, CESAR FAX, 1995;4(6).

Indicator Description

Drug use among arrestees is a widely cited indicator of the prevalence of illicit substance use at the community level. It is made possible in some communities by the ongoing surveillance system maintained by the National Institute of Justice, Drug Use Forecasting (DUF) system. The advantage of this indicator is that it directly measures substance use behavior, rather than relying upon an indirect measure. Focusing on the behavior of arrestees is advantageous because people who are arrested are thought to engage in more risky drug use behavior than the general population. Thus, trends in drug use among arrestees, such as an upswing in heroin use among arrestees, may foreshadow trends that will affect other community populations.

The DUF method is to test urine samples that are taken at the time of arrest for the presence of numerous drugs: cocaine, marijuana, opiates, multiple drugs, other drugs (PCP, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates and propoxyphene). Use in the prior two days will generate a positive result for most drugs. Exceptions are PCP and marijuana, which can be detected for several weeks after use.

What to Measure

The total number of arrestees testing positive for drug use at the time of arrest as a percentage of all arrestees who are tested.

Communities that participate in the DUF surveillance program tend to use a standard method that tracks drug use among male arrestees.

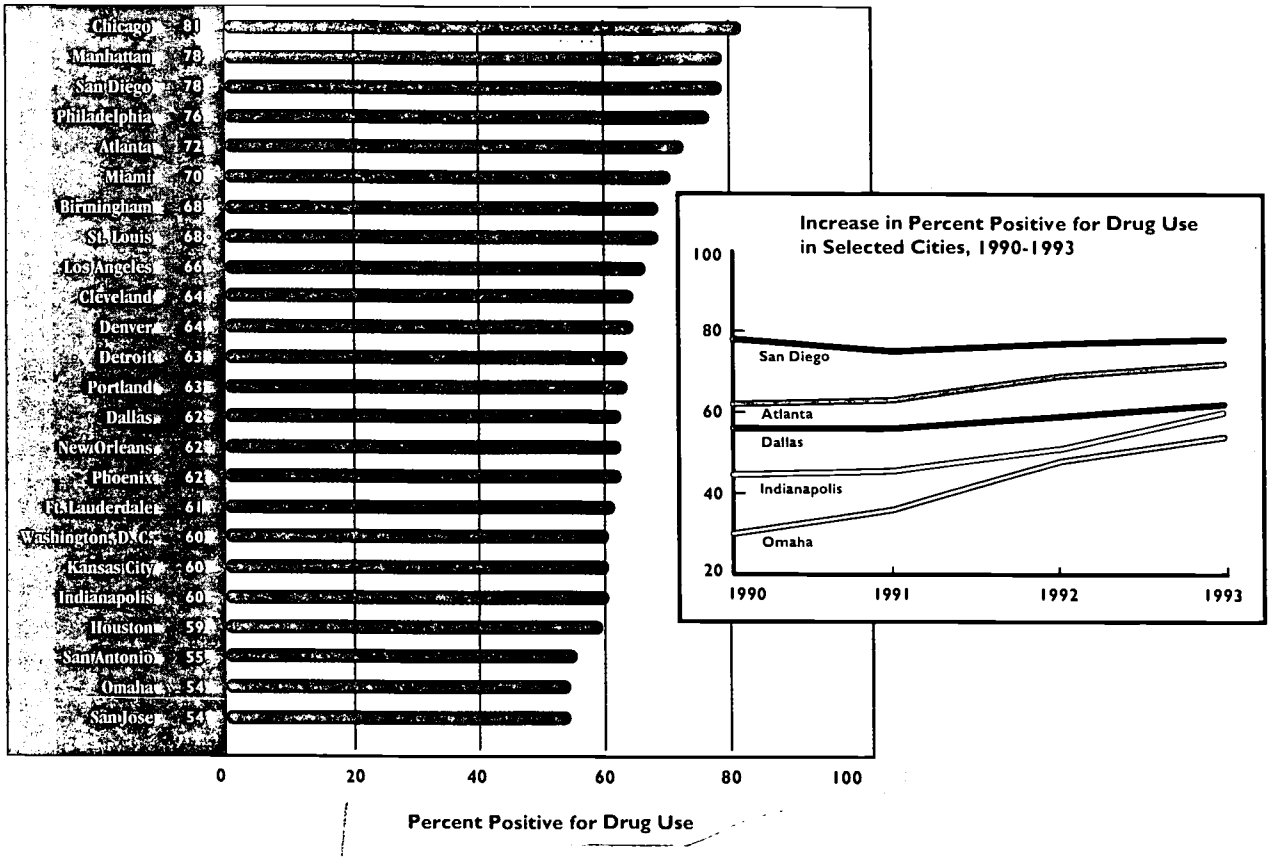
Selected DUF communities also test women arrestees and juvenile arrestees or detainees and report rates for these populations as well. It may be possible to follow trends on the use of specific drugs among arrestees (i.e., cocaine, heroin). Another alternative is to separately report drug use by criminal charge at time of arrest (i.e., assault, burglary, drug sale/possession).

Where to Find Local Data

Increasingly, local areas are starting pretrial drug testing programs as part of a routine court reporting system. These programs may become a source of local data.

About two dozen communities currently participate in a national DUF System, started in 1987 (see chart on next page). More communities are expected to join this program in the future. In DUF cities, volunteer arrestees are interviewed and tested periodically throughout the year.

Drug Use Among Adult Male Booked Arrestees, 1993



NOTE: Kansas City data based on 1992 data.

SOURCES: National Institute of Justice. Drug Use Forecasting. 1993 Annual Report on Adult Arrestees: Drugs and Crime in America's Cities. Washington, DC: U.S. Department of Justice, National Institute on Justice, November 1994; and DUF annual reports from 1992, 1991, and 1990.

Example Rates

In DUF cities, and probably other communities as well, the level of drug use among arrestees is very high. In 1992, the level of use ranged between 47 and 77 percent among adult male arrestees, depending upon location and the type of crime with which they are charged.

How to Interpret

DUF is designed to detect drug use patterns among arrestees and is generally thought to produce reliable estimates for the arrestee population under study. In particular, the use of urine tests rather than the reliance on self-report of drug use is a strength that ensures accurate reporting of drug use. Even so, the estimates undoubtedly do not capture all drug use among this population.

Technical Notes:

Comparisons across years and DUF sites are sometimes difficult to interpret because each site determines which group of arrestees to sample. Some DUF sites, but not all, focus on inner-city neighborhoods. Some focus on arrestees charged with felony crimes, others do not.

SOURCE: Reardon, J.A. The Drug Use Forecasting Program. *Measuring Drug Use in a "Hidden Population"*. NCJ 144784. Washington, DC: National Institute of Justice, US Department of Justice, November 1993.

The most serious limitation of this indicator is that it is not available for most communities. Nevertheless, where it is available, it provides detailed longitudinal information on the patterns of substance use and the extent of drug use among this high-risk target population group.

While some arrestees decline to participate, these refusals are monitored by DUF. In communities where the refusal rate is exceptionally high, conclusions must be more cautious. Also, across-year or across-city comparisons, as the chart on page 15 indicates, may reflect some bias in the level of drug use if the law enforcement agencies differ over time or across communities in the pattern of arrests. For example, pursuing drug trafficking might be more intense than in more or less prior years or in some cities more than others.

Do not conclude that drug use is the cause of criminal activity simply because drug use is frequently found among arrestee populations. This link alone is insufficient to show that drug use caused the criminal behavior.

The level of drug use among arrestees may or may not change as drug use patterns in other population groups change. This indicator should be used in conjunction with other information to determine if the trends appear to generalize to a broader local group. However, trends in the types of drugs used (i.e., more heroin use) may reflect greater local drug availability of certain substances that will be the same for other population groups as well.

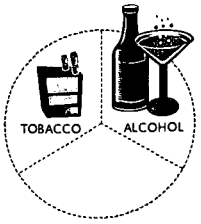
Further Reading

National Institute of Justice. *Drug Use Forecasting: 1993 Annual Report on Adult Arrestees, Drugs and Crime in America's Cities*. Washington, DC: U.S. Department of Justice. National Institute of Justice, November 1994.

DUF publications are produced quarterly and annually. Please contact either the National Criminal Justice Reference Service (NCJRS) at 1-800-851-3420 or NIJ at 202-514-5981 to receive the latest DUF publications.

7 Household Spending on Alcohol and Tobacco:

The annual dollars spent on alcoholic beverages and tobacco products as measured in consumer surveys



Data Found in Reporting System Communities Only

Indicator Description

The average amount spent for alcoholic beverages and tobacco products and supplies is an indicator of substances being consumed and the impact on the household budget. When adjusted for price differences over time or across communities, it is a proxy measure of the actual use or consumption of alcohol and/or tobacco products by households. The Bureau of Labor Statistics conducts a household expenditure survey for 26 metro communities that captures this information.

Alcohol

This indicator measures household spending on beer, wine and spirits, both at home and away from home during the year using the standard techniques and definitions used in the Consumer Expenditure Survey (CES).

Tobacco products and supplies

This indicator measures household spending on cigarettes, other tobacco products and tobacco supplies during the year.

What to Measure

The federal Consumer Expenditure Survey measures the average household expenditure, or dollars spent, in the metropolitan area on either alcoholic beverages, tobacco or combined alcohol and tobacco.

When tracked over time, the dollars spent should be adjusted for inflation using the consumer price index or actual information on cigarette and alcohol prices.

It is also meaningful for communities to compare the expenditures to average total household income and average expenditures for food and groceries. These measures help interpret the magnitude of alcohol and tobacco spending on the household budget.

Where to Find Local Data

Only certain metropolitan communities that participate in the federal Consumer Expenditure Survey will have this information available (see next page). The survey collects current expenditure data which provide a continuous flow of information on the buying habits of consumers. The data are necessary for future revisions of the Consumer Price Index.

To obtain the historical and recent data from the CES for a particular community, contact the regional office of the Bureau of Labor Statistics (see Chapter 5, Bureau of Labor Statistics (BLS) Regional Offices).

Example Rates

As with most items, expenditures vary by geographic area, reflecting buying patterns and local prices. Using the consumer price index, dollars spent can be standardized over time and across communities.

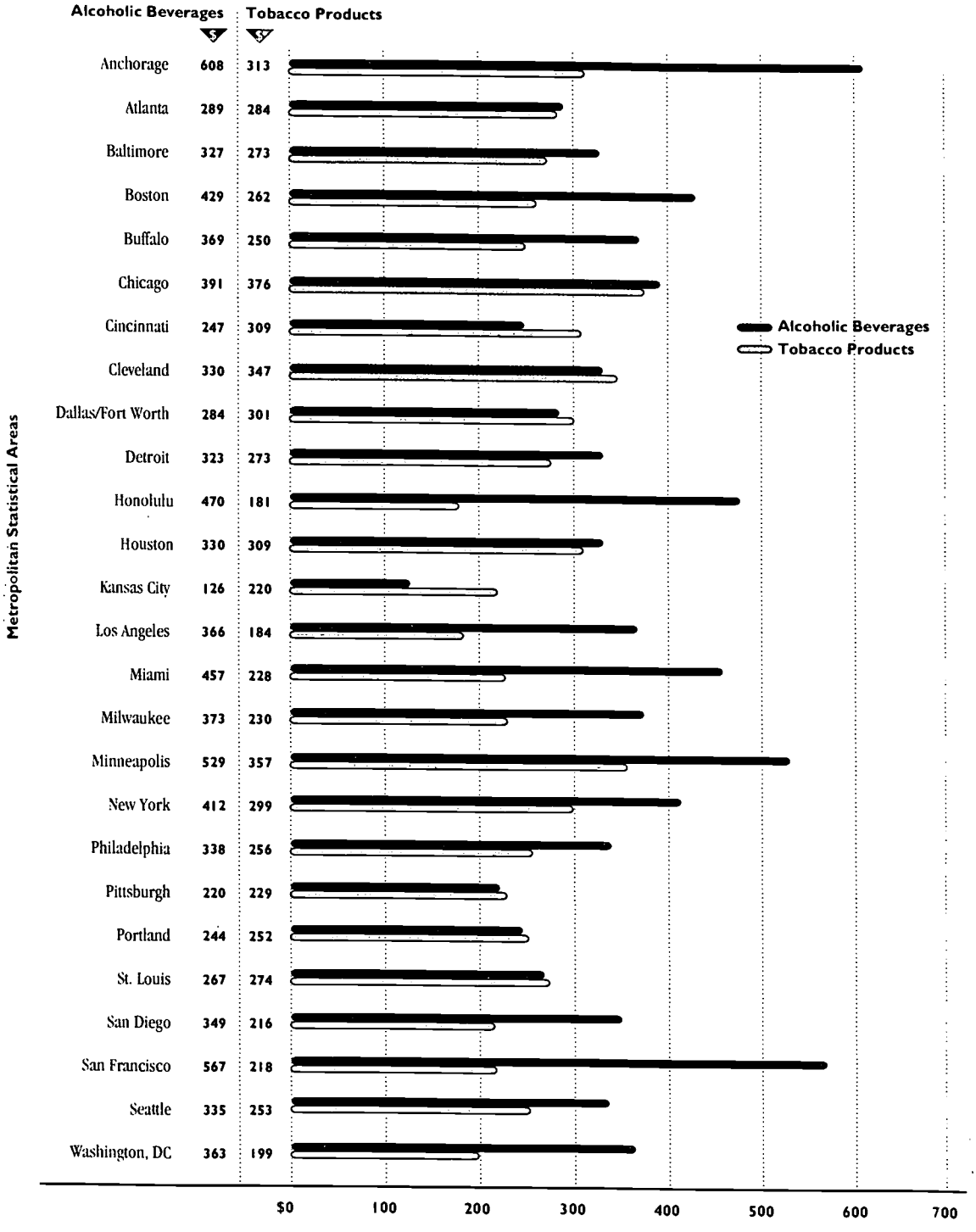
Did You Know?

Junior and senior high school students drink 35 percent of all wine coolers sold in the United States (31 million gallons) and consume 1.1. billion cans of beer (102 million gallons) each year. Surveys have shown that labeling is a big problem. Two out of three teenagers cannot distinguish alcoholic from nonalcoholic beverages because they appear similar on store shelves.

SOURCE: *The Christian Science Monitor* June 26, 1992; 84(140):19.

Use

Average Annual Household Expenditures on Alcoholic Beverages, Tobacco Products/Smoking Supplies, 1990-1991



NOTE: To the extent prices and taxes differ across cities, the difference in average expenditures reflects both differences in prices as well as differences in consumption.

SOURCE: US Department of Labor, Bureau of Labor Statistics, *Consumer Expenditure Survey, 1990-1991*, Press release, Table 3.

How to Interpret

The most serious limitation of this indicator is that it is available for only 26 communities. For those metro areas, however, it is a valuable proxy measure. The Consumer Expenditure Survey (see Further Reading) provides interesting tabulations for different types of families as well as the average for households.

When interpreting tobacco and alcohol dollars spent, there are several things to remember. Even though dollars spent is a valid and reliable measure, it is not a direct measure of the alcohol or tobacco used.

When interpreting average dollars spent, remember that it reflects both the proportion of households who purchase *any* alcohol or tobacco products, and the *amount* of tobacco products and alcohol purchased. A change in average dollars spent may reflect changes in either or both of these behaviors. For example, a decline in average tobacco product expenditures may occur if fewer households have members who smoke or if smokers are smoking less.

Also, different communities pay different prices for the same products and pay different tax rates. Thus, some communities may spend more because of higher prices, rather than a greater consumption level.

Further Reading

U.S. Department of Labor, Bureau of Labor Statistics. *Consumer Expenditure Survey 1991*, Report Number 835.

8. School-Based Substance Abuse Education Programs:

The presence of primary and secondary school educational programs on tobacco, alcohol and other drugs in public and private schools.

Thurston County, Washington

In Thurston County, Washington, approximately 40 percent of 6th, 8th, 10th and 12th graders surveyed thought alcohol and other drug education should begin at the 3rd grade level or earlier. Only one percent of 12th graders believed alcohol and drug education should begin in the 11th or 12th grades.

SOURCE: Together! A Youth Violence, Alcohol, Drug Prevention Program Serving Thurston County. Community Youth Agenda. Olympia, Washington. August 1994.

Indicator Description

The provision of educational programs in public schools about tobacco, alcohol and other drugs is an indicator of a community's capacity to prevent use among children and adolescents.

What to Measure

Count the number of grade levels where written substance abuse prevention curriculum has been adopted and is used during the year.

Your coalition may establish certain quality measures the curriculum should address. Communities also may want to report the number of classroom hours devoted to substance abuse education, if schools can provide this information.

Where to Find Local Data

Currently there are no uniform data collection efforts to track the number or types of prevention programs in school systems. A community group should contact the local school districts and try to retrieve written examples of curriculum for each grade level. You might also decide to interview school officials further, if you have the resources for some detective work. The following kinds of information may be available: the presence of anti-substance abuse programs, the proportion of classrooms that have used the curriculum, the number of hours when, and the grade levels where student instruction is offered.

Example Rates

The National School Boards Association reported in a 1989 national survey that district-wide anti-smoking education programs existed in 78 percent of high schools, in 81 percent of middle and junior high schools, and in 75 percent of elementary schools.

How to Interpret

About three-quarters of the states require school drug and alcohol policies and alcohol and other drug education and prevention programs. The major difficulty in using this measure is that the quality and extensiveness of the curricula are difficult to report on and evaluate in a consistent way over time or across communities. There are several types of curriculum that focus on both the individual and the peer group. The U.S. Department of Education has begun a

process to assess curricula, develop criteria for selecting curricula, and make general recommendations for school districts. This process may lead to better potential indicator measures as well.

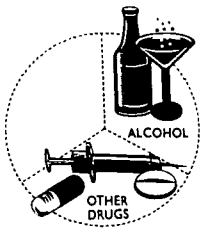
There are other education-based resources that communities and schools can tap into at the U.S. Center for Substance Abuse Prevention, the U.S. Department of Education, and local coordinators for the Safe and Drug-Free Schools and Communities project (see Chapter 5, list of Coordinators for Drug-Free Schools).

The U.S. Department of Health and Human Services has established the provision of these programs as a public health objective: "To provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as part of quality school health education."

Further Reading

Office for Substance Abuse Prevention. Prevention Plus II: Tools for Creating and Sustaining Drug-Free Communities. DHHS Publication No. (ADM)89-1649. Rockville, MD: OSAP, 1989.

Office for Substance Abuse Prevention. Prevention Plus III: Assessing Alcohol and Other Drug-Prevention Programs at the School and Community Level. DHHS Publication No. (ADM)91-1817. Rockville, MD: OSAP, 1991.



9 Self-Help Meetings:

The number of weekly open self-help meetings held in the community.

Indicator Description

The number of self-help meetings is an indicator of the community's informal support system and capacity to promote sobriety. Together with measures of the people in treatment (see People in Treatment profile), this measure helps describe the local services available. The presence and number of self-help local meetings indicate the community's capacity to provide alternatives for people in recovery. Because self-help meetings are confidential, it is not possible to learn about the number of people attending the meetings.

Alcoholics Anonymous is the most widely-known organization that provides a forum for individuals to pursue recovery using the self-help strategy. The meetings are sometimes part of a formal treatment regime or aftercare plan. These meetings, however, may well be the only support a person has pursued to gain sobriety.

What to Measure

The number of open meetings per week in the community. It is appropriate to count AA and NA meetings separately.

As an informal support network, there is no routine information reported on the attendance at meetings or composition of the group attending such meetings. Open meetings are different from those restricted to clients in specific treatment programs. It is appropriate to separately tally different types of meetings when possible: AA, NA, or alternative meetings, such as Rational Recovery.

Where to Find Local Data

Typically, a local or state Alcoholics Anonymous organization will provide lists of weekly meetings in each town. Also, you may discover that alternative self-help organizations exist. There may be a local Narcotics Anonymous, Cocaine Anonymous, Rational Recovery, or Smokers Anonymous organization. Contact the state or local chapters of these organizations to receive a list of the current meetings in the area. If the chapter cannot be identified through a local phone book or social service referral source, contact the national organization. The AA world headquarters' number is (212) 686-1100.

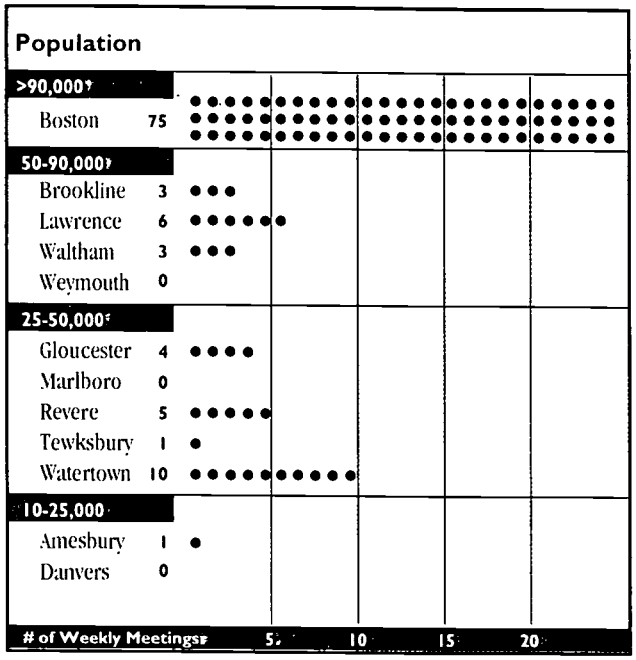
Example Rates

Using Massachusetts as an example, the number of meetings for selected towns is given on the next page.

How to Interpret

When interpreting the information, remember that meeting size is not standard and may range from very large forums to small intimate groups. There is also no way to classify meetings in terms of the types of persons who attend. Thus, a community may appear to have as much of this informal capacity as other communities within the state, yet certain population groups (i.e. women, ethnic minorities) may not be attending any meetings. Also, people may prefer to attend meetings in

Weekly Self-Help Meetings in Selected Massachusetts Communities: 1990-1992



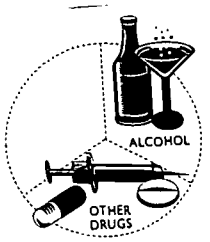
SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services. *Indicators of Substance Use in Massachusetts 1985-1992*. Report prepared by Health and Addictions Research, Inc. September 1994.

communities other than their own home town, for example near their work. Therefore, the number of meetings in a community may not accurately indicate the accessibility or use of this informal support.

Be cautious when trying to interpret this measure as an indicator of substance use or need. Changes in the number of meetings over time probably reflect changes in the way meetings are locally organized, the convenience in locating public sites for meetings, and other changes in the climate of the self-help movement. While the number of meetings may be linked in some way to the level of substance abuse problems, the link is indirect. Therefore, there is no accurate way to determine the extent of a substance abuse problem, based upon the number of meetings.

Further Reading

Massachusetts Department of Public Health, Bureau of Substance Abuse Services. *Indicators of Substance Use in Massachusetts 1985-1992*. Report prepared by Health and Addictions Research, Inc. September 1994.



10. People in Treatment:

The number of people currently enrolled in specific substance abuse treatment programs in the community.

Rhode Island

In the late 1980s, Rhode Island's Division of Substance Abuse asked a research group to assess the State's drug treatment needs and make recommendations for its treatment system. Assessors used a telephone drug use survey. To meet the need for drug treatment, assessors recommended tripling drug treatment services. If the state were to treat all addicts who wanted it, services would have to be expanded by 26 percent. In response, the state provided $700,000 for new methadone maintenance slots and another $3.9 million for the construction and operation of a 60-bed adolescent treatment facility. Private agencies added 300 methadone slots, 600 outpatient drug-free slots, and sixty 28-day residential treatment slots.

SOURCE: McAuliffe, W.E.; Breer, P.; Ahmadifar, N.W.; and Spino, C. Assessment of drug abuser treatment need in Rhode Island. *American Journal of Public Health*, 1991: 81(3): 365-371.

Indicator Description

Various measures indicate a community's capacity to prevent or treat substance abuse problems. One indicator is the number of people currently enrolled in treatment programs. It is common to count the client census in treatment facilities on a particular day each year. Enrollment reflects treatment demand but it is also closely related to the community's treatment capacity.

What to Measure

The number of people in public and/or private treatment in specific alcohol and drug abuse programs.

These programs are typically located in hospitals, residential units, halfway houses, mental health centers and outpatient clinics. The preferred way to express the number of people treated, for tracking over time or across communities, is the number per 100,000 population.

Some state data systems may report the number in treatment on a particular day, or the average daily census of clients. Other state data systems may count the total number of admissions to specialty treatment in the entire year. The number of *admissions* is different from the number of *people* because many clients are admitted more than one time, or they are transferred across programs. This results in duplicate counts of some clients.

Communities may be interested in separate reports of the number of people treated in certain treatment settings (i.e., residential, inpatient, outpatient) or in certain age groups.

Where to Find Local Data

Communities can rely upon data gathered by federal governments and state agencies. Community groups, however, can supplement these data if they are incomplete.

Nearly all states maintain admission or client information for publicly-funded programs. Contact state alcohol and drug authorities to receive reports on the volume of admissions in a given community. A special request for data analysis may be necessary (see Chapter 5, list of Alcohol and Drug Abuse authorities).

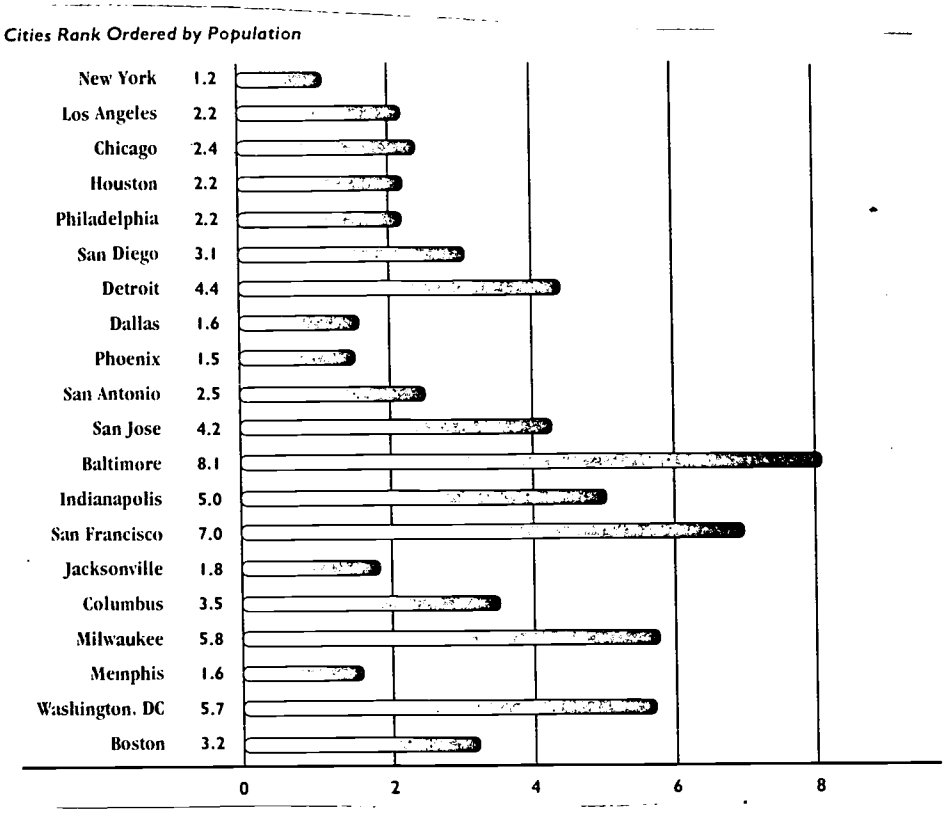
Your group could be the first to ask for community-level data. Trend information from your community may not be possible. In those circumstances, some communities will retrieve their own information from known treatment facilities in their community. Specialty treatment units usually list their services in local phone books and with local United Ways. Typically, the state has a unit that licenses drug and alcohol treatment programs. Contacting these groups is one way to learn about treatment units that are located in your community.

Your group can get historical or current information by contacting one or several facilities on these local lists that serve the most people in your community. Ask about total enrollment numbers on a particular day, such as the last day of the previous month.

Example Rates

On September 30, 1991, there were over 800,000 clients receiving drug and/or alcohol specialty treatment across the nation. This

Client Treatment Rates in the 20 Largest U.S. Cities, 1992



NOTE: Clients in treatment on Sept. 30, 1992.

SOURCE: Analysis is based upon all treatment units that reported valid data with a location in the city. No attempt has been made to impute for missing data. Brandeis University, Institute of Health Policy analysis of the 1992 National Drug and Alcoholism Treatment Unit Survey.

translates to a prevalence rate of approximately 300 clients per 100,000 population. This rate varies tremendously by state and city, reflecting both different capacity and demand.

How to Interpret

The number of people in treatment can be thought of as a measure of a community's capacity to treat substance abuse problems. Remember that the capacity of specialty units is only one part of total treatment capacity. This is because some people seek counseling from individual professionals, help from acupuncturists, natural healers, other informal sources, ministers and other clergy. People in recovery may use local self-help programs as well (see Self-Help Meetings profile).

The number of people in local facilities may be an undercount of the true capacity used because people may seek treatment in programs located outside their community.

The number of people in treatment is often used to describe the level of substance use in a community. However, the capacity to treat is quite different from the level of need in a community. The number of people who use treatment is far fewer than the number of people with substance abuse problems that need treatment.

Technical Note:

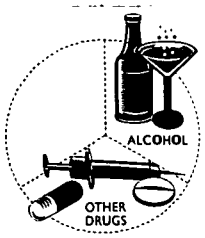
Some cities and treatment programs keep track of the number of names on a waiting list to enter specialty substance abuse treatment programs. This information is used as evidence that a greater treatment capacity is needed.

HEALTHY PEOPLE 2000

A national service objective has been established to provide comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people, including people with low incomes, women, youth, minorities, and inmates in correctional facilities. Furthermore, an objective has been established to increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.

Further Reading

Substance Abuse and Mental Health Services Administration. *National Drug and Alcoholism Treatment Unit Survey: 1991 Main Findings Report*, USDHHS publication number SMA 93-2007, 1993.



11. Substance Use Arrests:

Arrests for alcohol and drug-related violations, including driving under the influence, liquor law violations, public drunkenness, illicit drug trafficking and illicit drug possession.

San Francisco County

San Francisco County tracks reports of burglary as the property crime most closely associated with heroin abuse. Burglaries rose nearly 20 percent between 1987 and 1990, remained unchanged in 1991, rose another 7 percent in 1992, and dropped back to the 1990-91 level during January to April 1993.

SOURCE: National Institute on Drug Abuse. *Community Epidemiology Work Group. Epidemiologic Trends in Drug Abuse.* NIH Publication No. 93-3645. Rockville, MD: NIDA, 1993.

Indicator Description

The number of arrests is an indicator of the police response to substance abuse violations. Arrest data reflect several things: (a) the type of federal, state and local statutes that prohibit certain activities, (b) the degree of law enforcement targeted at substance abuse, and (c) the number of violations being committed.

These arrest data are sometimes interpreted as police effectiveness at combatting substance abuse problems — or, alternatively, as evidence of changes in the number of violations. Arrest data, however, must be interpreted carefully. It collectively measures the type of statutes, the degree of enforcement and the number of violations.

It is valuable to monitor four arrest indicators defined in the following ways:

1. *Driving under the influence*

   Arrests for driving or operating any vehicle while meeting the legal definition of intoxication. The level of blood alcohol concentration which is considered intoxicated varies according to state statute.

   See the Join Together map of states with lower Blood Alcohol Content (BAC) levels and/or Pending Legislation for minors on the next page.

2. *Other alcohol offenses*

   Arrests for other alcohol offenses include liquor law violations, which include sale of alcohol to minors, possession of alcohol in an open container in a public place, and public drunkenness. Many localities will now transport inebriated persons to detoxification programs rather than arrest for public drunkenness violations.

3. *Illicit drug trafficking*

   Illicit drug offenses include the sale and manufacture of controlled substances. Local law enforcement agencies may target trafficking but not pursue arrest for possession of small quantities of drugs.

4. *Illicit drug possession*

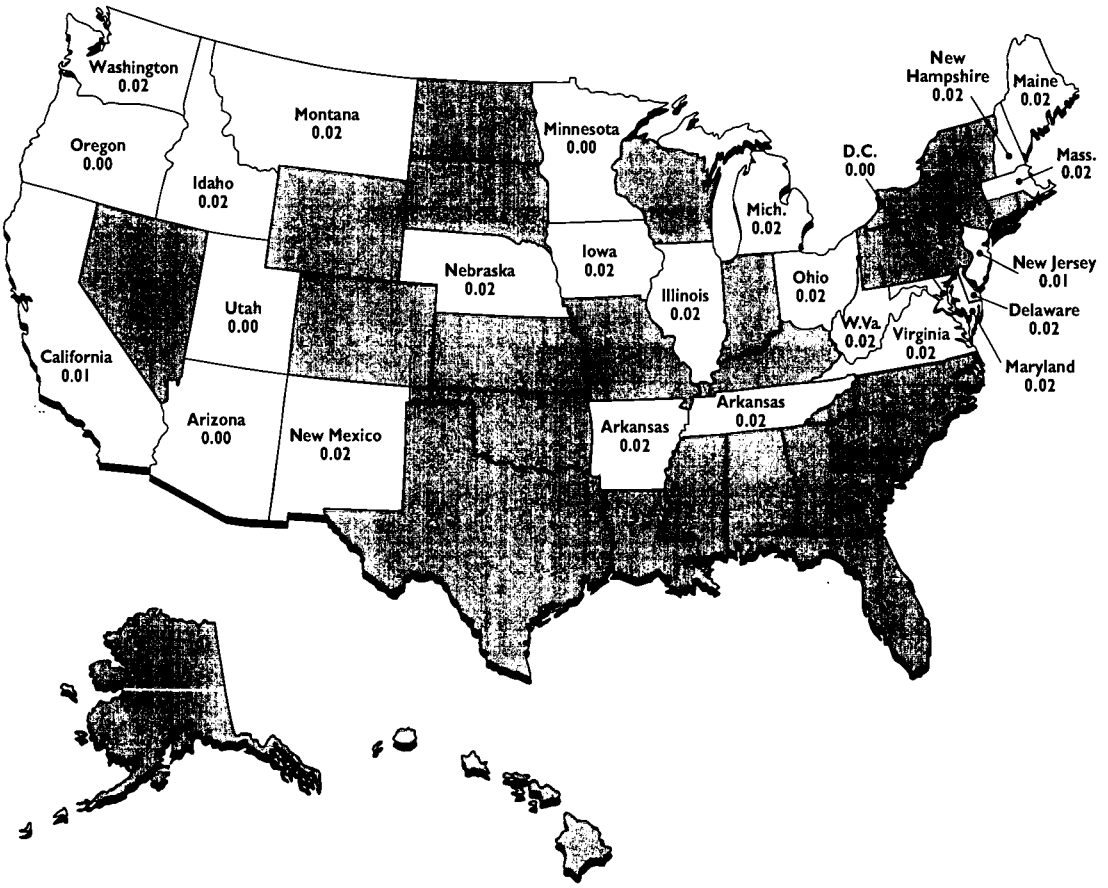
   Arrests for possessing small quantities of controlled substances intended for personal use.

What to Measure

The preferred measure is a population-based arrest rate, (for example, the number of arrests for driving or operating any vehicle while intoxicated) per 100,000 population of driving age (i.e., 16 years of age).

A community could also calculate the percent of all arrests that are substance abuse-related.

States with Zero Tolerance Limits for Minors



HEALTHY PEOPLE 2000

The U.S. Department of Health and Human Services has established the following protection objectives:

Extend to 50 states driver's license suspension/revocation laws for people determined to have been driving under the influence of intoxicants.

Extend to 50 states legal blood alcohol concentration tolerance levels of .04 for motor vehicle drivers aged 21 and older and .00 percent for those younger than age 21.

Where to Find Local Data

Contact the FBI for consistently tabulated historical data. Communities may request data from the FBI by calling (202) 324-5015 or writing to:

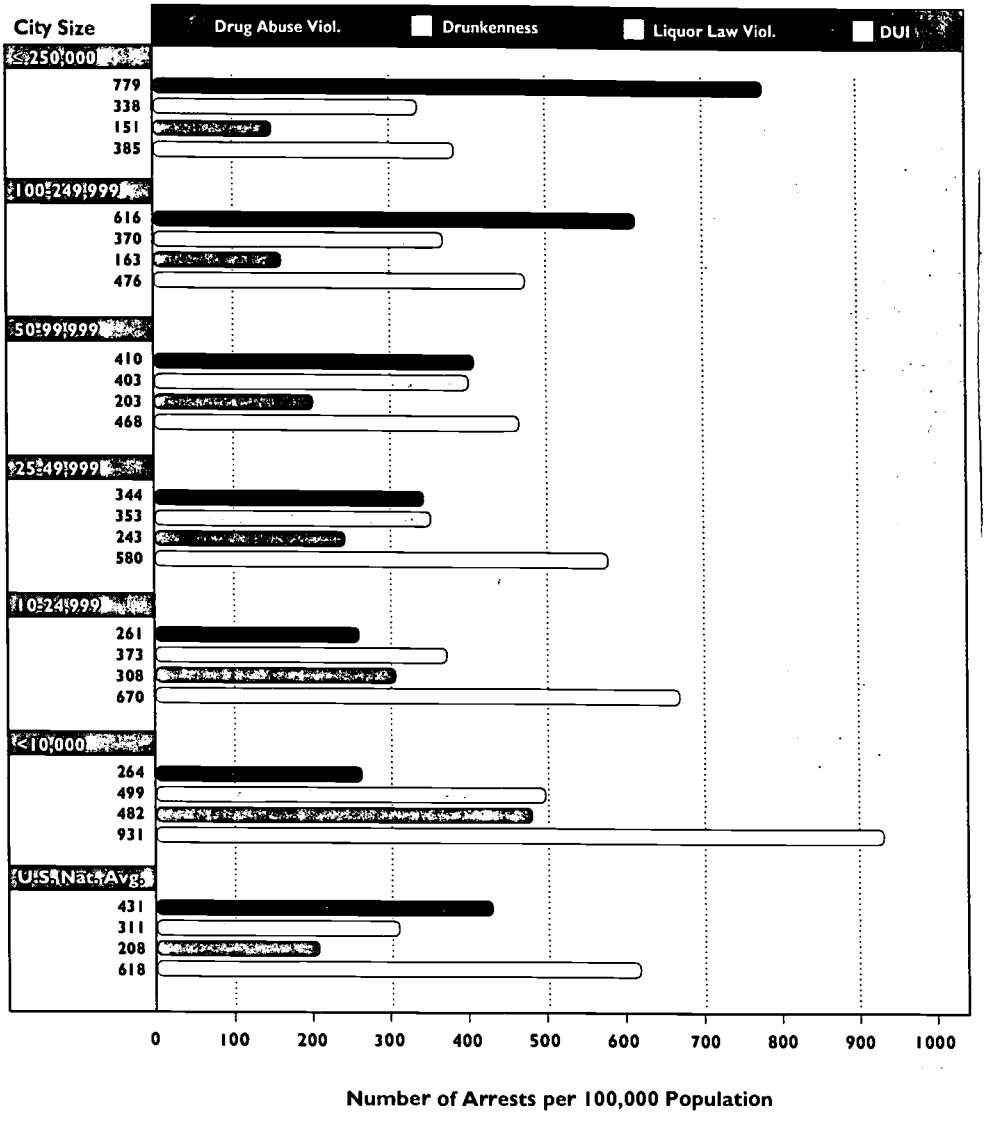
Uniform Crime Reports
Criminal Justice Information Services Division
FBI/GRB
Washington, DC 20535

These historical data can be supplemented with individual state Uniform Crime Report programs. Forty-four states and the District of Columbia have their own state-level UCR programs. (The states that do not have Uniform Crime Reporting Programs are Indiana, Mississippi, Missouri, New Mexico, Ohio and Tennessee). The FBI data set may have some

Substance Use Arrest Rates by Community Size, 1992

Technical Note:

The Federal Bureau of Investigation maintains the Uniform Crime Reporting (UCR) data set, a nationwide cooperative statistical effort of over 16,000 city, county and state law enforcement agencies (about 95 percent of law enforcement agencies) who voluntarily report data on crimes brought to their attention. The UCR is considered a census which compiles information monthly from local law enforcement agencies. Contributors forward data either directly to the FBI or through a state level Uniform Crime Reporting Program. Because the data are maintained at the local law enforcement agency level, communities can extract local data from either the state data set or the FBI maintained data set.



SOURCE: Federal Bureau of Investigation. *Uniform Crime Reports for the United States, 1992*. Table 31, p. 220. Washington, DC: U.S. Government Printing Office, 1993.

advantages over state data in that data discrepancies are thoroughly examined before data are reported. It is likely, however, that data for a particular time period become available earlier from the state reporting programs.

Communities may request data by contacting the Uniform Crime Reporting Program in their state (see Chapter 5, list of UCR Programs). By contacting the local law enforcement agency, a community also may be able to retrieve arrest

information which can be classified into neighborhoods or smaller geographic areas. One caution when using local law enforcement agency data is to be aware of all law enforcement agencies making investigations and arrests in the area. Examples may include: precinct constables, alcoholic beverage control commissions, Federal Drug Enforcement Agents and FBI Agents.

How to Interpret

Arrest data indicators are sensitive to the type of local statutes and the level of police enforcement as well as the level of substance abuse problems in a community. As such, great care must be taken when interpreting changes in arrest rates. For example, when there is a special sting operation or sobriety road block set up by police, arrest increases could show the effectiveness of these strategies. In this instance, however, arrest increases cannot be interpreted as indicating an increase in substance abuse problems. When tracking arrest data over a period of time within a community, it is often impossible to determine if an increase or decrease in arrests is related to changes in police enforcement or to changes in community problems or to some combination of both. It is important to involve local police departments in order to arrive at the most valid interpretation of your community's data collection effort on substance abuse-related arrest rates.

If a community can argue that the level and kind of police activities or procedures have been consistent over time, any observed trends for DUIs or other alcohol and drug offenses may be interpreted as related to drinking or drug use behavior. Comparing a trend in DUI arrests to other alcohol trends may increase a community's confidence that alcohol behaviors are changing, not police activities. A limitation to using arrest data as an indicator of community substance abuse problems still exists, however. As with other indicators, there are essentially only a small number of arrests compared to the frequency of the offenses. For example, the number of arrests for driving under the influence is only the tip of the iceberg in terms of how frequently people drive intoxicated.

Did You Know?

There may be discrepancies in tracking juvenile arrest data, according to some crime data users. On one hand, the juvenile system does not include reports on those over age 18. Meanwhile, adult arrest data tend to neglect underage drinking. This is because arrest data under-report the number of drug possession and distribution offenses, since the data capture only the most serious offenses at the time of an arrest.

Further Reading

Federal Bureau of Investigation, U.S. Department of Justice. *Uniform Crime Reports for the United States*, 1992. Washington, DC: U.S. Government Printing Office, 1993.

Join Together. *Community Action Guide to Save Lives!* Strategies to Reduce Underage Access to Alcohol and Save Lives in Your Community. Boston, MA: Join Together, 1992.

12. Alcohol and Tobacco Excise Taxes:

The dollar value of the taxes levied on alcohol or tobacco substances.

Little Rock, Arkansas

In addition to excise taxes, some communities tap into general purpose taxes as a source of funding for substance abuse programs. In 1993, Little Rock Arkansas passed a 1/2 cent sales tax for general city operations and safety measures. It was sold to the voters, in part, as a way to fund substance abuse treatment services in the city. While the majority of the money is not earmarked, about $500,000 was earmarked for crime watch programs called Neighborhood Alert Centers each year for five years. And $300,000 of the tax will support adolescent substance abuse treatment services.

SOURCE: Little Rock Fighting Back Mid-Course Assessment, May 1994.

Indicator Description

The amount of combined local, state and federal taxes is one indicator of the regulation of cigarettes and alcoholic beverages. Historically, taxation has generated revenues for broad public purposes, but this focus is changing. Increasingly, communities and states are viewing higher taxes as one public health method to discourage the purchase of alcohol and tobacco, especially among minors. Furthermore, in some states the proceeds from these taxes are dedicated to public health programs, including substance abuse treatment programs, prevention campaigns and other public education efforts.

What to Measure

- *Cigarettes*

  The value of the local excise tax on a pack of cigarettes.

- *Alcoholic beverages*

  The value of the local excise tax on a specific type of beverage: beer, wine or spirits. Each type of alcoholic beverage is taxed separately.

Be aware that most communities do not have a local excise tax on these products. Indeed, some states have statutes that prohibit such local taxation.

It is also meaningful to report the tax as a percent of the total price. The percent can be thought of as the total impact of the tax on the price of purchasing cigarettes or alcohol. Because of inflation, the tax impact declines over time unless the tax rates are increased frequently.

Where to Find Local Data

- *Cigarettes*

  When a local excise tax exists, a community must contact the local Department of Revenue to obtain the current and historical tax rates. To find background information on state and federal cigarette taxes, contact the Tobacco Institute (see Additional Resources, list of national resources).

- *Alcoholic Beverages*

  There are two potential sources for information on local alcoholic beverage taxes:

The Beer Institute compiles data on state excise and other taxes assessed by municipalities or county governments (see Chapter 5, National Resources).

And, state Alcoholic Beverage Control boards or revenue departments may be contacted for information as well, particularly the regulation of wine and spirits (see Additional Resources, Directory of State Agencies for Alcohol Consumption Data. List of Alcohol Beverage Control boards).

Example Rates

There are 373 cities that have local cigarette taxes. Forty-nine cities also tax other tobacco products. These cities are located in Alabama, Alaska, Illinois, Louisiana, Missouri, New York, Ohio and Tennessee. There are also 38 local counties with cigarette taxes in these same states, with the exception of New York and Alaska.

There are local alcohol taxes in addition to state excise taxes. States with communities that

State Cigarette and Beer Excise Taxes

have such taxes include California, District of Columbia, Florida, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, New York City, Ohio, Rhode Island, Tennessee, Vermont and Washington.

How to Interpret

Communities may be influential in working for increased tax rates or new taxes on alcohol and tobacco. In those instances, higher taxes may reflect less tolerance for the purchase of tobacco or alcohol than other communities. Some communities and states promote higher tax expenses as one way to deter purchase of these products.

Higher tax rates also reflect a community's preference to use excise taxes on these products rather than financing public programs from income, property or sales taxes. It should not be interpreted, however, as the only measure of a community's commitment to prevention or deterrence efforts.

The impact of local taxes should be interpreted along with federal and state tax information as well. The federal excise tax on tobacco and alcoholic beverages has been rather stable. The current rate for cigarettes is $0.24 per pack. Cigarette tax rates vary widely across the states: the lowest state tax rate on cigarettes is in Virginia ($0.025) and the highest is in Massachusetts (approximately $0.51).

The federal taxes on alcoholic beverages are: Beer (6 pack) $0.33; Wine (750 ml) $0.21; and Distilled Spirits (750 ml) $2.14. State alcohol tax rates vary tremendously across states and by type of beverage.

State	Cigarette Excise Taxes per Pack, Jan. 1993	Beer Excise Taxes per Gallon, April 1992
Alabama	$.165	$.53
Alaska	.290	.35
Arizona	.180	.16
Arkansas	.220	.23
California	.350	.20
Colorado	.200	.08
Connecticut	.450	.19
Delaware	.240	.16
DC	.500	.09
Florida	.339	.48
Georgia	.120	.48
Hawaii	.500[a]	.89
Idaho	.180	.15
Illinois	.300	.07
Indiana	.155	.12
Iowa	.360	.19
Kansas	.240	.18
Kentucky	.030	.08
Louisiana	.200	.32
Maine	.370	.35
Maryland	.360	.09
Massachusetts	.510	.11
Michigan	.250	.20
Minnesota	.480	.15
Mississippi	.180	.43
Missouri	.130	.06
Montana	.193	.14
Nebraska	.270	.23
Nevada	.350	.09
New Hampshire	.250	.35
New Jersey	.400	.16[b]
New Mexico	.150	.18
New York	.390	.21
North Carolina	.050	.48
North Dakota	.290	.16
Ohio	.240	.11
Oklahoma	.230	.40
Oregon	.280	.08
Pennsylvania	.310	.08
Rhode Island	.370	.10
South Carolina	.070	.77
South Dakota	.230	.27
Tennessee	.130	.13
Texas	.410	.19
Utah	.265	.36
Vermont	.200	.27
Virginia	.025	.26
Washington	.340	.15
West Virginia	.170	.18
Wisconsin	.380	.06
Wyoming	.120	.02

SOURCES: The Tobacco Institute, *Tax Burden on Tobacco Historical Compilation*, Vol. 27, 1993. Washington, D.C., p.viii. Research Institute of America, Inc., *State and Local Taxes: All States Tax Guide*. New York, N.Y., 1992, pp. 272-A, 272-B, 271, 272, 272-C, 272-D.

[a]= Hawaii tax on cigarettes is 40 percent of wholesale price.
[b]= New Jersey tax on beer effective 7/1/92.

SOURCE: Tobacco Institute. *The Tax Burden on Tobacco, Historical Compilation*, 1994.

Further Reading

Tobacco Institute. *The Tax Burden on Tobacco, Historical Compilation*, Vol 28, 1993. Washington, DC: Tobacco Institute, 1994.

Distilled Spirits Council of the United States, Inc. *Public Revenues from Alcohol Beverages: 1993*. Washington, DC: Distilled Spirits Council of the United States, Inc., December 1994.

Distilled Spirits Council of the United States, Inc. *Summary of State Laws and Regulations Relating to Distilled Spirits, 28th Edition*. Washington, DC: Distilled Spirits Council of the United States, Inc., December 1993.

13. Student Disciplinary Actions:

Public school suspensions or other sanctions due to possession, use or sale of alcohol, illicit drugs or tobacco.

Maryland

The Center for Substance Abuse Research (CESAR) has reports on student disciplinary incidents in Maryland. Data are retrieved from the 1989-90 Maryland State Department of Education. Statewide there were 685 disciplinary actions for the possession/use of alcohol or drugs and 91 actions for alcohol or drug distribution. Possession/use actions most frequently involved alcohol (58%) or marijuana (19%). About 4% of the possession/ use actions involved hallucinogens and under 1% involved cocaine or stimulants. Suspension for distribution primarily involved alcohol (60%), marijuana (23%) or hallucinogens (13%).

SOURCE: CESAR, Maryland Drug Indicators, 1992.

Indicator Description

Disciplinary actions issued by school officials against students for possession, use or sale of alcohol, illicit drugs or tobacco on school property is one measure of enforcement and also is related to the availability of substances on school property.

What to Measure

The preferred measures are the number of public school suspensions due to possession, use or sale of alcohol, illicit drugs or tobacco which can be expressed as the number of substance use-related suspensions per 1,000 students enrolled.

Other Measures

Your community may be interested in tracking disciplinary actions by type of substance or type of activity. For example, your community may want to look at disciplinary actions specific to marijuana or alcohol.

Where to Find Local Data

There are no uniform data collection efforts to track the number of student disciplinary actions in school systems. Each district uses different procedures. A community group may contact the local school district or individual secondary schools to see if they will release counts on the number of disciplinary actions. The following kinds of information may be available: the type of substance involved, the grade of the student involved, the reason for the disciplinary action.

Example Rates

Data on disciplinary incidents are recorded by schools but, typically, are not publicly released. Uniform example rates are not available.

How to Interpret

There are major challenges to finding and interpreting reliable information on student disciplinary actions.

First, we learned that local groups may find it difficult to obtain information from school systems. School systems are apparently reluctant to release this kind of information. They are concerned about privacy issues and other sensitivities. Your group may have to build up a trusting relationship over time with local schools.

Also remember that school incidents only capture those students who attend school. This indicator does not include youth who do not attend school and who perhaps are at higher risk for alcohol and substance abuse.

Finally, even when the information is available, there may be biases because it is not collected in a uniform way across school systems. In particular, each school uses its own procedures to determine when a suspension or warning will be issued. It is possible that in some schools, students who are apprehended for possession or use of a substance on school property may be issued a warning under some circumstances but suspended under other circumstances. These biases will complicate the interpretation of trend data.

Environment/Regulation/Activities

Further Reading

Center for Substance Abuse Research. *Moryland Compendium of Drug Abuse Indicators*. University of Maryland, College Park. 1992.

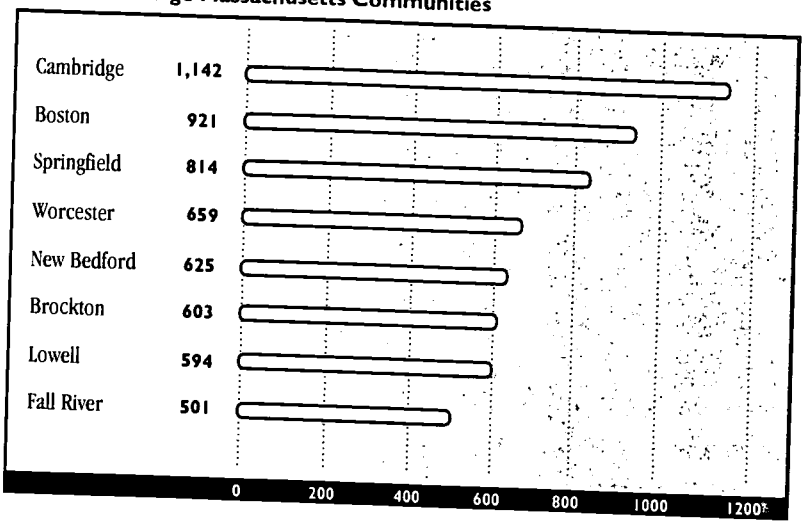
Alcohol/Drug Hospital Cases per 100,000 Population

Did You Know?

The abuse of alcohol, illicit drugs and tobacco contributes significantly to hospital costs. According to recent estimates using 1991 data, substance abuse-related hospital cases account for 1 out of 5 Medicaid hospital days or 4 million days of care annually. In 1994, this would account for $8 billion in Medicaid expenditures.

SOURCE: Fox K., J.C. Merrill, H. Chang, J.A. Califano. "Estimating the Costs of Substance Abuse to the Medicaid Hospital Care Program," *American Journal of Public Health*, 1995; 85(1):48-54.

In Selected Large Massachusetts Communities



SOURCE: Health and Addictions Research, Inc. Indicators of Substance Use in Massachusetts: 1985-1992. Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 1994.

Technical Note:

Studies show that a large portion of people with substance abuse histories are not adequately identified and treated. One recent study of a psychiatric teaching hospital shows that 70 percent of admitted patients with a history of substance abuse did not have a formal diagnosis. Half of the patients received no documented treatment for substance abuse.

SOURCE: Milling, R.N.; Faulkner, L.R.; and Craign, J.M. Problems in the recognition and treatment of patients with dual diagnoses. *Journal of Substance Abuse Treatment*, 1994; 11(3):267-71.

The total number of hospital cases may vary over time and across communities depending upon differences and changes in the health care system. Thus, using the percent of discharges, rather than some other rate, has some advantages.

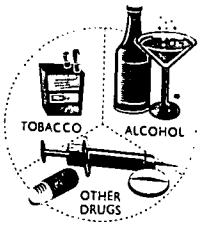
Communities could also track the number of cases for specific types of disorders (substance abuse treatment versus injury or disease, for example) or for particular age or ethnic population groups. Another measure would be the substance abuse discharge rate per 100,000 population. It should be noted, however, that in most communities there has been an overall decline in the number of hospitals discharges as a result of changes in insurance, financing and overall organization of medical care.

Where to Find Local Data

Medical information of this nature must be retrieved by studies using acute hospital discharge records, which may be maintained by a state or local group, such as the state health department, a state hospital association or the Medicaid program. Some, but not all, communities will be located in states that have analyzed such hospital discharge data. Communities

14. Substance Use-Related Hospital Cases:

The number of hospital cases with diagnoses related to the use of alcohol, other drugs or tobacco.



Data Found in Reporting System Communities Only

Indicator Description

Studies have found that hospitalizations are frequently associated with substance abuse treatment or complications from use. Thus, one indicator of substance abuse harm is the number of hospital cases with substance abuse-related diagnoses. Because the level of harm is related to the level and pattern of substance use in a community, hospital cases are also an indirect indicator of substance use in a community. Hospital cases are closely related to another community indicator, substance abuse-related deaths (see Substance Use Deaths on page 57).

What to Measure

The preferred measure is the percent of hospital discharges associated with a primary diagnosis related to substance abuse.

Four related indicator measures are:

- *Alcohol-related cases*
  The number of hospital discharges for the treatment of alcohol abuse disorders and for diseases and injuries directly and/or indirectly attributable to alcohol use (see page 57 for list of diseases).

- *Drug-related cases*
  The number of hospital discharges for the treatment of illicit drug abuse disorders and for diseases and injuries directly and/or indirectly attributable to illicit drug use.

- *Tobacco-related cases*
  The number of hospital discharges related to diseases associated with tobacco use.

- *Substance abuse-related problems of newborns*
  The number of hospital discharges for newborns with one or more of the following diagnoses: fetal alcohol syndrome, fetal drug-induced disorder, newborn drug withdrawal syndrome or another alcohol or drug problem diagnosis (see Child Abuse Reports on page 52).

When identifying hospital cases, some hospital discharges will have diagnoses related to more than one substance. Care should be taken to count those cases only once or to note how many hospital cases are counted under two or three measures.

Technical Note:

Nearly all states maintain some type of hospital data reporting system on medical discharges, according to a guide published by American Hospital Publishing, Inc. They vary by type of data they record and how readily it can be accessed. More than half of states have data on emergency room visits as well. The guide tells you who to contact, what data are available, and some of the details on the kinds of records kept. Before data are requested from any source, the guide advises that you telephone the source to confirm that the data sought are available, the cost and exact procedures for obtaining information.

Be aware that even among states with discharge data systems, not all states will have conducted analysis of substance abuse related discharges.

Consult *The Health Care Data Source Book: Finding the right information and making the most of it.* by John D. Fry and Robert W. Young for the American Hospital Publishing, Inc., 1992.

Multnomah County, Oregon

The annual number of births of drug-affected newborns in Multnomah County, Oregon, reached a peak in 1989 at 291 drug-affected babies, a seven-fold increase since 1986 when there were 42 drug-affected births. Since 1989, the annual number of drug-affected births has steadily decreased, but the 1992 level remains nearly four times that of the number in 1986.

SOURCE: Regional Drug Initiative. *Drug Impact Index, Fourth Edition.* Portland, OR. June 1993.

must rely upon the analysis of other government or research groups (see Chapter 5, Directory of State Health Departments). While many states have a hospital record system, not all states have devoted the necessary resources to routinely analyze these data.

Birth certificate records maintained by the state vital statistics unit are another source of information. Birth certificates have confidential items that may be checked by the attending physician to indicate that alcohol, drugs or tobacco were used during pregnancy. Some state units may summarize this information periodically for local areas. Little is known about the reliability of this type of information on birth certificates. It is generally considered to be a serious undercount, and perhaps biased count, of the actual involvement of substance abuse. Physicians are reluctant to ask questions about substance abuse and to record such information, which may be stigmatizing.

How to Interpret

These hospital data can provide valuable information on the harmful impact of substance abuse on the health of the community's citizens.

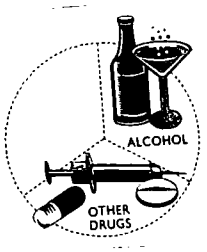
If the data are retrievable, be aware of several issues when interpreting trend data. Over long periods of time, the customary way of recording hospital information undergoes changes. For example, since the crack epidemic in the late 1980s, there has been much more attention paid to studying the impact of drug abuse on newborns. This is suspected to have led to better reporting of drug use on hospital records. This is important when examining data over long time periods.

The U.S. Department of Health and Human Services has established a national health objective to reduce the incidence of fetal alcohol syndrome (FAS) to no more than 0.12 per 1,000 live births. For American Indians and Alaska Natives the target rate is no more than 2 FAS cases per 1,000 live births.

Further Reading

Fox K., J.C. Merrill, H. Chang, J.A. Califano. "Estimating the Costs of Substance Abuse to the Medicaid Hospital Care Program," *American Journal of Public Health* 1995; 85(1):48-54.

Health and Addictions Research, Inc. *Indicators of Substance Use in Massachusetts: 1985-1992*. Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 1994.



15. Child Abuse Reports:

The number of child abuse reports to child welfare authorities. In some states, the number of child abuse reports will include drug-exposed newborns.

Indicator Description

Many states report that there are a growing number of parents being reported to child welfare agencies. This increase in child abuse and neglect, in many instances, appears to be associated with more documented abuse of alcohol and other drugs. The number of child abuse and neglect cases among substance abusing parents is, thus, one indicator of harm to family functioning and child health.

A related measure is the number of drug-exposed newborns reported to authorities. In at least 19 states, medical personnel and others are required to report incidences of drug-exposed newborns to the child welfare agencies. And in one state, substance abusing pregnant women are also reported.

What to Measure

The number of child abuse/neglect victims.

In some communities there is no distinction made where parental substance abuse has been a factor. In communities where information on substance abuse is reported, however, these cases may be tracked.

The same definition of a case should be used to track the number of cases over time. States use different reporting conventions to track child abuse. The various definitions include "alleged reports," "substantiated" cases, "investigated" cases, and the number of victims or family cases.

To track change over time it is useful to report the number of cases per 100,000 children in the population. It is also useful to track over time the percent of all child abuse cases where parental substance abuse is a factor.

Where drug-exposed newborns are not required to be reported to the child welfare agency, it may be possible to learn the number of newborns affected by drugs or alcohol from hospital records (see Hospital Cases profile).

Where to Find Local Data

Individual communities should contact the appropriate state agency, such as the department of social services, for trend data on their community. There will be a federally-appointed liaison for child abuse and neglect in each state who may be a repository of local information (see Chapter 5, Contacts for Annual State Survey of Current Trends in Child Abuse).

Finding the appropriate agency may require some detective work. States define their own investigative procedures and child welfare service systems. There may be a number of data sources to be contacted within the state.

Milwaukee County

Between 1987 and 1993, the number of child abuse and neglect cases reported by the Milwaukee County Department of Health and Human Services increased from about 7,000 cases to more than 10,000 cases. Between 1990 and 1993 the number of referrals for drug-exposed infants increased nearly three times — from 110 to 312 referrals.

Contact:
James Mosley, Project Director
1726 North First
Milwaukee, WI 53212
(414) 374-7882

SOURCE: Milwaukee County Fighting Back

Example Rates

The number of child abuse/neglect cases varies tremendously across states and local jurisdictions. In most states cases have been increasing in recent years.

While in 1985 the average rate was about 30 children reported for maltreatment per 1,000 children in the U.S., the rate increased to about 44 per 1,000 children in 1994.

Most states have identified substance abuse as one factor driving up child neglect reporting levels; the majority of states have identified substance abuse as one of the most frequent problems of families on the caseload. The association between substance abuse and child neglect or abuse also appears to vary tremendously across states. Only eight states routinely document the involvement of substance abuse in families where child abuse/neglect is alleged. The number of births to women who use drugs during pregnancy varies across hospitals and states, averaging in some reports to be about 12 percent of all births.

How to Interpret

Although this indicator taps into an important harm from substance abuse, interpreting trends in the data is particularly challenging. This is because most cases of child abuse and neglect and of drug use during pregnancy are not reported. However, recent public awareness of child abuse may be leading to increased reports. Also, attention to substance abuse has led to changes in documentation by child welfare agencies. Thus, the increase in reports may reflect more public awareness, improvements in reporting systems and more attention to drug and alcohol problems, in addition to an increase in drug and alcohol problems among families. Each community must investigate the factors that may be leading to changes in the number of substance abuse related cases.

Because of differences in state and local child abuse statutes and practices, it is also difficult to accurately interpret differing rates among communities. For example, the scope of what constitutes reportable acts of child abuse and neglect (i.e., whether drug-exposed newborns are included) varies by state statutes and local practices.

Did You Know?

Serving at-risk pregnant women and children requires interagency partnership. Project CONNECT is a New York State-New York City collaborative venture to coordinate and expand services to women and children in three areas of New York City with the highest rates of morbidity and mortality. Many providers participate, including substance abuse treatment and foster care preventive services.

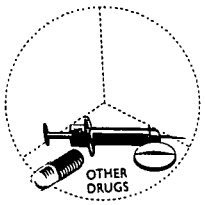
SOURCE: Randolph, L.A. and Sherman, B. R., Project CONNECT: an interagency partnership to confront new challenges facing at-risk women and children in New York City. *Journal of Community Health, 1993; 18(2): 73-81.*

Further Reading

McCurdy, K. and Daro, D. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1993 Annual Fifty State Survey, Working Paper Number 808.* Chicago, IL: The National Committee to Prevent Child Abuse, April 1994.

National Center on Child Abuse and Neglect. *National Child Abuse and Neglect Data System, Working Paper 1:* 1990 Summary Data Component. DHHS Publication No. (ACF)92-30361. Rockville, MD: National Center on Child Abuse and Neglect, April 1992.

Center for the Future of Children. Drug Exposed Infants. *The Future of Children, Vol. 1, No. 1* (Spring 1991). Los Altos, CA: The Center for the Future of Children.



16. Drug-Related AIDS Cases:

The number of new cases in drug-related HIV exposure categories that meet the federal definition of AIDS.

Washington, DC

One quarter of the 11,924 AIDS cases reported in the Washington D.C. metropolitan statistical area through September 30, 1994 were associated with injection drug use, according to data from the District's agency for HIV/AIDS. The majority of the drug-related AIDS cases were among heterosexuals, which makes injection drug use the most prevalent mode of exposure among heterosexuals in the District.

SOURCE: Center for Substance Abuse Research. One-fourth of all reported AIDS cases in D.C. metropolitan areas are associated with drug use. CESAR FAX, 1994; 3(48). University of Maryland at College Park.

Indicator Description

In 1993, over 100,000 new adult/adolescent AIDS cases were reported to the Centers for Disease Control and Prevention. Cases are reported according to their HIV-exposure category.

Exposure categories related to injecting drug use accounted for 28 percent of the new cases in 1993 and 25 percent of the cumulative total of cases. In some communities, the link between drug use and AIDS is even stronger.

Although this indicator measures a serious consequence of drug use, for a number of reasons, it should be used with caution as a measure of the actual level of community illicit drug use.

What to Measure

The annual number of new AIDS cases whose method of exposure is related to intravenous drug use.

This should be determined based upon reports to the CDC or the state public health department. It is best expressed as the number of cases per 100,000 population.

Another measure is the cumulative number of AIDS cases or deaths related to intravenous drug use.

The methods of exposure that are related to intravenous drug use include: intravenous (IV) drug user, heterosexual contact sex with an IV drug user, and men who have sex with men and also inject drugs. Pediatric cases include some cases where the mother is in an HIV-risk category associated with injecting drug use or having sex with an injecting drug user.

Where to Find Local Data

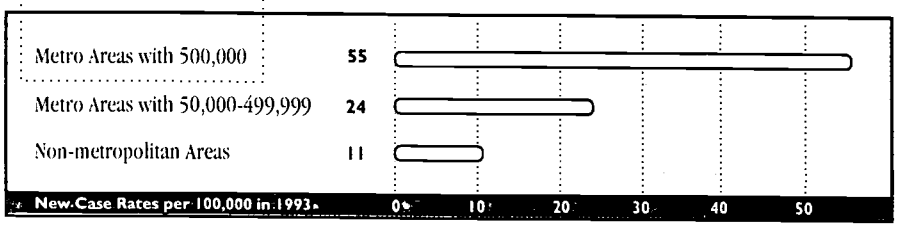
Contact the local or state public health department to obtain the number of cases for a local community (see Chapter 5, Directory of State Health Departments). There is usually no charge for requests to state health departments for AIDS case data. Public health departments generally do not report separately for geographic areas with less than 5 cases. For larger areas, reports may be available for geographic areas as small as zip codes.

The CDC also produces estimates of AIDS cases for the largest metropolitan areas. It maintains the AIDS Surveillance System, which compiles data in all 50 states and the District of Columbia.

Only about 70 percent of AIDS cases are reported within six months of diagnosis. It is wise for communities to ask for updates on the number of cases for previous as well as current years.

AIDS Case Rates for Metropolitan Areas and Non-Metropolitan Areas

AIDS case rates are highest in large metropolitan areas



SOURCE: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*. 1994; 5(4):p. 7.

Technical Note:

The number of AIDS cases in communities is based upon those reported to the Centers for Disease Control and Prevention (CDC) as meeting the federal definition of Acquired Immune Deficiency Syndrome (AIDS). AIDS is a specific group of diseases or conditions associated with severe immunosuppression related to infection with the human immunodeficiency virus (HIV). The CDC expanded the definition of AIDS in 1987 and again in 1993.

The initial impact of expanding the case definition in 1993 is likely to produce many new reports of AIDS cases for that year. In fact, the number of cases in 1993 may surpass those reported for 1994 because of this reporting change. This change should be noted when developing trend data over periods with new case definitions.

Example Rates

In 1993, the total number of new AIDS cases was 40.8 per 100,000 population. The rate varies enormously by geographic area. The highest rate of new cases was reported in the District of Columbia, with about 274 new cases per 100,000 residents.

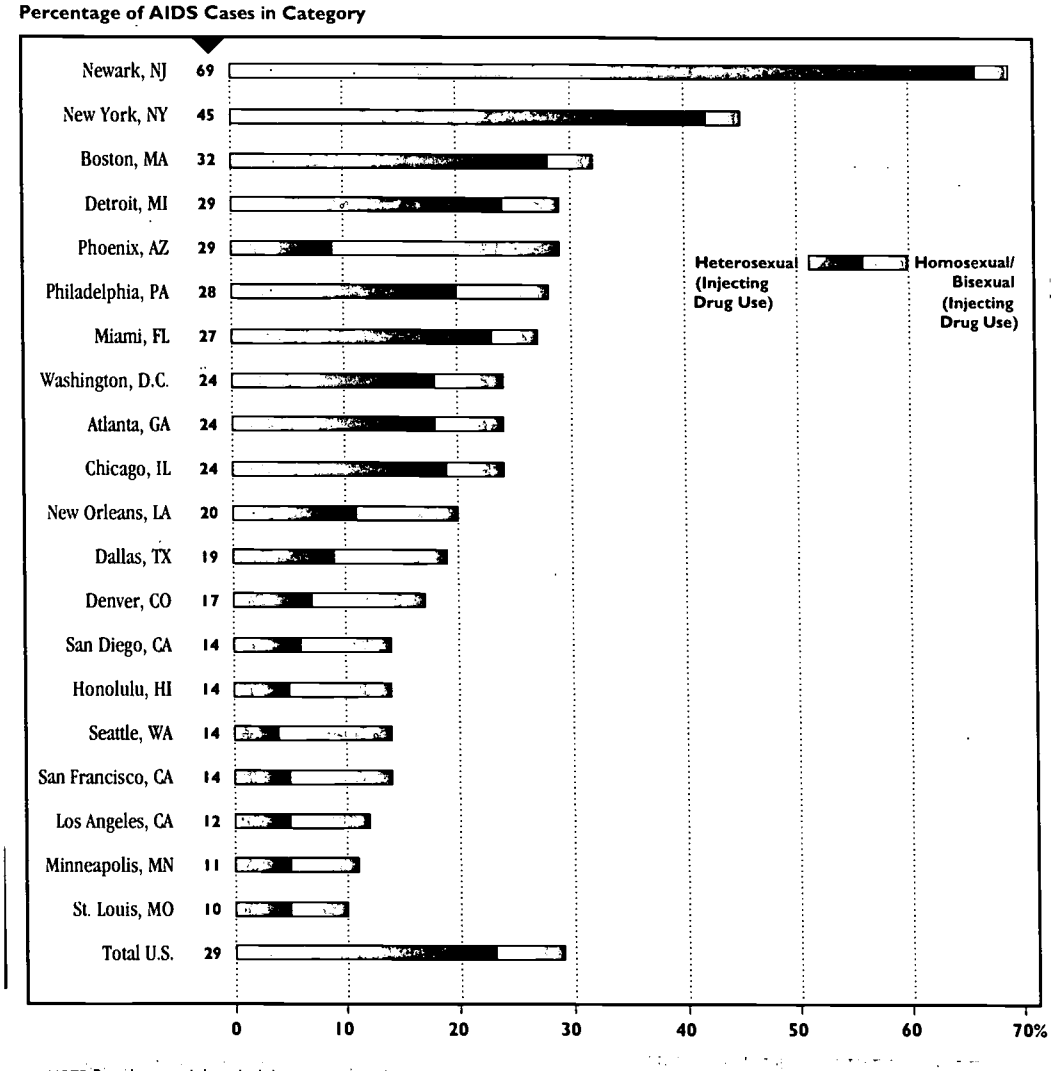
How to Interpret

Tracking drug-related AIDS cases over time helps portray the community impact of illicit drug behavior. It complements but does not replace other measures of harm.

The number of drug-related AIDS cases are most closely linked to the behaviors of intravenous drug users. It is less closely linked to other illicit drug use and alcohol use. Also, there is a substantial lag between when someone gets infected with HIV and the onset of AIDS symptoms. Thus it is an indicator of risk behavior from several years ago. This lag is typically several years, but individual latency periods vary widely.

The association between intravenous drug use and HIV infection varies tremendously across communities and over time. In some communities (typically coastal urban areas), a much larger proportion of intravenous drug users may be infected, while in other communities (typically rural), the relationship between intravenous drug use and HIV infection may be more obscure due to less exposure.

Percentage of Cumulative AIDS Cases Associated with Injecting Drug Use, 1993



NOTE: Based upon adult and adolescent cases only.

SOURCE: National Institute on Drug Abuse. *Community Epidemiology Work Group. Epidemiologic Trends in Drug Abuse.* NIH Publication No. 93-3645. Rockville, MD: NIDA, 1993. Exhibit 1, p. 57. Percentages were rounded to nearest whole number by Brandeis University.

Further Reading

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report,* 1994; 5(4): 1-33.

Centers for Disease Control and Prevention. Update: Impact of the *Expanded AIDS Surveillance Case Definition for Adolescents and Adults on Case Reporting - United States, 1993.* Morbidity and Mortality Weekly Reports, 1994; 43(9): 160-170.

17 Substance Use-Related Deaths:

- ***Deaths that result, either directly or indirectly, from tobacco, alcohol and/or other drug use.***

Data Reliable for Larger Communities Only

Indicator Description

Premature deaths are a commonly cited measure of the harm from substance abuse. Deaths related to use may be the result of disease associated with chronic use or abuse; of disease from high risk behavior resulting in exposure to infectious agents; or of unintentional injury associated with alcohol or drug use such as driving or boating under the influence.

Tracking the level of health problems also gives an indirect measure of the level of alcohol use within a community. This link is made because the level of health harm is indirectly related to the overall drinking patterns in a community.

What to Measure

Estimates of the number of substance abuse-related deaths are typically based upon the known number of actual deaths for certain causes in a community.

Substance abuse causes are conditions that are either directly or indirectly linked to tobacco, alcohol or other drug use.

What a community measures will largely be dependent upon the type of reports available from local and state health departments.

- *Direct alcohol deaths*

  These include alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcoholic polyneuropathy, alcohol cardiomyopathy, alcoholic gastritis, alcoholic fatty liver, acute alcoholic hepatitis, alcoholic cirrhosis of liver, alcoholic liver damage (unspecified), excessive blood level of alcohol, and accidental poisoning by ethyl alcohol, not elsewhere specified.

- *Indirectly-related alcohol deaths*

  A portion, not all, of 25 other death causes are attributable to alcohol use. These deaths include certain malignant tumors, diabetes, pneumonia, cirrhosis and pancreatitis.

- *Direct drug deaths*

  Drug withdrawal syndrome in newborns, poisoning by opiates, and other narcotics, or psychotropic agents, accidental poisoning by opiates, methadone, barbiturates and other substances, and suicide by specific drugs.

- *Indirectly-related drug deaths*

  A portion, not all, of the deaths from AIDS, endocarditis, cerebrovascular stroke, congenital syphilis, burns, hepatitis A, B, and C, trauma and tumors.

- *Tobacco-related deaths*

  A portion, not all, of the deaths from various tumors (e.g., bladder, colorectal, esophageal, laryngeal, lung, oral); respiratory disease deaths (e.g., asthma, bronchitis); cardiovascular disease: coronary artery, coronary heart, myocardial infarction, peripheral vascular disease; cerebrovascular stroke; various pregnancy complications and newborn low birth weight.

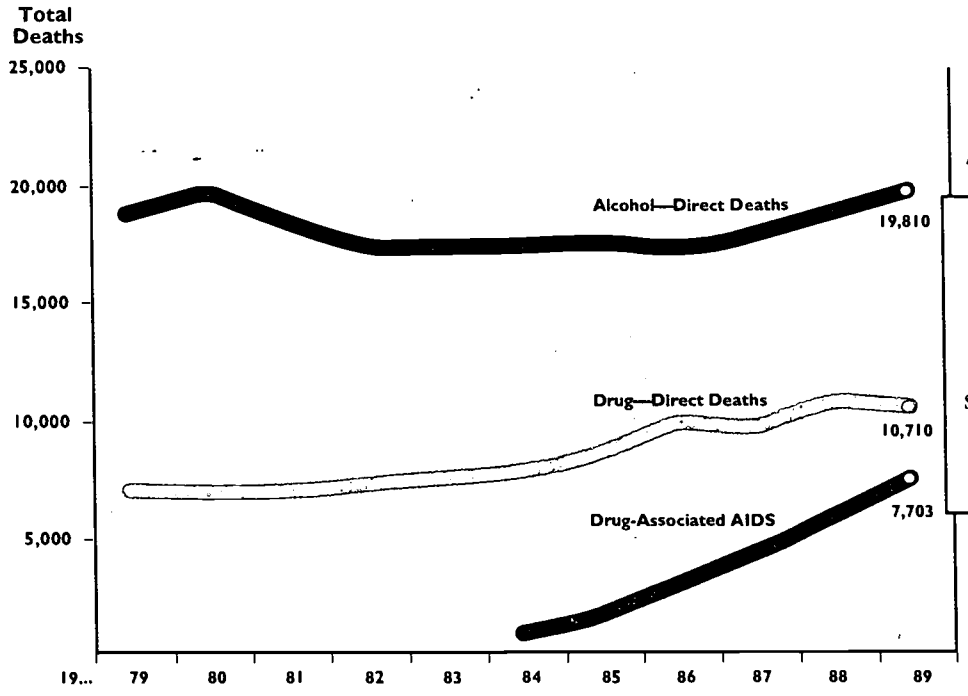
Your community will be dependent upon how the local and state health departments report different death rates. The preferred measure for the purpose of tracking substance abuse deaths in a community over time is the "age-specific" death rate. That is, the number of deaths for specific age-groups, divided by the number of people in the age-group population. By comparing age-

Northwest New Mexico

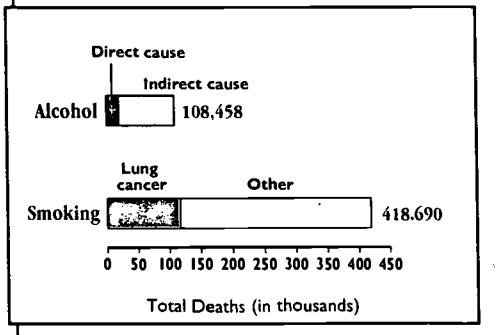
The unparalleled impact of substance abuse on the Northwest New Mexico region caught the attention of the national reviewers who funded the Fighting Back Regional Council. Death rates from cirrhosis of the liver in McKinley County were three times higher than the national average, alcohol-related traffic accidents were seven times higher, chronic alcoholism rates were 19 times higher, and deaths from all alcohol-related causes were four times higher. McKinley County had the highest composite index of alcohol-related problems of all 3,107 counties in the U.S. in the time period 1975-1980, according to analysis by the National Institute on Alcoholism and Alcohol Abuse.

SOURCE: Taking the Long View: A Review of Substance Abuse-related Social Indicators in McKinley County, New Mexico. A report of the Northwest New Mexico Fighting Back Regional Council, 1994.

Alcohol and Illicit Drug Deaths



Annual Deaths from Smoking and Alcohol Use



SOURCE: Institute for Health Policy, Brandeis University. *Substance Abuse: The Nation's Number One Health Problem.* Princeton, N.J.: the Robert Wood Johnson Foundation, 1993.

HEALTHY PEOPLE 2000

The U.S. Department of Health and Human Services has established the following objectives related to deaths resulting from substance use:

Reduce cirrhosis deaths to no more than 6 per 100,000 people.

Reduce drug-related deaths to no more than 3 per 100,000 people.

Slow the rise in lung cancer deaths to a rate of no more than 42 per 100,000 people.

Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people.

specific rates over time, any remaining trends that are seen are not explained by shifts in the community's age structure or in population growth or other size changes. Your health department may report deaths by 5-year age groups.

Another way to express death counts is as an age-adjusted rate. Your local or state health department may use this approach. It involves statistically weighing the death counts each year to reflect the population age groups of a specific baseline year.

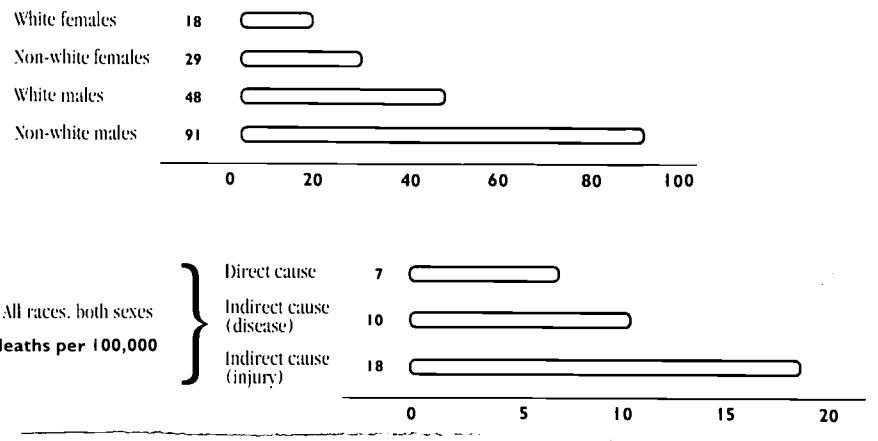
Where to Find Local Data

Call the local and state health departments to see what analyses are done for local towns and communities (see Chapter 5, State Health Departments). All health departments rely upon analyzing the death records maintained as part of the vital statistics program. States typically publish some analyses from these records. Most states and a few local areas will have conducted sophisticated studies to report upon all conditions associated with substance abuse. But each health department should be able to report upon at least some conditions.

Ask first about deaths from specific conditions associated with alcohol, drug and tobacco deaths. These deaths will include those described above under direct cause of death. At the minimum, ask about lung cancer, pulmonary disease, alcoholic and nonalcoholic cirrhosis, alcohol and drug overdoses.

Some health departments may conduct more complex analyses, such as counting deaths based upon the underlying and contributing cause of death. If they count both direct and indirect causes of death, they should assign a portion of the indirect disease and injury deaths to substance abuse causes.

U.S. Age-Adjusted Alcohol Deaths per 100,000 Population, 1989



SOURCE: Stinson, F.S., Dufour, M. C., Steffens, R., and DeBakey, S. F., Epidemilogic Bulletin 32: Alcohol-Related Mortality, 1979-1989. *Alcohol Health and Research World, 17* (3): 251-260, 1993.

Example Rates

Death rates from substance-related causes vary by age group, gender, sex and race. (See chart above.) Therefore the rate of death from these causes will depend upon the demographic composition of the community.

How to Interpret

Because deaths are relatively infrequent, only large communities can meaningfully interpret changes in death rates over time. Smaller communities may want to average the death data from several years, to get the rate per year that can then be compared to other time periods. For example, a national report of alcohol deaths in all counties produced by the National Institute on Alcoholism and Alcohol Abuse groups county data into three year periods, rather than tracking single years.

It is safe to presume that the deaths identified as substance abuse-related are an undercount of the true number. This is because the stigma associated with alcohol and other drugs leads to sensitivity in reporting these types of diseases as the cause of death. Physicians must indicate on a death certificate the causes of death, classifying the underlying cause. However, they use discretion in how they record these causes.

Deaths from disease, such as lung cancer and cirrhosis, tend to indicate a chronic pattern of substance use over many years. Thus, when interpreting this information remember it may not be sensitive to the harm associated with new or young smokers, drinkers, and drug users.

Injury deaths are more likely to reflect substance use patterns among young users. Thus, tracking injury deaths may lead to different trends from disease deaths. The most common alcohol-related injury cause of death is traffic fatalities (see Traffic Fatalities profile).

Did You Know?

Each year, nearly half a million Americans die from alcohol, tobacco and illicit drugs, making substance abuse the single largest preventable cause of death in the country. A person dying from alcohol-related causes loses, on average, 26 years off the normal life span; drug-related causes, over 37 years; and smoking-related causes, about 20 years. AIDS among injecting drug users is the fastest growing cause of death among substance abusers.

SOURCE: Institute for Health Policy, Brandeis University and The Robert Wood Johnson Foundation. *Substance Abuse: The Nation's Number One Health Problem: Key Indicators for Policy.* Princeton, NJ: RWJF, October, 1993

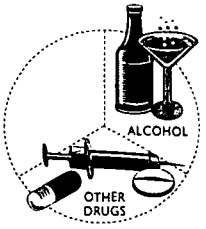
Further Reading

Institute for Health Policy, Brandeis University and The Robert Wood Johnson Foundation. *Substance Abuse: The Nation's Number One Health Problem: Key Indicators for Policy.* Princeton, NJ: RWJF, October, 1993.

National Institute on Alcohol Abuse and Alcoholism. *U.S. Alcohol Epidemiologic Data Reference Manual. County Alcohol Problem Indicators, 1986-1990.* Volume 3, Fourth Edition. July 1994.

Shultz, J.M.; Parker, D.L.; Rice, D.P. *Alcohol-Related Disease Impact (ARDI): Computer Software and Documentation.* Prepared for Centers for Disease Control. October 1989.

Stinson, F.S. and DeBakey, S.F. Alcohol-related mortality in the United States, 1979-1988, *British Journal of Addiction,* 1992; 87: 777-783.



18. Tuberculosis Incidence:

The number of new positive cultures for M. tuberculosis.

Data Reliable for Larger Communities Only

Indicator Description

A portion of new tuberculosis cases in the United States have been shown to be associated with drug and alcohol use and HIV infection. The number of tuberculosis cases in a community is correlated with, but not a cause of, the harm associated with alcohol and drug use.

What to Measure

The number of newly diagnosed tuberculosis cases during the year reported to the local health department or the Centers for Disease Control and Prevention (CDC).

This rate is usually expressed as the number of new cases per 100,000 population.

Some areas may have reasonable estimates of the number of cases that appear to be associated with drug use or excessive alcohol use, as well.

A community may also wish to track the cumulative, rather than annual, number of TB cases.

Where to Find Local Data

Most states require that laboratories notify the health department about patients with positive M. tuberculosis cultures. The local and state health departments will have summary information for a particular community (see Additional Resources, Directory of State Health Departments).

Example Rates

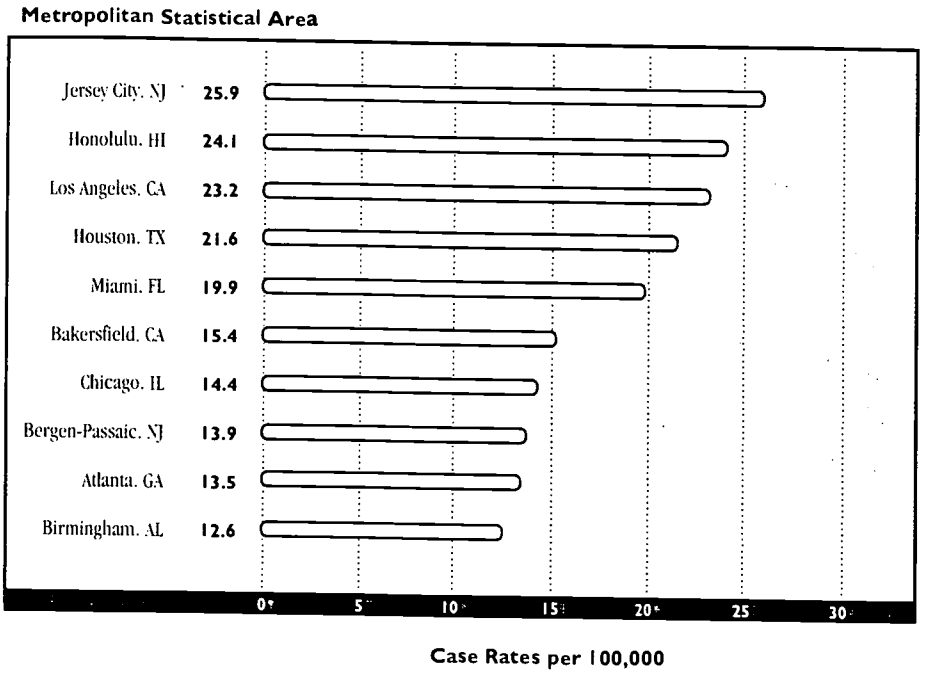
The number of TB cases is typically very small in all communities. In 1993, 25,287 cases of TB population were reported to the CDC from the 50 states and the District of Columbia and New York City. In 1993, the state of New York and the District of Columbia had the highest rates of TB cases (21.7 and 27.9 per 100,000 population, respectively). Idaho had the lowest rate (1.0 per 100,000 population).

The table on the next page gives examples of the cities with the highest new case rates.

How to Interpret

The most important consideration in using TB cases as a measure is that the total number of cases may be generally too small for tracking reliable annual trends. This is a particular issues when tracking the number of cases among excessive alcohol and drug users. People with drug and alcohol abuse disorders are a high-risk group for TB. It is important to note when interpreting data, however, that not all TB cases are associated with alcohol and drug use. Furthermore, most changes in new case rates do not

Large Metropolitan Areas with The Highest Tuberculosis Case Rates, 1993



NOTE: Case rates are based on all verified TB cases per 100,000 population.

SOURCE: Centers for Disease Control and Prevention, Division of Tuberculosis Elimination. Tuberculosis Case Rates by State: United States, 1993. October 1994.

HEALTHY PEOPLE 2000

The national objective to reduce the incidence of tuberculosis established by the U.S. Department of Health and Human services is no more than 3.5 cases per 100,000 people.

appear to be directly related to changes in substance abuse behavior, which reflects more diverse groups coming in contact with this airborne disease.

Also, since January 1993, the CDC in conjunction with state and local health departments implemented an expanded surveillance system for tracking tuberculosis. The expansion of the TB surveillance system coincided with the revision of the AIDS surveillance case definition. The revised AIDS cases definition classifies as AIDS cases HIV-infection in persons who have either pulmonary TB or extrapulmonary TB. As a consequence, HIV-infected persons with pulmonary or extrapulmonary TB may have been reported to the AIDS surveillance program at the local or state health department but not to the TB program, resulting in a possible undercount of TB cases. Nevertheless, tuberculosis is such a substantial public health problem, it is important to establish its link to substance abuse behaviors, where appropriate.

Further Reading

CDC. Expanded Tuberculosis Surveillance and Tuberculosis Morbidity - United States, 1993. *Morbidity and Mortality Weekly Report*, 1994; 43:20, 361-366.

Centers for Disease Control and Prevention, Division of Tuberculosis Elimination. Tuberculosis Case Rates by State: United States, 1993. October 1994.

19 Traffic Fatalities:

The rate of single-vehicle crashes that result in a fatality and occur at night. Single-vehicle nighttime crashes are used as a surrogate measure for alcohol-involved crashes.

Data Reliable for Larger Communities Only

Indicator Description

Substantial evidence links drinking alcohol with fatal motor vehicle traffic crashes. A community may track traffic fatalities as a measure of alcohol-related harm. The association of drinking alcohol with fatal traffic crashes involving a single vehicle at night is so well established that communities that can track single-vehicle nighttime fatal crashes as a measure of alcohol-involved crashes. As much as 80 percent of these events are thought to involve alcohol. Conversely, the proportion of daytime fatal crashes involving alcohol is far lower.

An advantage of the traffic fatality indicator is that the data are readily available to communities of all sizes. The location of fatal crashes can be pinpointed to the "street" level, for sub-community analyses.

A research disadvantage is that the events are relatively rare and require a large population base for stable trends.

What to Measure

The number of events per 100,000 population over age 16. The event counted is single-vehicle fatal crashes occurring at night.

Nighttime is commonly defined as between 6 pm and 5:59 am. In addition to counting the number of crashes, a community can count the number of deaths, since one crash may result in more than one death.

The total number of fatal crashes may be too low to track reliably over time. To supplement this information, a community can also track the number of non-fatal single vehicle traffic crashes occurring at night. A much smaller proportion of these non-fatal crashes are estimated to be alcohol-involved.

When doing cross-community comparisons, the total number of fatal crashes, alcohol and non-alcohol involved, varies dramatically. Thus, rather than compare population-based crash rates, it is better to compare across communities the percent of all crashes in each community that are alcohol-involved.

Where to Find Local Data

Communities may obtain data on local fatal traffic crashes by contacting the National Center for Statistics and Analysis (NCSA) within the National Highway Traffic Safety Administration (NHTSA). The NCSA will respond to requests for specific local data. It is possible to obtain data for one or more years at the county or city level. In some cases, it may be possible to obtain specific highway-level data.

Requests for tapes, reports and information should be sent in writing to:

National Highway Traffic Safety Administration
National Center for Statistics and Analysis
Fatal Accident Reporting System
NRD-31
400 Seventh Street, SW
Washington, DC 20590

Technical Note:

Not all localities collect blood alcohol content (BAC) data from drivers involved in traffic crashes, which would enable specific crashes to be attributed to alcohol use. Some communities do report BAC level information on at least some drivers or pedestrians involved in fatal crashes. When this information is reported, it can be used in addition to single vehicle nighttime crashes. This information, however, might not be consistently collected by highway patrols using reliable techniques over time. If used, a BAC level equal to or greater than 0.10 grams/deciliter is considered legally intoxicated in most states. An alcohol-involved fatality is one where BAC is greater than 0.01 grams/deciliter.

HEALTHY PEOPLE 2000

A national benchmark has been established by the U.S. Department of Health and Human Services to reduce deaths caused by alcohol-related motor vehicle crashes to no more than 8.5 per 100,000 people. This rate has been achieved.

Communities that wish to track non-fatal crashes as well should contact the state highway department and ask for information on the number of single vehicle non-fatal crashes occurring at night (see Additional Resources, list of State Highway Departments).

Example Rates

The FARS has indicated that in 1992, the rate of U.S. traffic fatalities was 15.38 per 100,000 population, or 22.88 per 100,000 licensed drivers. Not all of these fatalities occurred in single vehicle nighttime events or were alcohol-involved. About two-thirds of all fatal crashes are at night; about 60 percent of fatal crashes involve single vehicles. Of all fatal crashes in 1992, about 45 percent were alcohol-involved, a rate which has been declining substantially.

How to Interpret

This indicator measures one aspect of community harm from alcohol use. It is also an indirect measure of the prevalence of alcohol use while driving. While it does not capture all alcohol-related harm or all alcohol use, it is extremely useful for tracking changes over time and comparisons across communities. The measure is reliable and can be extracted from archival record systems that are available for all communities.

Caution should be used in interpreting changes in traffic fatalities. The number of fatal traffic crashes is related not only to the prevalence of alcohol use, but also to seat belt use, police enforcement, speeding, road engineering, use of air bags and other safety devices and road conditions. Changes in these related safety issues may confuse the interpretation of trends in some communities—however the rates are too low for useful comparisons in smaller communities.

Technical Note:

The National Highway Traffic Safety Administration (NHTSA) within the Federal Department of Transportation (DOT) maintains a database of fatal accidents, the Fatal Accident Reporting System (FARS). Within this system, DOT reports on all traffic fatalities and specifically on alcohol-related traffic fatalities. NHTSA defines a fatal traffic crash as being alcohol-related if either a driver or non-occupant (e.g. pedestrian) had a blood alcohol concentration (BAC) of 0.01 grams per deciliter (g/dl) or greater in a police-reported traffic crash. Persons with a BAC of 0.10 g/dl or greater involved in fatal crashes are considered to be intoxicated. NHTSA contracts with an agency in each state government to code information to three standardized FARS forms: the accident level form, the vehicle level form and the driver level form. Reports are issued annually with a lag time of about two years. Data from the FARS system is checked and cleaned in a consistent fashion over time and across communities.

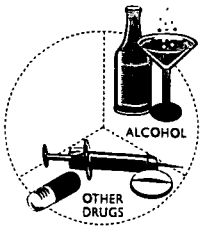
Further Reading:

National Highway Traffic Safety Administration. *Traffic Safety Facts 1992: A Compilation of Motor Vehicle Crash Data from the Fatal Accident Reporting System and the General Estimates System (Revised 1992 Data).* Washington, DC: U.S. Department of Transportation, 1994.

National Highway Traffic Safety Administration. *Fatal Accident Reporting System 1991: A Review of Information on Fatal Traffic Crashes in the United States.* Washington, DC: U.S. Department of Transportation, 1993.

Zobeck, T.S., Stinson, F.S., Grant, B.F., Bertolucci, D. *Trends in Alcohol-Related Fatal Traffic Crashes, United States: 1979 - 91. Surveillance Report #26.* National Institute on Alcohol Abuse and Alcoholism. November 1993.

National Highway Traffic Safety Administration. *Traffic Safety Facts 1992: Alcohol.* Washington, DC: U.S. Department of Transportation.



20. Emergency Room Episodes:

Medical crisis associated with alcohol or drug use resulting in emergency room attention.

Data Found in Reporting System Communities Only

Indicator Description

Emergency room episodes resulting from substance use are an indicator of the level of community harm from substance abuse. Emergency room use contributes to the high medical costs associated with substance abuse.

Events that lead to emergency room use reflect the prevalence of drug use in a community, characteristics of the drugs being used, and practices of combining substances that may have lethal effects.

Technical Note:

The Drug Abuse Warning Network is maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). It is a large-scale ongoing drug abuse data collection system of certain emergency rooms and medical examiners. Its purpose is to identify substances associated with drug abuse episodes that are reported by DAWN-affiliated facilities, to monitor drug abuse patterns and trends, and to assess the health hazards associated with drug abuse. For emergency room data, an episode report is submitted for each patient who visits a DAWN emergency room for a drug abuse reason.

What to Measure

The annual number of emergency room episodes where staff have identified alcohol or other drug use as a factor.

The number of episodes can be expressed as a rate per 100,000 population or a percentage of all visits to the reporting emergency rooms.

There are a number of substance use reasons for emergency room episodes, including suicide attempts, overdose and dependence. Communities may report separately the number of drug episodes for different reasons. Further, communities may report the percent of episodes associated with different types of substances (*i.e.*, cocaine, heroin, other drugs in combination with alcohol).

Where to Find Local Data

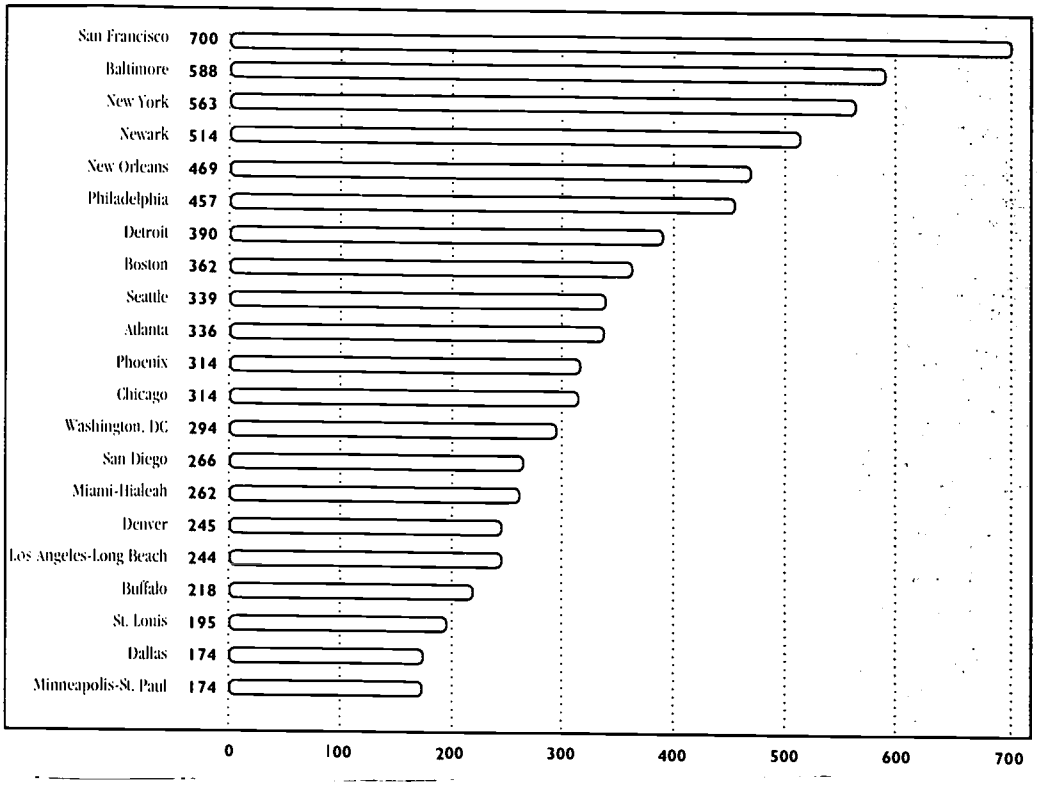
This indicator is likely to be available in only those communities that participate in special surveillance programs run by a local health department, the Centers for Disease Control, or the long-standing Drug Abuse Warning Network (DAWN) surveillance program. The first step is to discover if any local emergency rooms participate in such a program. If so, you can then contact the group that operates the surveillance program. The state alcohol and drug abuse authority would be one agency to contact (see Chapter 5, list of alcohol and drug abuse agency directors).

There are 21 DAWN-reporting metropolitan areas (see page 65). The data for these areas are routinely reported by the Substance Abuse and Mental Health Services Administration. Certain other communities or individual hospitals may operate a reporting program such as DAWN, although these communities would be the exception, not the rule.

How to Interpret

This indicator is a direct measure of emergency room use attributable to substance use. However, not all medical crises that arise from alcohol or drug use are brought to the attention of the emergency room staff, and some episodes may go unreported or undetected depending upon the reporting practices of the emergency room staff. Nevertheless, emergency room use is generally a valid and reliable measure of substance abuse related harm, unless these reporting problems are common.

Emergency Room Drug Abuse Episodes per 100,000 Population by Metropolitan Area: 1992



SOURCE: Substance Abuse and Mental Health Services Administration. *Annual Emergency Room Data 1992, Data from the Drug Abuse Warning Network.* Rockville, MD: U.S. DHHS, March 1994.

The number of emergency room episodes is related to the level of drug use in a community. Emergency room trends may reflect both changes in level of community drug use, and other changes as well. There are a few things to be aware of when interpreting emergency room episodes as a measure of community substance use. First, the same person may use the emergency room for a drug-related episode more than one time, even many times, during a year. Thus, the number of episodes will be more than the number of people involved.

Second, this indicator is sensitive not only to the level of abuse, but also to the types of substances available and the purity of such substances, the pattern of mixing or combining different drugs in a harmful way, the mode of administration, and the number of suicide attempts. In particular, sudden changes often reflect a change in drug purity, not a sudden increase or decrease in use. Changes over time often reflect new patterns of combining various substances in a way that leads to more or less harm. For these reasons great care should be taken in interpreting trends as a change in the community's level of drug abuse.

Further Reading

Substance Abuse and Mental Health Services Administration. *Annual Emergency Room Data 1992, Data from the Drug Abuse Warning Network* (DAWN). Rockville, MD: U.S. Department of Health and Human Services, 1994.

Chapter 4

Using and Interpreting Substance Abuse Indicators

How Communities Can Use Indicator Data

Community coalitions and other groups can play a leadership role in the use of substance abuse indicator data. We developed this handbook because we believe that local community groups are well positioned to observe, track, and interpret community trends. Once substance abuse indicator data are collected, your coalition can engage in a number of related activities:

Interpreting Local Trends

Indicator data may be widely cited in the popular press, but it usually lacks a local focus. Your community group can provide the local press and other groups with data about local substance abuse issues. (See *Working with the Media*, page 14.) Pulling together data from many different sources helps to tell a consistent story. Your group might examine recent national reports as examples of how to present the data with a story, such as *Substance Abuse: The Nation's Number One Health Problem, Key Indicators for Policy*, the Brandeis University and The Robert Wood Johnson Foundation report, and *Keeping Score: What We are Getting for our Federal Drug Control Dollars* by Drug Strategies. Local patterns will be substantially different from the national trends, reflecting local demographics, service delivery and social history. Your group can help tell that story.

Using the wealth of statistical data available to describe the scope and nature of community social problems and activities can be a daunting task. Community groups that make the investment can use indicators described in this handbook to translate complex data into information about local substance abuse patterns.

Community Action Based Upon Data

Indicator monitoring can change the very nature of the way communities perceive the problem and also how they organize to reduce substance abuse. When confronted with community denial, coalitions can use indicator data to establish that local problems are more far-reaching or more entrenched than publicly acknowledged.

Current community resources and activities can be refocused to address problems resulting in the most harm. New activities may be started to better address new aspects of problems.

Monitoring Change

Indicator monitoring is one of the most straightforward ways to assess the direction and amount of change in certain community problems. When new policies and programs are established, indicator data may help track the impact. When programs and policies are associated with favorable changes in indica-

tors, community groups may be able to build or strengthen local support for these activities. Monitoring substance abuse problems using the most valid and reliable measures will help focus community attention and direct future actions towards the most pressing aspects of these problems.

The Limits of Indicator Monitoring: Interpreting Challenges

It is also challenging to draw valid conclusions about changes observed in local indicator data. This handbook guides your group to the issues that should be discussed when interpreting what may appear as favorable or unfavorable trends. The handbook guides you to the appropriate data sources. It also points out some common interpretation pitfalls and will help in both selecting and interpreting available data. Also presented are some common problems and strategies to avoid or minimize confusion when interpreting the indicator data you have gathered.

Measuring Change When Events Are Rare

The Problem: Measuring some events are critical to policy development, even though these events are infrequent (fatal traffic crashes, illicit drug abuse deaths). When events are rare, a small increase or decrease in the number of events leads to abrupt changes in rates. Not all events can be tracked at the community level because of this problem of small numbers. The problem of "rare events" is particularly chronic for coalitions in small or rural areas.

Possible Strategies: To avoid unwarranted conclusions, it is advisable to group events in such a way as to increase the number of observed events. A common strategy is to group data from several years together, and report the change in the grouped-year average over a period of time. This approach is used by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) when they report alcohol mortality data for the nation's counties. Another strategy is to combine data from related indicators, but this must be done carefully. For example, rather than tracking death data for individual causes, combine different causes in a meaningful way.

The Effects of Changing Local Demographic Characteristics

The Problem: Community population characteristics may change over time in ways that affect the indicators but are unrelated to changes in substance abuse problems or activities: There may be growth or decline in overall population. The number of young people may grow faster than other age groups, rapid immigration, or the population may be aging .

Possible Strategies: Indicator measures should typically be expressed as "population-based rates." The most common expression of a population-based rate is the number of events (i.e., traffic crashes) per 100,000 people living in the community. It is irrelevant which population base is used to construct the rate as long as it is consistently used through the time period studied (i.e., 10,000 or 1,000 population may be used rather than 100,000 population.) When the age distribution is related to the frequency of an event, it is recommended that the rate be calculated for a particular age-segment of the population (i.e., traffic crashes per 100,000 people over age 15).

Changes in Reporting Programs, Data Surveillance, or Local Policies

The Problem: It is not uncommon for surveillance systems to change over time; sometimes reflecting improved, changed or expanded definitions, sometimes reflecting more or less attention paid to record-keeping. These changes may result in abrupt increases or decreases of reported indicator events. Similarly, there may be changes in the political climate, legislation, or community priorities that make the reporting of events more or less common.

Possible Strategies: Community groups are in a good position to monitor changes in local surveillance systems (i.e., local law enforcement programs). Interpreting the data is complex, and requires intimate knowledge of community changes. If your coalition includes members from agencies which maintain these data sources, you will be able to take advantage of this as you interpret your data. When using national data, it is important to contact the source and read related reports to detect what data reporting changes have occurred. The indicator profiles identify some of these systemwide changes that should be noted.

Glossary of Indicator Terminology and Additional Resources

Availability:
The extent of effort required to gather data on the indicator over the time period.

Comparison Communities:
Communities with similar characteristics that are chosen for comparison purposes. When interpreting changes in trends, it is useful to compare changes in your community to other communities of similar size, for example.

Geographic Mapping Systems:
A set of computer software increasingly being used to display data for particular zip codes, census tracts, or local areas. Sometimes referred to as Geographic Information Systems (GIS).

Incidence:
The number of new cases per year with the characteristic you are counting, such as the number of new drug-related arrests.

Indicator:
A measure to be monitored that signifies the rate of a type of activity, in this case, a substance abuse-related activity.

Population Rate:
The number of events that occur for a population of a given size, such as per 100,000 people.

Prevalence:
The total number of cases on a given day or in a year with the characteristic you are counting, including new cases and cases from the previous period.

Relevance:
The degree to which the indicator measures an important dimension of the community's substance abuse problem.

Reliability:
When a study can be repeated and the same results occur, it is said to be reliable.

Trend:
Comparing the same indicator measure over time. To establish a trend requires collecting data for many years.

Validity:
How well an indicator represents what it is intended to measure; and how well a specific measure represents the indicator.

Additional Resources

State Alcohol and Drug Agencies

Participants in the State Alcohol and Drug Abuse Profile Data

Alabama
AL Department of Mental Health and Mental Retardation
Division of Substance Abuse Services
200 Interstate Park Drive, P.O. Box 3710
Montgomery, AL 36193
(205) 270-4650

Alaska
AK Department of Health and Social Services
Division of Alcoholism and Drug Abuse
P.O. Box 110607
Juneau, AK 99811-0607
(907) 465-2071

Arizona
AZ Department of Health Services
Office of Substance Abuse
Division of Behavioral Health Services
2122 East Highland
Phoenix, AZ 85016
(602) 381-8996

Arkansas
AR Bureau of Alcohol and Drug Abuse Prevention
108 E. 7th Street, 400 Waldon Building
Little Rock, AR 72201
(501) 682-6650

California
CA Governor's Policy Council on Drug and Alcohol Abuse
1700 K Street, 5th Floor
Sacramento, CA 95814-4037
(916) 445-1943

Colorado
CO Department of Health
Alcohol and Drug Abuse Division
4300 Cherry Creek Drive, South
Denver, CO 80222-1530
(303) 692-2930

Connecticut
CT Department of Public Health and Addiction Services
150 Washington Street
Hartford, CT 06106
203-566-4282

Delaware
DE Division of Alcoholism, Drug Abuse and Mental Health
1901 N. DuPont Highway
Newcastle, DE 19720
(302) 577-4461

District of Columbia
DC Alcohol and Drug Abuse Services Administration
1300 First Street, N.E., Suite 300
Washington, DC 20002
(202) 727-9393

Florida
FL Department of Health and Rehabilitation Services
Alcohol and Drug Abuse
1317 Winewood Blvd.
Building 6, Room 183
Tallahassee, FL 32301
(904) 488-8304

Georgia
GA Alcohol and Drug Services Section
Two Peachtree Street, N.E., 4th Floor
Atlanta, GA 30303
(404) 657-6400

Hawaii
Alcohol and Drug Abuse Division
HI Department of Health,
P.O. Box 3378
Honolulu, HI 96801
(808) 586-3962

Idaho
ID Department of Health & Welfare
Bureau of Substance Abuse
450 West State Street, 3rd Floor
Boise, ID 83702
(208) 334-5935

Illinois
IL Department of Alcoholism and Substance Abuse
100 West Randolph, Suite 5-600
James R. Thompson Center
Chicago, IL 60601
(312) 814-2291

Indiana
Family and Social Services Administration
Division of Mental Health,
Bureau of Addiction Services
402 W. Washington Street, W-353
Indianapolis, IN 46204-2739
(317) 232-7816

Iowa
IA Department of Public Health
Division of Substance Abuse and Health Promotion
Lucas State Office Building, 3rd Floor
Des Moines, IA 50319
(515) 281-4417

Kansas
KS Alcohol and Drug Abuse Services
300 S.W. Oakley, Biddle Building
Topeka, KS 66606-1861
(913) 296-3925

Kentucky
Division of Substance Abuse
KY Department of Mental Health and Mental Retardation Services
275 East Main Street
Frankfort, KY 40621
(502) 564-2880

Louisiana
LA Department of Health and Hospitals
Office of Alcohol and Drug Abuse
1201 Capitol Access Road
P.O. Box 2790 - BIN #18
Baton Rouge, LA 70821-2790
(504) 342-6717

Maine
Office of Substance Abuse
State House Station #159
24 Stone Street
Augusta, ME 04333-0159
(207) 287-6330

Maryland
MD State Alcohol and Drug Abuse Administration
201 West Preston Street
Baltimore, MD 21201
(410) 225-6925

Massachusetts
MA Department of Public Health
Division of Substance Abuse Services
150 Tremont Street
Boston, MA 02111
(617) 727-7985

Michigan
MI Department of Public Health
Center for Substance Abuse Services
3423 N. Logan/M.L. King, Jr., Blvd.
P.O. Box 30195
Lansing, MI 48909
(517) 335-8808

Minnesota
MN Department of Human Services
Chemical Dependency Program Division
444 Lafayette Road
St. Paul, MN 55155-3823
(612) 296-4610

Mississippi
Division of Alcohol and Drug Abuse
MS Department of Mental Health
Robert E. Lee State Office Building, 11th Floor
Jackson, MS 39201
(601) 359-1288

Missouri
MO Department of Health
Division of Alcohol and Drug Abuse
1706 E. Elm Street
Jefferson, MO 65109
(314) 751-4942

Montana
MT Department of Corrections and Human Services
Alcohol and Drug Abuse Division
1539 11th Avenue
Helena, MT 59601-1301
(406) 444-2827

Nebraska
Division of Alcoholism and Drug Abuse
NE Department of Public Institutions
P.O. Box 94728
Lincoln, NE 68509-4783
(402) 471-2851, ext. 5583

Nevada
Bureau of Alcohol and Drug Abuse
NV Department of Human Resources
505 East King Street, Room 500
Carson City, NV 89710
(702) 687-4790

New Hampshire
NH Office of Alcohol and Drug Abuse Prevention
105 Pleasant Street
Concord, NH 03301
(603) 271-6119

New Jersey
NJ Department of Health, CN 362
Division of Alcoholism, Drug Abuse and Addiction Services
Trenton, NJ 08625-0362
(609) 292-9068

New Mexico
Department of Health
Behavioral Health Services Division of Substance Abuse
Harold Runnels Building
Room 3200 North, 1190 St. Francis Drive
Santa Fe, NM 87501
(505) 827-2601

New York
NY State Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526
(518) 457-2061 or 7629

North Carolina
NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Alcohol and Drug Services
325 North Salisbury Street
Raleigh, NC 27611
(919) 733-4670

North Dakota
ND Department of Human Services
Division of Alcoholism and Drug Abuse
Professional Building
1839 East Capitol Avenue
Bismarck, ND 58501
(701) 224-2769

Ohio
OH Department of Alcohol and Drug Addiction Services
Two Nationwide Plaza, 12th Floor
280 N. High Street
Columbus, OH 43215-2537
(614) 466-3445

Oklahoma
OK Department of Mental Health and Substance Abuse Services
Substance Abuse Services
P.O. Box 53277, Capitol Station
Oklahoma City, OK 73152-3277
(405) 271-8653

Pennsylvania
PA Department of Health
Pennsylvania Office of Drug Abuse and Alcohol Programs
P.O. Box 90
Harrisburg, PA 17108
(717) 787-9857

Rhode Island
RI Department of Substance Abuse
P.O. Box 20363
Cranston, RI 02920
(401) 464-2091

South Carolina
SC Department of Alcohol and Other Drug Abuse Services
3700 Forest Drive, Suite 300
Columbia, SC 29204
(803) 734-9520 or 9527

South Dakota
SD Department of Human Services
Division of Alcohol and Drug Abuse
Hillsview Plaza, East Highway 34
c/o 500 E. Capitol
Pierre, SD 57501-5090
(605) 773-3123

Tennessee
TN Department of Health
Bureau of Alcohol and Drug Abuse Services
Tennessee Tower, 312 8th Avenue, North
Nashville, TN 37247-4401
(615) 741-1921

Texas
TX Commission on Alcohol and Drug Abuse
710 Brazos Street, Suite 403
Austin, TX 78701-2576
(512) 867-8802

Utah
Department of Human Services
UT State Division of Substance Abuse
120 North 200 West, 4th Floor, Room 413
Salt Lake City, UT 84103
(801) 538-3939

Vermont
VT Office of Alcohol and Drug Abuse Programs
103 South Main Street
Waterbury, VT 05676
(802) 241-2170 or 2175

Virginia
VA Department of Mental Health, Mental Retardation and Substance Abuse Services
Office of Substance Abuse Services
109 Governor Street
P.O. Box 1797
Richmond, VA 23214
(804) 786-3906

Washington
WA Department of Social and Health Services
Division of Alcohol and Substance Abuse
P.O. Box 45330
Olympia, WA 98504-5330
(206) 438-8200

Additional Resources
(continued)

West Virginia
WV Division of Alcoholism and Drug Abuse
State Capitol Complex
1900 Kanawah Boulevard
Building 6, Room B-738
Charleston, WV 35305
(304) 558-2276

Wisconsin
WI Bureau of Substance Abuse Services
One West Wilson Street, P.O. Box 7851
Madison, WI 53707
(608) 266-3719

Directory of State Uniform Crime Reporting Programs

Alabama
Alabama Criminal Justice
Information Center
770 Washington Avenue, Suite 350
Montgomery, AL 36130
(205) 242-4900
Fax (205) 242-0577

Alaska
Uniform Crime Reporting Section
Department of Public Safety
Information System
5700 East Tudor Road
Anchorage, AK 99507
(907) 269-5659
Fax (907) 269-5617

Arizona
Arizona Department of Public Safety
Uniform Crime Reporting
P.O. Box 6638
Phoenix, AZ 85005
(602) 223-2263
Fax (602) 223-2915

Arkansas
Arkansas Crime Information Center
One Capitol Mall, 4D-200
Little Rock, AR 72201
(501) 682-2222
Fax (501) 682-7444

California
Law Enforcement Information Center
Department of Justice
P.O. Box 903427
Sacramento, CA 94203-4270
(916) 227-3509

Colorado
Uniform Crime Reporting
Colorado Bureau of Investigation
690 Kipling Street
Denver, CO 80215
(303) 239-4300
Fax (303) 235-0568

Connecticut
Uniform Crime Reporting Program
Department of Public Safety
1111 Country Club Road, P.O. Box 2794
Middletown, CT 06457-9294
(203) 685-8030

Delaware
Uniform Crime Reporting
State Bureau of Identification
P.O. Box 430
Dover, DE 19903
(302) 739-5875 or 5879
Fax (302) 739-5888

District of Columbia
Data Processing Division
Metropolitan Police Department
300 Indiana Avenue, Northwest
Washington, DC 20001
(202) 727-4301
Fax (202) 727-3896

Florida
Uniform Crime Reports Section
Special Services Bureau
2331 Phillips Road, Room C-2009
Tallahassee, FL 32308
(904) 487-1179
Fax (904) 487-1030 or 4362

Georgia
Georgia Crime Information Center
Georgia Bureau of Investigation
P.O. Box 370748
Decatur, GA 30037
(404) 244-2614
Fax (404) 244-2725

Hawaii
Uniform Crime Reporting Program
Crime Prevention Program
Department of the Attorney General
810 Richards Street, Suite 701
Honolulu, HI 96813
(808) 586-1416
Fax (808) 586-1424

Idaho
Department of Law Enforcement
Criminal Identification Bureau
700 S. Stratford Drive #108
Meridian, ID 83680
(208) 884-7156
Fax (208) 327-7138

Illinois
Bureau of Identification
Illinois State Police
726 South College Street
Springfield, Il 62704
(217) 782-8263
Fax (217) 327-7138

Iowa
Iowa Department of Public Safety
Wallace State Office Building
Des Moines, IA 50319
(515) 281-8422
Fax (515) 242-6136

Kansas
Kansas Bureau of Investigation
1620 Southwest Tyler Street
Topeka, KS 66612
(913) 232-6000
Fax (913) 296-6781

Kentucky
Information Services Branch
Kentucky State Police
1250 Louisville Road
Frankfort, KY 40601
(502) 227-8783
Fax (502) 227-8734

Louisiana
Louisiana Commission on Law
Enforcement
1885 Wooddale Boulevard, 12th Floor
Baton Rouge, LA 70806
(504) 925-4440
Fax (504) 925-1998

Maine
Uniform Crime Reporting Division
Station #42
36 Hospital Street
Augusta, ME 04333
(207) 624-7004
Fax (207) 624-7088 or 7137

Maryland
Central Records Division
Maryland State Police Department
1711 Belmont Avenue
Baltimore, MD 21244
(410) 298-3883
Fax (410) 298-3198

Massachusetts
Crime Reporting Unit
Uniform Crime Reports
CIS 5th Floor, Massachusetts State Police
1010 Commonwealth Avenue
Boston, MA 02115
(617) 566-4500
Fax (617) 566-8249

Michigan
Uniform Crime Reporting Section
Michigan State Police
7150 Harris Drive
Lansing, MI 48913
(517) 322-5542
Fax (517) 322-0635

Minnesota
Minnesota Department of Public Safety
Office of Information Systems
Management
444 Cedar Street
Suite 100 - H, Town Square
St. Paul, MN 55101
(612) 296-7589
Fax (612) 282-6586

Montana
Montana Board of Crime Control
303 North Roberts
Helena, MT
(406) 444-3604
Fax (406) 444-4722

Nebraska
Uniform Crime Reporting Section
The Nebraska Commission on Law
Enforcement and Criminal Justice
P.O. Box 94946
Lincoln, NE 68509
(402) 471-3982
Fax (402) 471-2837

Nevada
Criminal Information Services
Nevada Highway Patrol
555 Wright Way
Carson City, NV 89711
(702) 687-5713
Fax (702) 687-3168

New Hampshire
Uniform Crime Report Supervisor
Division of State Police
10 Hazen Drive
Concord, NH 03305
(603) 271-2509
Fax (693) 271-1153

New Jersey
Uniform Crime Reporting
Division of State Police
P.O. Box 7068
West Trenton, NJ 08628-0068
(609) 882-2000 x 2392
Fax (609) 883-6913

New York
Statistical Services
New York State Division of Criminal
Justice Services
Executive Park Tower Building
8th Floor, Mail Room
Stuyvesant Plaza
Albany, NY 12203
(518) 457-8381
Fax (518) 457-3089

North Carolina
Crime Reporting & Field Services,SBI/DCI
407 North Blount Street
Raleigh, NC 27601
(919) 733-3171
Fax (919) 733-8378

North Dakota
Information Services Section
Bureau of Criminal Investigation
Attorney General's Office
P.O. Box 1054
Bismarck, ND 58502
(701) 221-5500
Fax (701) 221-5510

Oklahoma
UCR Section Supervisor
Oklahoma State Bureau of Investigation
6600 North Harvey, Suite 300,
Oklahoma City, OK 73116
(405) 848-6724
Fax (405) 843-3804

Oregon
Law Enforcement Data Systems Division
Oregon Department of State Police
400 Public Service Building
Salem, OR 97310
(503) 378-3057
Fax (503) 363-8249

Pennsylvania
Bureau of Research and Development
Pennsylvania State Police
1800 Elmerton Avenue
Harrisburg, PA 17110
(717) 783-5536
Fax (717) 783-4384

Rhode Island
Rhode Island State Police
P.O. Box 185
North Scituate, RI 02857
(401) 444-1120
Fax (401) 444-1133

South Carolina
South Carolina Law Enforcement
Division
P.O. Box 21398
Columbia, SC 29221-1398
(803) 896-7162
Fax (803) 896-7022

South Dakota
South Dakota Statistical Analysis Center
c/o 500 East Capitol Avenue
Pierre, SD 57501
(605) 773-6310
Fax (605) 773-6471

Texas
Crime Records Division
Uniform Crime Reporting Bureau
Texas Department of Public Safety
P.O. Box 4143
Austin, TX 78765-4143
(512) 465-2091 or 2078
Fax (512) 465-2885

Utah
Uniform Crime Reporting
Utah Department of Public Safety
Bureau of Criminal Identification
4501 South 2700 West
Salt Lake City, UT 84119
(801) 965-4445 or 4889
Fax (801) 965-4749

Vermont
Vermont Department of Public Safety
P.O. Box 189
Waterbury, VT 05676
(802) 244-8786
Fax (802) 244-1106

Virginia
Records Management Division
Department of State Police
P.O. Box 27472
Richmond, VA 23261-7472
(804) 674-2023 or 2143
Fax (804) 674-2105

Washington
Uniform Crime Reporting Program
Washington Association
of Sheriffs and Police Chiefs
P.O. Box 826
Olympia, WA 98507
(206) 586-3221
Fax (206) 586-7030

West Virginia
Uniform Crime Reporting Program
725 Jefferson Road
South Charleston, WV 25309
(304) 746-2159
Fax (304) 746-2230

Wyoming
Uniform Crime Reporting
Criminal Records Section
Division of Criminal Investigation
316 West 22nd Street
Cheyenne, WY 82002
(307) 777-7625
Fax (307) 777-7252

NON-PROGRAM STATES

Indiana
Indiana State Police
Indiana Government Center North
100 North Senate Avenue
Indianapolis, IN 46204
(317) 232-8340
Fax (317) 232-0652

Mississippi
No Contacts

Missouri
Statistical Analysis Center
Missouri State Highway Patrol
Department of Public Safety
P.O. Box 568
Jefferson City, MO 65102
(314) 751-3313
Fax (314) 751-9419

New Mexico
Incident-Based Reporting System
Project Manager
New Mexico State Police Complex
P.O. Box 1628
Santa Fe, NM 87504-1628
(505) 827-9113
(505) 827-3398

Ohio
Governor's Office of Criminal
Justice Services
400 East Town Street, Suite 120
Columbus, OH 43215
(614) 466-5126
Fax (614) 466-0308

Tennessee
Tennessee Bureau of Investigation
P.O. Box 100940
Nashville, TN 37224
(615) 741-4789
Fax (615) 741-4788

Directory of State Agencies for Alcohol Consumption Data

Alabama
Alabama ABC Board
State Administration Building
P.O. Box 1151
Montgomery, AL 36130
(205) 271-3840

Alaska
Alaska Department of Revenue
Pouch SA
Juneau, AK 998811

Arizona
Arizona Department of Revenue
1700 W. Monroe
Phoenix, AZ 85007
(602) 542-4475

California
Board of Equalization
Excise Tax Unit - ABC Reports
P.O. Box 942879
Sacramento, CA 94279-0001
(916) 739-2582

Colorado
Colorado Department of Revenue
Statistical Section State Capitol Annex
1375 Sherman Street
Denver, CO 80261
(303) 866-5595

Connecticut
Connecticut Department of Revenue
Services
92 Farmington Avenue
Hartford, CT 06105
(203) 566-8490 or 5926

Delaware
Delaware ABC Commission
Carvel State Building
820 French Street
Wilmington, DE 19801
(302) 571-3200

District of Columbia
D.C. Department of Finance & Revenue
Municipal Center
300 Indiana Avenue
Washington, DC 20001
(202) 727-6566

Florida
Florida Department of Business Regulation
Division of Alcoholic Beverages & Tobacco
Johns Building
725 S. Bronough Street
Tallahassee, FL 32399-1000
(904) 488-2014

Georgia
Georgia Department of Revenue
Alcohol & Tobacco Tax Unit
409 Trinity - Washington Building
Atlanta, GA 30334
(404) 656-4236

Hawaii
Hawaii Department of Taxation
P.O. Box 259
Honolulu, HI 96809

Idaho
Idaho Department of Revenue & Taxation
700 West State Street, P.O. Box 36
Boise, ID 83772
(208) 334-3560

Idaho Liquor Dispensary
P.O. Box 59
Boise, ID 83707

Illinois
Illinois Department of Revenue
Revenue Accounting Division
Consolidated Accounting
101 W. Jefferson Street
Springfield, IL 62794-9014
(217) 785-5988 or 7100

Iowa
Iowa Beer & Liquor Control Department
1918 S.E. Hulsizer Avenue
Ankeny, IA 50021
(515) 281-7364 or 7400

Kansas
Kansas Department of Revenue
Alcoholic Beverage Control
512 West 6th Street, 2nd Floor
Topeka, KS 66603
(913) 296-3946

Kentucky
Commonwealth of Kentucky
Miscellaneous Excise Tax Section
Revenue Cabinet
Frankfort, KY 40620
(502) 564-6823

Louisiana
Louisiana Department of Revenue &
Taxation
Excises Tax Division
P.O. Box 201
Baton Rouge, LA 70821-0201
(504) 925-7651

Maine
Maine Bureau of Alcoholic Beverages
State House Station 8
Augusta, ME 04333
(207) 289-3721

Maryland
Maryland Comptroller of the Treasury
Alcohol & Tobacco Tax Division
Goldstein Treasury Building
Annapolis, MD 21401-2999
(301) 974-3314

Massachusetts
Massachusetts Department of Revenue
100 Cambridge Street
P.O. Box 7012
Boston, MA 02204
(617) 727-3079

Michigan
Michigan Department of Commerce
Liquor Control Commission
P.O. Box 30005
Lansing, MI 48909
(517) 322-1345

Minnesota
Minnesota Department of Revenue
Alcohol, Tobacco & Special Taxes
St. Paul, MN 55164-3330
(612) 642-0460

Missouri
Missouri Department of Public Safety
Division of Liquor Control
P.O. Box 837
Jefferson City, MO 65102
(314) 751-5444

Nebraska
Nebraska Liquor Control Commission
Revenue
301 Centennial Mall South
P.O. Box 95046
(402) 471-2571

Nevada
Nevada Department of Taxation
Capitol Complex
Carson City, NV 89710-0003
(702) 687-4820

New Jersey
New Jersey Department of the Treasury
50 Barrack Street, CN 269
Trenton, NJ 08646-0269
(609) 984-5124

New Mexico
New Mexico Department of Taxation &
Revenue
P.O. Box 630
Santa Fe, NM 87503
(505) 827-0700

New York
New York Department of Taxation &
Finance
Miscellaneous Tax Bureau, State Campus
Albany, NY 12227
(518) 457-2605

North Dakota
North Dakota Office of the State Treasurer
Alcoholic Beverage Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2643

Oklahoma
Oklahoma Tax Commission
Alcohol & Tobacco Taxes Division
2501 Lincoln Boulevard
Oklahoma City, OK 73194
(405) 521-3720

Oregon
Oregon Liquor Control Commission
9079 S.E. McLoughlin Boulevard
P.O. Box 22297
Portland, OR 97222
(503) 653-3047

Pennsylvania
Pennsylvania Department of Revenue
Bureau of Examination
P.O. Box 8555
Harrisburg, PA 17105
(717) 787-5393

Pennsylvania Liquor Control Board
Northwest Office Building
Harrisburg, PA 17124
(717) 783-8415

Rhode Island
Rhode Island Department of Business
Regulation
Liquor Control Administration
233 Richmond Street, Suite 200
Providence, RI 02903
(401) 277-2562

Texas
Texas Alcoholic Beverage Commission
Capitol Station, P.O. Box 13127
Austin, TX 78711
(512) 458-2500

Virginia
Virginia Department of ABC
Division of Business Research
P.O. Box 27491
Richmond, VA 23261
(804) 367-8902 or 0716

Virginia Department of Taxation
P.O. Box 6L
Richmond, VA 23282-0001
(804) 367-8046

Washington
Washington Liquor Control Board
1025 E. Union
Olympia, WA 98504
(206) 753-6276 or 0430

West Virginia
West Virginia Beer
Wholesaler's Association
P.O. Box 294
Charleston, WV 25321
(304) 343-8514

Wisconsin
Wisconsin Department of Revenue
Excise Tax Bureau
Office Audit & Review Unit
P.O. Box 8905
Madison, WI 53708
(608) 266-7491

Contacts For Annual State Survey Of Current Trends in Child Abuse

Alabama
Department of Human Resources
Division of Family and Children's Services
50 N. Ripley Street
Montgomery, AL 36130-1801

Alaska
Social Services Program Coordinator
Division of Family and Youth Services
Department of Health and Social Services
P.O. Box 110630
Juneau, AK 99811-0630

Arizona
Operations Manager
Department of Economic Security
Administration for Children, Youth and
Families
1789 West Jefferson, Site Code 940A
Phoenix, AZ 85005

Arkansas
Department of Human Services
Division of Children and Family Services
P.O. Box 1437-830
626 Donaghey Plaza South
Little Rock, AR 72203-1437

Additional Resources
(continued)

California
Office of Child Abuse Prevention
CA Department of Social Services
744 P Street, MS 19-82
Sacramento, CA 95814

Colorado
Program Manager, Child Protection
Colorado Department of Social Services
225 E. 16th Avenue, Suite 475
Denver, CO 80203

Connecticut
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Delaware
Department of Services for Children, Youth and Their Families
Division of Child Protective Services
1825 Faulkland Road
Wilmington, DE 19805-1195

District of Columbia
Special Assistant to the Administrator
Family Services Administration
609 H Street, NE
Washington, DC 20002

Florida
Children and Families Program Office
Department of Health and Rehabilitative Services
2811 Industrial Plaza Drive
Tallahassee, FL 32301

Georgia
Unit Chief
GA Department of Human Resources
Division of Family and Children Services
#2 Peachtree Street, 12th Floor, Room 418
Atlanta, GA 30303

Hawaii
Assistant Program Administrator
Child Protective Services
Department of Human Services
810 Richards Street, Suite 400
Honolulu, HI 96813

Idaho
Grants/Contracts Officer
Department of Health and Welfare
Division of Family and Community Services
P.O. Box 83720, 450 W. State Street
Boise, ID 83720

Illinois
Administrator
Office of Planning and Training
IL Department of Children and Family Services
406 East Monroe
Springfield, IL 62701

Indiana
Supervisor
Institutional Child Protection Service Unit
Division of Family and Children
Indiana Family and Social Services Administration
Indiana Government Center South
402 West Washington Street, Room W364
Indianapolis, IN 46204

Iowa
Division ACFS
Bureau of Individual and Family Support and Protective Services
IA Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, IA 50319

Kansas
Kansas Department of Social and Rehabilitative Services
Youth and Adult Services
300 S.W. Oakley, Smith-Wilson Building
Topeka, KS 66606

Kentucky
Department for Social Services
Division of Family Services
Program Development Section
CHR Building, 6th Floor East
275 East Main Street
Frankfort, KY 40621

Louisiana
Family Services Section Administrator
Office of Community Services
Department of Social Services
333 Laurel Street
Baton Rouge, LA 70801

Maine
Director, Regional Operations for Child Welfare
Bureau of Child and Family Services
Department of Human Services
State House, Station 11
Augusta, ME 04333

Maryland
Family Preservation Manager
Maryland Department of Human Resources
Social Services Administration
311 West Saratoga Street, Room 530
Baltimore, MD 21201

Massachusetts
Coordinator of Field Services
Massachusetts Department of Social Services
24 Farnsworth Street
Boston, MA 02110

Michigan
MI Department of Social Services/OCYS
Protective and Preventive Services Division
P.O. Box 30037, 235 South Grand Avenue
Lansing, MI 48909

Minnesota
Supervisor
Family and Children's Services Division
Minnesota Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, MN 55155-3830

Mississippi
Program Manager
Office of Social Services
Mississippi Department of Human Services
P.O. Box 352
Jackson, MS 39205

Missouri
Assistant Deputy Director of Children's Services
Division of Family Services
Broadway State Office Building
P.O. Box 88
Jefferson City, MO 65103

Montana
Department of Family Services
P.O. Box 8005
Helena, MT s59604

Nebraska
Child Protective Services
Department of Social Services
P.O. Box 95026
Lincoln, NE 68509-5026

Nevada
NV Division of Child and Family Services
711 E. Fifth Street
Carson City, NV 89710

New Hampshire
Assistant Director of Prevention Services
NH Division for Children and Youth
6 Hazen Drive
Concord, NH 03301

New Jersey
Grants Manager
Department of Human Services, (CN 717)
Division of Youth and Family Services
50 East State Street, 6th Floor
Trenton, NJ 08625-0717

New Mexico
Child Abuse Prevention Coordinator
New Mexico Children, Youth and Families Department
Children's Bureau, Social Services Division
300 San Mateo Blvd., N.E., Suite 802
Albuquerque, NM 87108-1516

New York
Director, NY State Child Abuse Register
NY State Department of Social Services
40 North Pearl Street, 11th Floor, Section D
Albany, NY 12243-0001

North Carolina
Department of Human Resources
Division of Social Services
325 North Salisbury Street
Raleigh, NC 27603

North Dakota
Department of Human Services-CFS
600 East Boulevard
Bismarck, ND 58505

Ohio
Section Chief
Ohio Department of Human Services
Children's Services Section
65 East State Street, 5th Floor
Columbus, OH 43215-4213

Oklahoma
Program Supervisor
Child Welfare Services
Division of Children and Youth Services
Child Abuse and Neglect Section
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125

Oregon
Department of Human Resources
Children Services Division
198 Commercial Street, S.E.
Salem, OR 97310

Pennsylvania
Director, Protective Service Program
PA Department of Public Welfare
Office of Children, Youth and Families
P.O. Box 2675
Harrisburg, PA 17105-2675

Rhode Island
Executive Director
Child Protective Services
Department for Children & Their Families
610 Mt. Pleasant Avenue, Building 1
Providence, RI 02908

South Carolina
Director
Office of Family Preservation and Child Welfare
Department of Social Services
P.O. Box 1520
Columbia, SC 29202-1520

South Dakota
SD Department of Social Services/CPS
Kneip Building
700 Governor's Drive
Pierre, SD 57501

Tennessee
Director
TN Department of Human Services
Child Protective Services
400 Deaderick Street
Nashville, TN 37248-9300

Texas
Director
Texas Department of Protective and Regulatory Services
P.O. Box 149030
Austin, TX 78714-9030

Utah
CPS Specialist
UT Department of Human Resources/DFS
P.O. Box 45500
Salt Lake City, UT 84145-0500

Vermont
Policy and Practice Chief of Social Services
Department of Social & Rehabilitation Services
103 South Main Street
Waterbury, VT 05671-2401

Virginia
Department of Social Services
Child Protective Services Unit
730 East Broad Street
Richmond, VA 23229-8699

Washington
Department of Social and Health Services
Division of Children and Family Services
P.O. Box 45710
Olympia, WA 98504

West Virginia
CPS Program Specialist
Department of Health and Human Resources
Office of Social Services
Room 850, Building 6
State Capitol Complex
Charleston, WV 25305

Wisconsin
Department of Health and Social Services
Bureau for Children, Youth and Families
One West Wilson Street, Room 465
P.O. Box 7851
Madison, WI 53707

Wyoming
Department of Social Services
Hathaway Building #322
Cheyenne, WY 82002

Local Education Agencies with Youth Surveys

1993 Participants of the Youth Risk Behavior Surveillance System (YRBSS)

Baltimore City Schools
200 E North Avenue
Baltimore, MD 21202
(410) 396-8811
Fax (410) 396-8063

Boston Public Schools
High School Office
55 New Dudley Street
Boston, MA 02120
(617) 635-8875, ext. 148
(617) 635-9050
Fax (617) 635-8887

The School Board of Broward County (Fort Lauderdale)
School Health Department.
Kathleen C. Wright Administration Center
600 S.E. Third Avenue, 7th Floor
Fort Lauderdale, FL 33301
(305) 768-8974
Fax (305) 768-8969

Chicago Public Schools
Department of Instructional Support
1819 W. Pershing Road
Chicago, IL 60609
(312) 535-4240
Fax (312) 535-8028

The School Board of Dade County (Miami)
Comprehensive AIDS Information and Education Program
1444 Biscayne Boulevard, Suite 204-A
Miami, FL 33132
(305) 995-7118
Fax (305) 995-7122

Dallas Independent School District
Instructional Support Unit
3700 Ross Avenue, Box 93
Dallas, TX 75204
(214) 824-1620
Fax (214) 841-5005

Denver Public Schools
Department of Instructional Services
900 Grant Street
Denver, CO 80203
(303) 691-7408
Fax (303) 691-7393

City of Detroit School District
5057 Woodward, Room 1062
Detroit, MI 48202
(313) 494-1214
Fax (313) 494-1689

Houston Independent School District
3830 Richmond Avenue, Level 3 South
Houston, TX 77027
(713) 892-6165
Fax (713) 892-6188

Jersey City Board of Education
346 Claremont Avenue
Jersey City, NJ 07305
(201) 915-6039
Fax (201) 915-6787

Los Angeles Unified School District
Office of Instruction
450 North Grand Avenue, Room A-319
Los Angeles, CA 90012
(213) 625-6429 or 6411
Fax (213) 680-7860

Newark Board of Education
Division of Health Education
2 Cedar Street
Newark, NJ 07106
(201) 642-3108
Fax (201) 733-8701

New York City Board of Education
110 Livingston Street
Brooklyn, NY 11201
(718) 935-3252
Fax (718) 935-2805

Orleans Parrish School Board
4100 Touro St., Rooms 127 & 129
New Orleans, LA 70122
(504) 365-8980
Fax (504) 365-8979

The School District of Philadelphia
Division of Physical and Health Education
Administration Building, Room 323
21st Street South of the Parkway
Philadelphia, PA 19103
(215) 351-7221 or 299-8906
Fax (215) 299-7795

San Diego Unified School District
Health Services Department
4100 Normal Street
San Diego, CA 92103
(619) 293-8213
Fax (619) 294-2146

San Francisco Unified School District
AIDS Education for Youth
1512 Golden Gate, Room 10
San Francisco, CA 94115
(415) 749-3400
Fax (415) 749-3420

Seattle Public Schools
Health Curriculum
1330 North 90th, Room 101
Seattle, WA 98103
(206) 298-7987
Fax (206) 298-7804

Bureau of Labor Statistics (BLS) Regional Offices

Region I
1 Congress Street, Tenth Floor
Boston, MA 02114-2023
(617) 565-2327

Region II
201 Varick Street, Room 808
New York, NY 10014-4811
(212) 337-2400

Region III
P.O. Box 13309
Philadelphia, PA 19101-3309
(215) 596-1154

Region IV
1371 Peachtree Street, N.E.
Atlanta, GA 30367-2302
(404) 347-4416

Region V
230 S. Dearborn Street
Chicago, IL 60604-1595
(312) 353-1880

Region VI
525 Griffin Street, Room 221
Dallas, TX 75202-5028

Regions VII and VIII
911 Walnut Street
Kansas City, MO 64106-2009
(816) 426-2481

Regions IX and X
71 Stevenson Street
P.O. Box 193766
San Francisco, CA 94119-3766
(415) 744-6600

Directory of State Health Departments

Alabama
Public Health Department
434 Monroe Street
Montgomery, AL 36130-3017
(334) 613-5300

Alaska
Public Health Division
Alaska Office Building
P.O. Box 110610
Juneau, AK 99811-0610
(907) 465-3090

Arizona
Health Services Department
1740 W. Adams
Phoenix, AZ 85007
(602) 542-1000

Arkansas
Health Department
4815 W. Markham
Little Rock, AR 72205-3867
(501) 671-1450

California
Health and Welfare Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814-6404
(916) 654-3454

Colorado
Public Health and Environment Department
4300 Cherry Creek Drive, South
Denver, CO 80222
(303) 692-2000

Connecticut
Public Health and Addiction Services Department
150 Washington Street
Hartford, CT 06106
(203) 566-4800

Delaware
Health and Social Services Department
1901 N. duPont Highway
New Castle, DE 19720
(800) 464-4357

District of Columbia
Human Services Department
801 East Building
2700 Martin L. King Avenue, S.E.
P.O. Box 54047
Washington, DC 20032-0247
(202) 279-6070

Florida
Health and Rehabilitative Services Department
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(904) 487-2705

Georgia
Human Resources Department
Public Health Division
Two Peachtree Street
Atlanta, GA 30303
(404) 657-2700

Hawaii
Health Department
1250 Punchbowl Street
Honolulu, HI 96813
(808) 586-4400

Idaho
Health and Welfare Department
Health Division
450 W. State Street, P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5945

Illinois
Public Health Department
535 W. Jefferson Street
Springfield, IL 62761
(217) 782-6187

Indiana
Health Department
1330 W. Michigan Street, Box 1964
Indianapolis, IN 46206-1964
(317) 633-0100

Iowa
Public Health Department
Lucas Building
Des Moines, IA 50319-0075
(515) 281-5787

Kansas
Health and Environment Department
Landon State Office Building
900 S.W. Jackson Street
Topeka, KS 66612-1290
(913) 296-1500

Kentucky
Human Resources Cabinet
Health Services Department
275 E. Main Street
Frankfort, KY 40621-0001
(502) 564-3970

Louisiana
Public Health Office
325 Loyola Avenue, Box 60630
New Orleans, LA 70160
(504) 342-8092

Maine
Human Services Department
Health Bureau
State House Station #11
Augusta, ME 04333
(207) 287-3201

Maryland
Health and Mental Hygiene Department
201 W. Preston Street, 5th Floor
Baltimore, MD 21201
(410) 225-6860

Massachusetts
Public Health Department
150 Tremont Street
Boston, MA 02111
(617) 727-0201

Michigan
Public Health Department
Martin Luther King, Jr. Blvd.
P.O. Box 30195
Lansing, MI 48909
(517) 335-8000

Minnesota
Health Department
717 Delaware Street, S.E.
Minneapolis, MN 55440-9441
(612) 623-5000

Mississippi
Health Department
P.O. Box 1700
Jackson, MS 39215-1700
(601) 960-7400

Missouri
Health Department
P.O. Box 570
Jefferson City, MO 65102
(314) 751-6400

Montana
Health and Environmental Sciences Department
Cogswell Building
1400 Broadway, P.O. Box 200901
Helena, MT 59620
(406) 444-2544

Nebraska
Health Department
301 Centennial Mall South
P.O. Box 95007
Lincoln, NE 68509-5007
Fax (402) 471-0383

Nevada
Human Resources Department
505 E. King Street, Room 600
Carson City, NV 89710
Fax (702) 687-4733

New Hampshire
Health and Human Services
Public Health Services Division
6 Hazen Drive
Concord, NH 03301
(603) 271-4501

New Jersey
Health Department
Health & Agriculture Building
Public Health Service, CN 360
Trenton, NJ 08625-0360
(609) 292-7837

New Mexico
Health Department
Public Health Division
1190 St. Francis Drive, P.O. Box 26110
Santa Fe, NM 87502-6110
(505) 827-2389

New York
Social Services Department
40 N. Pearl Street
Albany, NY 12243
Fax (518) 474-7870

North Carolina
Environment, Health, and Natural Resources Department
P.O. Box 27687
Raleigh, NC 27611
(919) 733-4984

North Dakota
Preventive Health Section
1200 Missouri Avenue
P.O. Box 5520
Bismarck, ND 58502-5520
(701) 328-2493

Ohio
Health Department
246 N. High Street
P.O. Box 118
Columbus, OH 43266-0118
(614) 466-3543

Oklahoma
Health Department
1000 N.E. 10th Street
P.O. Box 53551
Oklahoma City, OK 73152
(405) 271-4200

Oregon
Health Division
P.O. Box 14450
Portland, OR 97214
(503) 731-4000

Pennsylvania
Health Department
Health and Welfare Building, Box 90
Harrisburg, PA 17108
(717) 783-5901

Rhode Island
Health Department
Three Capitol Hill
Providence, RI 02908-5097
(401) 277-2231

South Carolina
Health and Environmental Control Department
2600 Bull Street
Columbia, SC 29201
(803) 734-5000

South Dakota
Health Department
445 E. Capitol Avenue
Pierre, SD 57501-3185
(605) 773-3361

Tennessee
Health Department
312 Eighth Avenue, North
Nashville, TN 37247-0101
(615) 741-3111

Texas
Health Department
1100 W. 49th Street
Austin, TX 78756
(512) 458-7111

Utah
Health Department
288 N. 1460 West
Salt Lake City, UT 84116-0700
(801) 538-6101

Vermont
Health Department
P.O. Box 70
Burlington, VT 05402
(802) 863-7200

Virginia
Health Department
Main Street Station, P.O. Box 2448
Richmond, VA 23218
(804) 786-3561

Washington
Social and Health Services Department
P.O. Box 45010, MS 45010
Olympia, WA 98504-5010
(206) 753-7039

West Virginia
Public Health Bureau
Health and Human Resources Department
State Capitol Complex
Building 3, Room 206
Charleston, WV 25305
(304) 558-2971

Wisconsin
Health and Social Services Department
Health Division
P.O. Box 7850
Madison, WI 53707
(608) 266-1151

Wyoming
Health Department
5400 Bishop Boulevard
Cheyenne, WY 82002
(307) 777-7656

Regional Service Teams (RST) Program

RST #1 (CT, ME, MA, NH, RI, VT, NY)
(202) 260-2834

RST #2 (DE, DC, MD, NJ, OH, PA)
(202) 260-2648

RST #3 (KY, NC, SC, TN, VA, WV)
(202) 260-2844

RST #4 (AL, AR, GA, LA, MS)
(202) 260-3954

RST #5 (IA, MI, MN, ND, SD, WI)
(202) 260-1883

RST #6 (IL, IN, KS, MO, NE, OK)
(202) 260-2526

RST #7 (TX, AZ, CO, NV, NM, UT)
(202) 260-2661

RST #8 (ID, MT, OR, WA, WY, AK)
(202) 708-8529

RST #9 (CA, HI, AS, GU, MP, RP)
(202) 260-2831

RST #10 (FL, PR, VI)
(202) 260-1942

State Coordinators for Drug-Free Schools

Alabama
Governor's Office of Drug Abuse Policy
600 Dexter Avenue
Capital Building NB06
Montgomery, AL 36130
(334) 242-3178

Drug Education Program
State Department of Education
50 North Ripley Street
Montgomery, AL 36130
(334) 242-8199

Alaska
Alaska Department of Education
Governor's Prevention Grants
801 West 10th Street, Suite 200
Juneau, AK 99801-1894
(907) 465-8715

Alaska Department of Education
Division of Educational Program Support
801 West 10th Street, Suite 200
Juneau, AK 99801-1894
(907) 465-8730 or 2843

American Samoa

Department of Education
Drug-Free Schools Program
American Samoa Government
P.O. Box 1923
Pago Pago, AS 96799
(684) 633-5244

Arizona

Governor's Division of Drug Policy
Governor's Office/Arizona
1700 West Washington Street, #503
Phoenix, AZ 85253
(602) 542-3456

Arizona Department of Education
Title IV-Safe and Drug-Free Schools
1535 West Jefferson
Phoenix, AZ 85007
(602) 542-8728

Arkansas

Bureau of Alcohol and
Drug Abuse Prevention
Arkansas Department of Health
Freeway Medical Center
5800 West 10th Street, Suite 907
Little Rock, AR 72204
(501) 280-4511

Arkansas Department of Education
Drug Education
Four Capitol Mall, Room 405-B
Little Rock, AR 72201-1071
(501) 682-5170

California

Division of Children, Youth, Families
and Communities
Department of Alcohol and
Drug Programs
1700 K Street, Second Floor
Sacramento, CA 95814
(916) 327-8617

California Department of Education
Healthy Kids Program Office
721 Capital Mall, 3rd Fl.
Sacramento, CA 95814
(916) 657-2810

Colorado

Colorado Department of Local Affairs,
Community Partnership Office
1313 Sherman Street, Room 500
Denver, CO 80203
(303) 866-4965

Colorado Department of Education
Prevention Initiatives Unit
201 East Colfax Avenue
Denver, CO 80203
(303) 866-6869

Connecticut

Drug-Free Schools Coordinator
Office of Policy and Management
Policy Development and Planning
Division
450 Capitol Avenue, MS# 52CPD
P.O. Box 341441
Hartford, CT 06134-1441
(860) 418-6316

Connecticut Department of Education
Room 215, P.O. Box 2219
Hartford, CT 06145
(860) 566-6645

Delaware

Office of Prevention
Department of Services for Children,
Youth and their Families
1825 Faulkland Road
Wilmington, DE 19805-1195
(302) 633-2678

Department of Public Instruction
Health Education and Services
Townsend Building, P.O. Box 1402
Dover, DE 19903
(302) 739-4676

District of Columbia

Prevention and Youth Services
Addiction Prevention and
Recovery Administration
1300 First Street, NE, Suite 309
Washington, D.C. 20002
(202) 727-0716

Director
Giddings School, 315 G Street, SE
Washington, D.C. 20003
(202) 724-3610

Florida

Public Safety Policy Unit
Office of Planning and Budgeting
Executive Office of the Governor
501 South Calhoun Street, Room 415
Tallahassee, FL 32399
(904) 922-4020

Drug-Free Schools Program
Florida Educational Center
325 West Gaines Street, Suite 422
Tallahassee, FL 32399-0400
(904) 488-6304

Georgia

Substance Abuse Services
Georgia Department of Human Resources
2 Peachtree Street, NE, Suite 3-160
Atlanta, Ga 30303
(404) 657-2273

Georgia State Board of Education
Health and Physical Education
1952 Twin Towers East
Atlanta, GA 30334-5040
(404) 651-9406

Guam

Chief of Staff
Office of the Governor, P.O. Box 2950
Agana, Guam 96910
(671) 472-8931

Administrator
Department of Education
Office of Federal Programs, P.O. Box DE
Agana, GU 96910
(671) 472-8524

Hawaii

Department of Human Services
Office of Youth Services
1481 South King street
Honolulu, HI 96814
(808) 973-9494

Office of Instructional Services
Department of Education
1390 Miller St., Room 316
Honolulu, HI 96813
(808) 586-3446

Idaho

Idaho Department of Health and Welfare
Bureau of Substance Abuse
450 West State Street, 5th Floor
P.O. Box 83720
Boise, ID 83720
(208) 334-4944

Drug Education Consultant
Idaho Department of Education
Len B. Jordan Building, 650 W. State Street
Boise, ID 83720
(208) 332-6962

Illinois

Assistant to the Governor
Room 207 State House
Springfield, IL 62706
(217) 782-2654

Illinois State Board of Education
Grants and Application Section
100 North First Street
Springfield, IL 62777
(217) 782-3810

Indiana

Director of Prevention Resource
Development
Division of Mental Health
402 West Washington Street, Room W-353
Indianapolis, IN 46204-2739
(317) 232-7880

Additional Resources
(continued)

Department of Education
Center for School Improvement
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-6984

Iowa
Iowa Department of Public Health
Division of substance Abuse
Lucas State Office Building
Des Moines, IA 50319
(515) 281-4417

Substance Education Consultant
Iowa Department of Education
Grimes State Office Building
Des Moines, IA 50319
(515) 281-3021

Kansas
Office of the Attorney General
2nd Floor, Judicial Center
Topeka, KS 66612
(913) 296-2215

Kansas State Board of Education
120 East 10th Street
Topeka, KS 66612
(913) 296-6714

Kentucky
Cabinet for Human Resources
Department for Mental Health and Mental Retardations Services
Division of Substance Abuse
275 East Main sTreet
Frankfort, KY 40621
(502) 564-2880

State Department of Education
Title V Programs Branch
825 Capitol Plaza Tower
Frankfort, KY 40601
(502) 564-3791

Louisiana
Governor's DFSC Grant Program
Office of the Governor, P.O. Box 94004
Baton Rouge, LA 70804-9004
(504) 342-3422

Louisiana Department of Education
Bureau of Student Services
P.O. Box 94064
Baton Rouge, LA 70804-9064
(504) 342-3480

Maine
SDFSC Program
Maine Office of Substance Abuse
Information and Resource Center
Marquardt Building, 3rd Floor
159 State House Station
Augusta, ME 04333-8910
(207) 287-8907

Department of Education
24 Stone Street
State House Station #161
Augusta, ME 04333
(207) 287-4729

Maryland
Prevention Coordinator
Governor's Office of Crime Control and Prevention
300 East Joppa Road, Suite 1105
Towson, MD 21286-3016
(410) 321-3528

State Department of Education
Safe Leaning Environment Initiative Section
200 West Baltimore Street
Baltimore, MD 21202
(410) 767-0301

Northern Mariana Islands
Family Involvement Coordinator
Public School System
Lower Base P.O. Box 1370
Saipan, MP 96950
(670) 322-9827

Massachusetts
Governor's Alliance Against Drugs
John W. McCormack State Office Building
One Ashburton Place, Room 611
Boston, MA 02108
(617) 727-0786 ext. 578

Education Specialist IV
Learning Support Services Cluster
Massachusetts Department of Education
350 Main Street
Malden, MA 02148-5023
(617) 388-3300 ext. 415

Michigan
Office of Drug Alcohol Policy
Drug Education Division
124 W. Allegan, Suite 1200
P.O. Box 30026
Lansing, MI 48909
(517) 373-4700

Minnesota
State Department of Education
Grants Manager
550 Cedar Street, Room 976
St. Paul, MN 55101
(612) 296-8023

Mississippi
Division of Public Safety Planning
Department of Public Safety
401 North West Street
Jackson, MS 39201
(601) 359-7880

SDFS Programs
Mississippi Department of Education
550 High Street
Jackson, MS 39205-0771
(601) 359-3286

Missouri
Administrator
Division of Alcohol and Drug Abuse
P.O. Box 687
Jefferson City, MO 65101
(573) 751-4942

State Department of Elementary and Secondary Education, P.O. Box 480
Jefferson City, MO 65102
(314) 751-9053

Montana
Board of Crime Control
Montana Department of Justice
Scott Hart Building, Room 4-2
303 North Roberts Street
Helena, MT 59620
(406) 444-2947

State Department of Education
Office of Public Instruction
P.O. Box 202501
Helena, MT 59620-2501
(406) 444-4434

Nebraska
Division of Alcoholism and Drug Abuse
Department of Public Institutions
P.O. Box 94728
West Van Dorn and Folsom Streets
Lincoln, NE 68509-4728
(402) 479-5290

Director of Drug-Free Program
Nebraska State Department of Education
301 Centennial Mall South
Lincoln, NE 68509-4987
(402) 471-2448

Nevada
Intervention Specialist
Department of Human Resources
Bureau of Alcohol and Drug Abuse
505 East King Street, Room 500
Carson City, NV 89710
(702) 687-4790

State Department of Education
Office of Public Instruction
400 W. King Street, Capitol Complex
Carson City, NV 89710
(702) 687-9154

New Hampshire
New Hampshire Office of Alcohol and Drug Abuse Prevention
105 Pleasant Street, Office Park South
Concord, NH 03301
(603) 271-6105

Department of Education
State Office Park South
101 Pleasant Street
Concord, NH 03301
(603) 271-2717

New Jersey

New Jersey State Department of Education
Office of Educational Programs and Student Services
225 West State Street, CN500
Trenton, NJ 08625
(609) 633-6684

New Mexico

Division of Substance Abuse
Behavioral Health Services
1190 St. Francis Drive
P.O. Drawer 26110
Santa Fe, NM 87502-6110
(505) 827-2601

State Department of Education
120 South Federal Pl., Room 206
Santa Fe, NM 87501
(505) 827-1827

New York

Commissioner, NY State Office
Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203
(518) 457-2061

State Education Department
Comprehensive Health and Pupil Services, Room 319-MEB
Albany, NY 12234
(518) 486-6090

North Carolina

Alcohol and Drug Services
Governor's Council on Alcohol and Drug Abuse
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, NC 27603
(919) 733-4670

PCR 48 SDF Consultant
Department of Public Instruction
Student Support Services
301 North Wilmington Street
Raleigh, NC 27603-1725
(919) 715-1693

North Dakota

Division of Alcohol and Drug Abuse
North Dakota Department of Human Services
1839 East Capitol Avenue
Bismark, ND 58501-2152
(701) 328-9769

Department of Public Instruction
Office of Chemical Health
State Capitol, Ninth Floor
Bismarck, ND 58505
(701) 328-2269

Ohio

Prevention and Training Services
Ohio Department of Alcohol and Drug Addiction Services
280 North High Street, 12th Floor
Columbus, OH 43215-2537
(614) 752-8356

Department of Education
Division of Student Development
65 South Front Street, Room 611
Columbus, OH 43215-4183
(614) 466-2471

Oklahoma

Director of Prevention
ODMHSAS
P.O. Box 53277
Oklahoma City, OK 73152
(405) 522-3866

Health, Safety and Physical Education
Oklahoma Department of Education
2500 North Lincoln Boulevard
Oklahoma City, OK 73105-4599
(405) 521-4507

Oregon

Department of Human Resources
Office of Alcohol and Drug Abuse
500 Summer Street, NE, 3rd Floor
Salem, OR 97310
(503) 945-5763

Assistant Superintendent
State Department of Education
255 Capitol Street, NE
Salem, OR 97310
(503) 378-5585 ext. 663

Pennsylvania

Deputy Directory
Governor's Policy Office
Finance Building, Room 506
Harrisburg, PA 17120
(717) 787-1954

Division of Student Services
State Department of Education
333 Market Street
Harrisburg, PA 17126-0333
(717) 772-2429

Puerto Rico

Department of Education
Office of Federal Affairs
P.O. Box 759
Hato Rey, PR 00919
(809) 759-8910

Republic of Palau

Juvenile Justice Program and Planning
P.O. Box 100
Koror, RP 96940
(680) 488-1218

Bureau of Education
Division of Curriculum Development
P.O. Box 189
Koror, RP 96940
(680) 488-2670

Rhode Island

Rhode Island Department of Health
Division of Substance Abuse
3 Capitol Hill
Cannon Building, Room 105
Providence, RI 02908
(401) 277-4680

State Department of Education
Drug-Free Schools and Communities Program
22 Hayes Street, Room 313
Providence, RI 02908
(401) 277-6523

South Carolina

South Carolina Department of Alcohol and Other Abuse Services
3700 Forest Drive, Suite 300
Columbia, SC 29204-4082
(803) 734-9561

Drug-Free Schools and Communities
Department of Education
1429 Senate Street, Room 404
Columbia, SC 29201
(803) 734-8573

South Dakota

Department of Human Services
Division of Alcohol and Drug Abuse
East West Highway 84
500 East Capitol
Pierre, SD 57501-3182
(605) 773-3123

Additional Resources
(continued)

State Department of Education
700 Governor's Drive
Pierre, SD 57501
(605) 773-3566

Tennessee
Tennessee Department of Education
Drug-Free Schools Program
Gateway Plaza, 6th Floor
710 James Robertson Parkway
Nashville, TN 37243-0375
(615) 741-3248

Texas
Director of Justice Programs
Criminal Justice Division
Office of the Governor, P.O. Box 12428
Austin, TX 78711
(512) 463-1944

Division of Accelerated Instruction
Drug Abuse Prevention Program
1701 North Congress Avenue
Austin, TX 78701-1494
(512) 463-9374

Utah
Drug-Free Schools
Utah State Division of Substance Abuse
120 N. 200 West, Floor 4
Salt Lake City, UT 84103
(801) 538-3939

Utah State Office of Education
Drug-Free Schools Program
250 East 500 South
Salt Lake City, UT 84111
(801) 538-7713

Vermont
Vermont Agency of Human Services
103 South Main Street
Waterbury, VT 05671-0201
(802) 241-2234

DFS Program
Vermont Department of Education
120 State Street
Montpelier, VT 05620-2703
(802) 828-3124

Virgin Island
Youth Promotion and Delinquency Prevention
Department of Human Services
Knud Hansen Complex, Building A
1303 Hospital Ground
Charlotte Amalie, VI 00802
(809) 773-2323

Virginia
Special Assistant to the Governor for Drug Policy
Office of the Governor
9th Street Office Building
Richmond VA 23219
(804) 786-5351

Virginia Department of Education
P.O. Box 2120
Richmond, VA 23218-2120
(804) 225-2871

Washington
Department of Community, Trade and Economic Development
906 Columbia Street, SW
P.O. Box 48300
Olympia, WA 98504-8300
(360) 753-0738

Safe and Drug-Free Schools
OSPI
Old Capitol Building
P.O. Box 47200
Olympia, WA 98504-7200
(360) 753-5595

West Virginia
Criminal Justice and Highway Safety Office
Community and Industrial
1204 Kanawha Boulevard East
Charleston, WV 25301
(304) 558-8814

State Department of Education
Student Services and Assessment
Capitol Complex, B-057
Charleston, WV 25305-0330
(304) 558-2546

Wisconsin
Bureau of Community Programs
Department of Health and Social Services
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707
(608) 266-3719

Department of Public Instruction
Student Services/Prevention and Wellness Team
125 South Webster Street
P.O. Box 7841
Madison, WI 53707-7841
(608) 266-3390

Wyoming
Substance Abuse Consultant
Department of Health Division of Behavioral Health
Hathaway Building, Room 452
Cheyenne, WY 82002
(307) 777-6493

State Department of Education
School Improvement Unit
Hathaway Building, 2nd Floor
2300 Capitol Avenue
Cheyenne, WY 82002-0050
(307) 777-7168

I. Information Accessible Electronically

Join Together Online

A substance abuse resource center and a national electronic mail exchange for thousands of community leaders and activists. Includes funding news from the Federal Register, summaries of daily newspaper articles, updates on pending substance abuse legislation, and events calendar.

Contact: Join Together
441 Stuart Street, 6th Floor
Boston, MA 02116
(617) 437-1500
fax (617) 437-9394
E-mail: info@jointogether.org
http://www.jointogether.org

Handsnet

An electronic network connecting more than 3,500 health and human service organizations. A number of Information Forums offer human services news and policy, program and management information.

Contact: Handsnet
20195 Stevens Creek Blvd., Suite 120
Cupertino, CA 95014
(408) 257-4500
fax (408) 257-4560

National Clearinghouse for Alcohol and Drug Information (NCADI) Prevention Materials Database

Includes a current collection of primary prevention materials. Produced by NCADI for the Center for Substance Abuse Prevention (CSAP). Available on IBM compatible discs.

Contact: National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345
Rockville, MD 20852
(800) 729-6686

PREVline

An electronic community bulletin board dedicated to exchanging ideas and information concerning substance abuse prevention. Public access is available with e-mail, bulletin boards, downloadable files, and selected databases.

Full Internet access is provided at no charge to RADAR Associates and Specialty Centers and CSAP grantees, and to others by special arrangement. Full access provides direct connection to: World Health Organization in Geneva; MARVEL, Library of Congress; National Institutes of Health (NIH) Library; CORK, Dartmouth College; Cornell University Library; Join Together Network; and PAVNET, Partnerships Against Violence Network.

Contact: National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852
(800) 729-6686
(301) 468-2600

Can be accessed through the Internet via telnet (path: telnet ncadi.health.org/login: prevline) or directly via telephone to 301-770-0850, login: prevline.

II. Other National Resource Groups and Reports

Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration

CSAP manages the Community Partnership Demonstration Program. Under this program, CSAP has provided grants to 251 communities for the development of coalitions to prevent alcohol and other drug abuse.

Contact: Shakeh Kaftarian
(301) 443-9136

Center for Substance Abuse Treatment (CSAT)

Sponsors studies in the states to determine the demand and need for substance abuse treatment. The states will report the results in their Substance Abuse Prevention and Treatment Block Grant (SAPT) Applications. Such studies are designed to improve the allocation of treatment resources and the quality of care.

Contact: CSAT Grants Office
(301) 443-8926

Community Anti-Drug Coalitions of America (CADCA)

Created as a membership organization in 1992 in response to the needs of community coalitions to share ideas, problems, and solutions. Offers technical assistance on indicator monitoring and other areas.

Contact: CADCA
(703) 706-0560, fax (703) 706-0565

Join Together

Join Together is a national resource center created to help communities effectively fight substance abuse. It is funded by a grant from The Robert Wood Johnson Foundation. Its components include Public Policy Panels, Communications Program, Technical Assistance, National Computer Network and National Leadership Fellows Program.

Contact: (617) 437-1500

Justice Research and Statistics Associattion

Publishes annual *Directory of Criminal Justice Issues in the States* which indicates by jurisdiction many of the justice-related issues and problems examined by the State Statistical Analysis Centers (SACs) throughout the country. The Directory also summarizes research undertaken by the SACs in response to these issues.

Contact: JRSA (202) 624-8560

Office of Applied Studies, Substance Abuse and Mental Health Services Administration

Is responsible for the collection and compilation of several national data sets on treatment and epidemiology.

Contact: Office of Applied Studies
(301) 443-6237

Healthy People 2000

A national strategy for significantly improving the health of the nation. It addresses the prevention of major chronic illnesses, injuries, and infectious diseases.

Contact: Claude Hall, Jr., American Public Health Association
(202) 789-5600

The National Association of County Health Officials (NACHO)

Publishes a directory of local health officials and promotes inter-organizational communication in the public health field.

Contact: NACHO (202) 783-5550

Drugs & Crime Data Center & Clearinghouse

Publishes a national directory of state drug resources, maintains a reference database, and operates a toll-free number with information specialists.

Contact: 1600 Research Boulevard
Rockville, MD 20850
(800) 666-3332

Other Helpful References

"Substance Abuse: The Nation's Number One Health Problem; Key Indicators for Policy." The Institute for Health Policy, Brandeis University for The Robert Wood Johnson Foundation. October 1993.

"Data Collections on Key Indicators for Policy: Alcohol, Illicit Drugs, and Tobacco." Prepared by M. J. Larson, J. C. Buckley, and E. A. Elliott at the Institute for Health Policy, Brandeis University, 1995.

"The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985." U.S. Department of Health and Human Services. Prepared by the Institute for Health & Aging, University of California, San Francisco. 1990.

"Prevention Plus II. Tools for Creating and Sustaining Drug-free Communities." U.S. Department of Health and Human Services, Office for Substance Abuse Prevention. 1989.

"Prevention Plus III. Assessing Alcohol and Other Drug Prevention Programs at the School and Community Levels. A Four-Step Guide to Useful Program Assessment." U.S. Department of Health and Human Services. 1991.

"Community Strategies for Health. Fitting In the Pieces." American Public Health Association. Model Standards Project. Centers for Disease Control and Prevention.

"The Guide to Implementing Model Standards. Eleven Steps Toward a Healthy Community." American Public Health Association. Model Standards Project. Centers for Disease Control and Prevention.

"Healthy Communities 2000. Model Standards." Guidelines for Community Attainment of the Year 2000 National Health Objectives. The American Public Health Association, Inc. 3rd Edition, 1991.

"Model Standards Project. Media Relations." American Public Health Association. Centers for Disease Control and Prevention.

"The Future by Design. A Community Framework for Preventing Alcohol and Other Drug Problems Through a Systems Approach." U.S. Department of Health and Human Services. Office for Substance Abuse Prevention. 1991.

"Keeping Score: What Are We Getting For Our Federal Drug Control Dollars." Drug Strategies. Washington, DC. 1995.

Join Together Publications: Obtain by calling (617) 437-1500.

"Strategies to Reduce Underage Access to Alcohol and Save Lives in Your Community." Community Action Guide.

"Save Lives! Report and Recommendations of the Join Together Public Policy Panel on Underage Access to Alcohol."

"Health Reform for Communities: Financing Substance Abuse Services." Recommendations from a Join Together Policy Panel.

"Alcohol and Drug Abuse in America: Policies for Prevention."

"Community Action Guide to Policies for Prevention. The Recommendations of the Join Together Policy Panel on Preventing Substance Abuse."

"Take Action on Five Policies America Must Adopt to Reduce and Prevent Substance Abuse."

Join Together is primarily funded by a grant from The Robert Wood Johnson Foundation to the Boston University School of Public Health

Join Together
44 Stuart Street, 6th Floor
Boston, MA 02116

Tel: (617) 437-1500
Fax: (617) 437-9394
email: info@joingether.org
http://www.jointogether.org

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Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

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