

**Midcourse  
Review**



**Substance Abuse 26**

**Co-Lead Agencies:**

National Institutes of Health  
Substance Abuse and Mental Health Services Administration

**Contents**

Goal . . . . .	26-3
Introduction . . . . .	26-3
Modifications to Objectives and Subobjectives . . . . .	26-3
Progress Toward Healthy People 2010 Targets . . . . .	26-4
Progress Toward Elimination of Health Disparities . . . . .	26-7
Opportunities and Challenges . . . . .	26-9
Emerging Issues . . . . .	26-9
Progress Quotient Chart . . . . .	26-11
Disparities Table . . . . .	26-15
Objectives and Subobjectives . . . . .	26-18
References . . . . .	26-39
Related Objectives From Other Focus Areas . . . . .	26-42



# Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

---

## Introduction\*

Substance abuse has a major impact on individuals, their families, and their communities. The effects of substance abuse are cumulative, contributing to costly social, physical, mental, and public health problems. These problems include teenage pregnancy, HIV/AIDS, other sexually transmitted diseases (STDs), domestic violence, child abuse, motor vehicle crashes, physical fights, crime, homicide, and suicide. Advances in preventing substance abuse and the provision of treatment to substance users have contributed to improved lives for many Americans. Although disparities in access to substance abuse treatment remain, some progress in reducing them has been accomplished. With regard to disparities in attitudes toward drug and alcohol use, data demonstrate that the highest rates of disapproval exist among youth in select racial and ethnic populations.

An estimated 23 million Americans struggle with a drug or alcohol problem.<sup>1</sup> Eighty-five percent of persons with substance use problems did not feel that they needed treatment.<sup>2</sup> An estimated 1.2 million persons felt they needed treatment but did not get it, 441,000 persons reported that they made an effort but were unable to get treatment, and 792,000 persons reported making no effort to get treatment.<sup>2</sup> These estimates underscore the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

## Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

As stated in *Healthy People 2010*: "Most developmental objectives have a potential data source with a reasonable expectation of data points by the year 2004 to facilitate setting 2010 targets in the mid-decade review. Developmental objectives with no baseline at the midcourse will be dropped." Accordingly, at the midcourse review some developmental objectives and subobjectives were deleted because they lacked a data source. However, the U.S. Department of Health and Human Services (HHS) and the agencies that serve as the leads for the Healthy People 2010 initiative will consider ways to ensure these public health issues retain prominence despite their current lack of data.

Several subobjectives were deleted, and others were modified to reflect methodological changes in data sources. Changes also included revision of text and division of objectives into subobjectives. Five objectives remained developmental.

---

\* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at <http://wonder.cdc.gov/data2010>. See the section on DATA2010 in the Technical Appendix for more information.

Objective 26-1, alcohol- and drug-related motor vehicle deaths and injuries, was modified to reflect current data collection practices. Subobjectives addressing alcohol- and drug-related injuries as well as drug-related deaths were deleted (26-1b, c, and d), because reliable data were not available. However, objective 26-1a, alcohol-related motor vehicle crash deaths, was retained. This objective now tracks the number of traffic deaths in which drivers had a .08 percent blood alcohol concentration (BAC) or higher.

Objective 26-8, lost productivity due to alcohol and drug abuse, was revised and became measurable. The objective was split into two subobjectives: lost productivity due to alcohol abuse (26-8a) and lost productivity due to drug abuse (26-8b). Objective 26-18, treatment for illicit drug and alcohol problems, became measurable and was reworded and subdivided to more accurately reflect the identified data source and treatment populations covered under the objective. Subobjective 26-18a tracks persons who need treatment for drug problems; 26-18b tracks persons who need treatment for both alcohol and illicit drug abuse.

The National Household Survey on Drug Abuse underwent several methodological changes during the period from 1999 to 2001. The survey name was also changed to the National Survey on Drug Use and Health. As a result, new 2002 baselines and revised targets were established for adolescent alcohol or illicit drug use (26-10a), adult illicit drug use (26-10c), adult binge drinking (26-11c), adolescent binge drinking (26-11d), adolescent inhalant use (26-15), and adolescents' perception of risk associated with alcohol and drug use (26-17a, b, and c). New 2002 baselines were established for average age at first alcohol use (26-9a), average age at first marijuana use (26-9b), and adolescent marijuana use (26-10b).

Treatment for alcohol abuse (26-21) became measurable. The objective was reworded to more accurately reflect the data source.

Data sources were identified, and baseline data are anticipated before the end of the decade for the following five developmental objectives: alcohol-related hospital emergency department visits (26-5), intentional injuries from alcohol- and drug-related violence (26-7), substance abuse treatment in correctional facilities (26-19), hospital emergency department referrals for alcohol or drug programs and suicide attempts (26-22), and community partnerships and coalitions to prevent substance abuse (26-23). Because data sources are anticipated by the end of the decade but no data were available at the time of the midcourse review, these objectives are still categorized as developmental.

Objective 26-22 was revised to provide two subobjectives: persons referred for followup care for alcohol problems, drug problems after diagnosis, or emergency department treatment for one of these conditions (26-22a) and persons referred for followup care for suicide attempts after diagnosis or treatment in an emergency department (26-22b).

## **Progress Toward Healthy People 2010 Targets**

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 26-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

**Objectives that met or exceeded their targets.** Students, grades 9 through 12, riding with a driver who has been drinking (26-6) achieved its target. In addition, a nationwide legal standard of .08 percent BAC maximum levels for driving while intoxicated (DWI)<sup>3</sup> enforcement and prosecution (26-25) was achieved. This standard represents an effective tool in the effort to combat drunk driving. Research has found that passage of a 0.08 percent BAC per se law, particularly when accompanied by publicity, results in a 6 percent to 8 percent reduction in alcohol-related fatalities.<sup>4</sup> The proportion of 8th graders who disapprove of trying marijuana or hashish once or twice (26-16d) increased from 69 percent in 1998 to 76 percent in 2004, exceeding the target of 72 percent.

**Objectives that moved toward their targets.** Alcohol-related motor vehicle crash deaths (26-1a) showed progress. Between 1998 and 2002, this objective achieved 20 percent of the targeted change. Alcohol-related fatalities decreased during the 1980s and early 1990s due to several factors, including tougher penalties for impaired drivers, raising the legal drinking age to 21 years, enhanced law enforcement, and the proliferation of grassroots organizations.<sup>5</sup> Since progress began to stall in the mid-1990s, the National Highway Traffic Safety Administration (NHTSA) has pursued a number of key strategies, including:<sup>6</sup>

- High-visibility law enforcement to promote general deterrence.
- Support of prosecutors handling DWI<sup>3</sup> cases.
- Use of DWI/drug courts to closely supervise high-risk offenders.
- Routine use of alcohol screening and brief interventions by medical and health care professionals.

In addition, NHTSA is developing strategies to reduce impaired-driving fatalities among persons at greatest risk.<sup>7</sup> Regarding youths, pursuant to congressional direction, the Substance Abuse and Mental Health Services Administration (SAMHSA) has convened an Interagency Coordinating Committee to Prevent Underage Drinking in which NHTSA is participating.<sup>7</sup>

The proportion of adults who exceed low-risk drinking guidelines (26-13) decreased between 1992 and 2002. As illustrated in the Progress Quotient (see Figure 26-1), the proportion of females who exceed low-risk drinking guidelines (26-13a) achieved 77 percent of the targeted change. In comparison, the proportion of males who exceed low-risk drinking guidelines (26-13b) achieved 54 percent of the targeted change. Between 1998 and 2004, the number of high school seniors never using alcohol (26-9c) or illicit drugs (26-9d) achieved 40 percent and 30 percent of their respective targeted changes. Overall drug use continued to decline: 600,000 fewer teens used drugs in 2004 than in 2001.<sup>8</sup>

When youth do not try drugs in their teenage years, their likelihood of having substance use problems later in life is reduced.<sup>9</sup> Adolescents' disapproval of substance abuse is inversely related to their reports of use.<sup>9</sup> From 1998 to 2004, increasing numbers of young people disapproved of substance use and abuse. Between 1998 and 2004, 8th graders' disapproval of one to two alcoholic drinks per day (26-16a) increased from 77 percent to 79 percent, achieving 33 percent of the targeted change. Disapproval of trying marijuana by 10th graders (26-16e) also increased, achieving 25 percent of the targeted change. Slight increases occurred in 12th graders' disapproval rates for daily alcohol use (26-16c) and trying marijuana (26-16f).

Adolescents' perception of the risk of smoking marijuana once a month (27-17b) achieved 75 percent of its targeted change between 2002 and 2003. In contrast, adolescents' perception of the risk of weekly binge drinking (26-17a) achieved 8 percent of the targeted change.

Between 1997 and 2002, treatment admissions for injection drug use (26-20) achieved 86 percent of the targeted change. Persons seeking help for intravenous or injection opioid abuse experience several barriers to treatment.<sup>10</sup> The most effective form of therapy—opioid agonist medical maintenance<sup>10</sup>—is limited to established treatment programs that do not reach patients in certain regions of the United States. New medications (buprenorphine products) and a new treatment modality (office-based opioid agonist medical maintenance) are expanding treatment options for injection drug use and bringing such emerging therapies into mainstream medicine.<sup>11</sup> SAMHSA is collaborating with the Food and Drug Administration to ensure that treatment centers for injection drug users are fully accredited and that physicians receive training on the use of buprenorphine in the treatment of persons with opioid addictions.

Several subobjectives experienced progress of less than 5 percent toward their targeted changes: cirrhosis deaths (26-2), adolescent use of marijuana (26-10b), adult use of illicit drugs (26-10c), and binge drinking in the past month by adults and adolescents (26-11c and d).

**Objectives that demonstrated no change.** Average age at first use of alcohol and marijuana among adolescents aged 12 to 17 years (26-9a and b) showed no change from 2002 to 2003. Also demonstrating no change were the proportion of adolescents who remained drug and alcohol free in the past 30 days (26-10a), binge drinking in the past 2 weeks by college students (26-11b), the proportion of 10th graders who disapprove of one to two drinks per day (26-16b), and the proportion of adolescents who perceive that using cocaine once per month poses a great risk (26-17c). In 2004, SAMHSA's Center for Substance Abuse Prevention implemented the Strategic Prevention Framework State Incentive Grant (SPF SIG) program, one of many efforts to improve and disseminate prevention strategies throughout the Nation.<sup>12</sup> The program's goals are as follows:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking.
- Reduce substance abuse-related problems in the community.
- Build prevention capacity and infrastructure at the State and community levels.

Every SPF SIG grantee is expected to conduct a needs assessment; mobilize and build capacity; develop a comprehensive strategic plan; implement evidence-based programs, practices, and policies, along with the community-level infrastructure to support them; and monitor and evaluate effectiveness and sustainability. Through the SPF SIG program, SAMHSA is working with its State and community partners to improve prevention and move these objectives toward their targets.

One initiative being implemented by SAMHSA's Center for Substance Abuse Treatment is the Targeted Capacity Expansion Campus Screening and Brief Intervention grants, which are promoting screening, brief interventions, and referrals to treatment among college and university students with a high risk of substance abuse disorders.<sup>13,14</sup> These grants are intended to expand existing campus-based medical services by integrating student health programs with screening and interventions for substance abuse and to motivate students to take appropriate action. In addition to the SPF SIG program, examples of effective programs to prevent drug abuse are reviewed in the National Institute on Drug Abuse (NIDA) publication, *Preventing Drug Abuse among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*.<sup>15</sup> The SPG SIG and the NIDA publication are efforts of HHS to address substance abuse among youth and other populations.

The number of States that have administrative license revocation laws for DWI (26-24) also showed no change. NHTSA continues to encourage States to require prompt, mandatory administrative revocation

or suspension of driver's licenses for alcohol and other drug test failure or refusal. As of December 2003, 41 States and the District of Columbia had adopted some form of administrative license revocation.<sup>16</sup>

**Objectives that moved away from their targets.** Drug-induced deaths (26-3) and drug-related emergency department visits (26-4) moved away from their targets. Drug-induced deaths are a broad measure of the overall impact of all drugs, making interpretation of the lack of progress difficult. SAMHSA's Drug Abuse Warning Network survey, which provides data on drug-related emergency department visits (26-4), has undergone significant revisions. The revisions have affected interpretation of trends. This change and other factors complicate analysis of progress toward the target.

Annual per capita alcohol consumption (26-12) moved away from its target. Again, interpretation is difficult, because drinking patterns vary significantly within the Nation's population.<sup>17</sup> More research is necessary to better understand changing patterns of heavy, moderate, light, and low-risk drinkers and to combine aggregate data, surveys, and longitudinal or panel studies to ask more specific questions about the Nation's drinking patterns.<sup>17</sup>

Subobjectives 26-14b and c—steroid use among 10th and 12th graders—moved away from their targets. Inhalant use in the past year among adolescents aged 12 to 17 years (26-15) also exhibited a 5 percent movement away from the targeted change.

The treatment gaps for alcohol or illicit drugs (26-18) and treatment for alcohol abuse (26-21) remain substantial and have moved away from their targets. These gaps suggest that treatment capacity should be expanded.<sup>18</sup> Dissemination of evidence-based treatment modalities and expanded services can contribute to reducing treatment gaps.

**Objectives that could not be assessed.** Although data sources were identified, no data were available for assessing five objectives: alcohol-related hospital emergency department visits (26-5), intentional injuries from alcohol- and drug-related violence (26-7), substance abuse treatment in correctional facilities (26-19), hospital emergency department referrals for alcohol or drug problems and suicide attempts (26-22), and community partnerships and coalitions to prevent substance abuse (26-23). Data beyond the baseline were not available for lost productivity in the workplace due to alcohol and drug use (26-8).

## Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 26-2), which displays information about disparities among select populations for which data were available for assessment.

Some progress in reducing disparities was made. The Asian or Pacific Islander population had the best rates for the objectives and subobjectives regarding alcohol-related motor vehicle deaths (26-1a), cirrhosis deaths (26-2), and drug-induced deaths (26-3). The Asian population had the best rates for average age at first use of marijuana (26-9b), adult binge drinking (26-11c), adult males and females exceeding low-risk drinking guidelines (26-13a and b), and adolescents' perception of risk of smoking marijuana once a month (26-17b).

The black population had the best rates for high school seniors who have never used alcohol (26-9c), high school seniors who have never used illicit drugs (26-9d), high school senior binge drinking in the past

2 weeks (26-11a), 8th graders' steroid use in the past year (26-14a), 10th graders' steroid use in the past year (26-14b), 12th graders' steroid use in the past year (26-14c), 10th graders' disapproval of one to two drinks a day (26-16b), 12th graders' disapproval of one to two drinks a day (26-16c), and 12th graders' disapproval of trying marijuana (26-16f). The black non-Hispanic population had the best rates for adolescents who have not used alcohol or illicit drugs in the past 30 days (26-10a), adolescents who have used marijuana in the past 30 days (26-10b), adolescents' perception of risk of more than five drinks one to two times a week (26-17a), adolescents' perception of risk of using cocaine once a month (26-17c), treatment for illicit drug problems in the past year (26-18a), treatment for alcohol and illicit drug problems in the past year (26-18b), and treatment for alcohol abuse (26-21).

Females had better rates than males except for the following objectives for which males had the better rate: 9th through 12th graders' riding in the past 30 days with a driver who has been drinking (26-6), high school seniors who have never used alcohol (26-9c), adolescents who have had no alcohol or illicit drugs in the past 30 days (26-10a), adolescents' inhalant use in the past year (26-15), adolescents' perception of risk of using cocaine once a month (26-17c), treatment for illicit drug problems in the past year (26-18a), treatment for alcohol and illicit drug problems in the past year (26-18b), and treatment for alcohol abuse (26-21). The male rates were at least twice the female rates for alcohol-related motor vehicle deaths (26-1a), cirrhosis deaths (26-2), adult binge drinking (26-11c), and steroid use by 10th graders (26-14b).

Disparity measures for education level were available for cirrhosis deaths (26-2), drug-induced deaths (26-3), females aged 21 years and older who exceeded low-risk drinking guidelines in the past year (26-13a), and males aged 21 years and older who exceeded low-risk drinking guidelines in the past year (26-13b). Persons with at least some college had the best rates for all of these objectives and subobjectives except females aged 21 years and older who exceeded low-risk drinking guidelines in the past year (26-13a). The best group for this subobjective was high school graduates.

In general, the disparities with respect to income level were less than 10 percent or not statistically significant. Poor persons (mostly those with family incomes less than \$20,000 per year) had the best rate for no alcohol or illicit drug use in the past 30 days by adolescents (26-10a); binge drinking in the past 30 days by adults (26-11c); binge drinking in the past 30 days by adolescents aged 12 to 17 years (26-11d); and adolescents aged 12 to 17 years who perceived risk in having five or more drinks one to two times per week (26-17a), smoking marijuana once a month (26-17b), using cocaine once a month (26-17c), as well as for treatment for alcohol and illicit drug problems in the past year (26-18b) and treatment for alcohol abuse (26-21).

Progress in reducing disparities among population groups was mixed. Disparities in binge drinking decreased over time by 10 to 49 percentage points between groups for three subobjectives: white and black high school seniors (26-11a), male and female high school seniors (26-11a), and male and female college students (26-11b). Reductions in the disparities over time for steroid use were observed between Hispanic and black 8th, 10th, and 12th graders (26-14a, b, and c); male and female 8th, 10th, and 12th graders; and white and black 8th graders (26-14a).

Some objectives showed a variety of changes (decreases and increases) in disparity across population groups. Disparities in cirrhosis (26-2) and drug-induced (26-3) deaths between the white non-Hispanic and Asian or Pacific Islander populations increased, while disparities between males and females declined. The disparity in cirrhosis deaths (26-2) increased for high school graduates relative to the population with at least some college. The disparity in drug-induced deaths (26-3) between persons with less than a high school education and those with at least some college declined. Disparities in disapproval



of one to two drinks per day declined between Hispanic and white as well as male and female 8th graders (26-16a), between white and black 10th graders (26-10b), and between male and female 12th graders (26-16c). However the disparity between Hispanic and white 12th graders relative to black 12th graders increased. Disparities in disapproval of trying marijuana increased between black and white 8th graders (26-16d) and decreased between white and Hispanic 10th graders (26-16e).

An increase in disparity for adult binge drinking was observed between Native Hawaiian or other Pacific Islander and Asian populations (26-11c). Increases in disparities were also seen in adult females exceeding low-risk drinking guidelines (26-13a) for the American Indian or Alaska Native, Hispanic, and white non-Hispanic populations relative to the Asian population. Similarly, increases in disparities were seen in adult males exceeding low-risk drinking guidelines (26-13b) for the American Indian or Alaska Native and Hispanic populations relative to the Asian population.

## Opportunities and Challenges

Substance abuse and mental illness are associated with risky behaviors that may lead to STDs, including HIV.<sup>19</sup> Injection drug use remains a primary vector of co-infection with hepatitis.<sup>20</sup> Persons with HIV/AIDS and injection drug users are among the largest populations needing substance abuse treatment and HIV/AIDS prevention and treatment services.<sup>21</sup> HIV infection among females in the United States is associated primarily with unprotected heterosexual contacts.<sup>21</sup> Pediatric AIDS is a particularly virulent problem among the children of persons involved in drug-related lifestyles.<sup>22</sup>

Designated States or U.S. jurisdictions with high AIDS rates are required to set aside a percentage of their Substance Abuse Prevention and Treatment Block Grant funds to provide HIV early intervention services (pretest counseling, testing, posttest counseling, and therapeutic measures to prevent and treat deterioration of immune system and other medical conditions). In 2004, SAMHSA began the Rapid HIV Testing Initiative, which provides free rapid oral fluid HIV 1 and 2 test kits to qualified programs in support of early intervention services. Key elements in preventing the spread of HIV/AIDS and hepatitis must include improved access to mental health and substance abuse treatment for injection drug users, as well as risk reduction prevention programs that promote awareness of the consequences of substance abuse and its association with increased sexual risk-taking and STDs.

As noted earlier, rates of adolescents' disapproval toward drug and alcohol use have shown improvement, and disapproval is inversely related to use. Prevention programs can capitalize accordingly and create initiatives that reinforce risk-reducing behaviors.

## Emerging Issues

Research continues to provide valuable new information for improving drug abuse prevention and treatment services, especially among children, adolescents, and young adults. Ongoing monitoring and surveillance of drug use trends, such as those conducted by the NIDA Community Epidemiological Work Group<sup>23</sup> and the SAMHSA State Epidemiology and Outcomes Workgroup,<sup>24</sup> can inform resources allocation for prevention and treatment.

In 2001, approximately 1,700 college students aged 18 to 24 years died from alcohol-related unintentional injuries. Furthermore, the high proportion of binge drinkers in the college population did not decline between 1999 and 2002.<sup>25</sup> The National Institute on Alcohol Abuse and Alcoholism (NIAAA) published

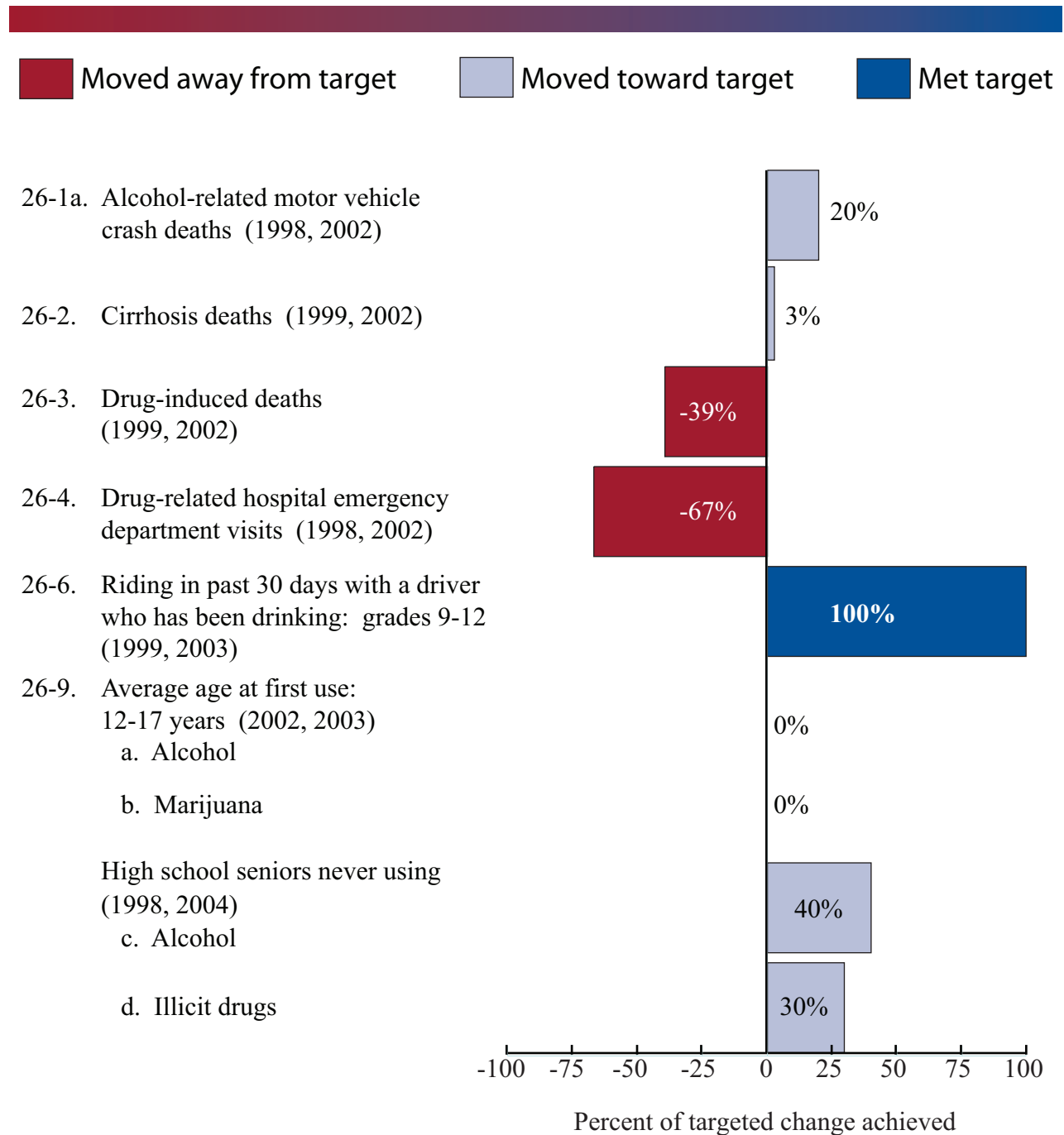
a report,<sup>26</sup> prepared by a task force of college presidents and research scientists that examined the magnitude of college drinking problems and identified scientifically validated programs and policies found to reduce associated problems. A copy of the report was sent to every college president in the United States. Recently, NIAAA has supported scientific research at 15 colleges and universities and the California University system to test additional proposed interventions to reduce college drinking.

A perspective that addresses brain development in adolescence is essential for understanding underage drinking and for the development of successful interventions. Drug and alcohol use in early adolescence affects the development of the adolescent brain.<sup>27</sup> Early use of alcohol is a risk factor for later alcohol-related problems, including alcohol dependence. The problems peak among persons between the ages of 18 and 24 years.<sup>9</sup> An NIAAA task force is addressing this critical public health problem in the context of adolescent brain development. As a first step, NIAAA has published a special issue of *Alcohol Research & Health*.<sup>28</sup> Future efforts will focus on fully integrating a developmental approach to understanding and addressing drinking by youth.

Another issue is methamphetamine, a highly addictive and dangerous drug.<sup>29</sup> Research shows that methamphetamine abuse is spreading, especially in rural areas. Methamphetamine production and supply patterns have been changing. Production in small, clandestine labs in the United States has been decreasing. An increasing proportion of methamphetamine used in the United States is being produced in large labs in Mexico and distributed by Mexican drug trading organizations.<sup>30</sup> Additional health risks are associated with the cleanup of methamphetamine laboratories.<sup>31</sup>

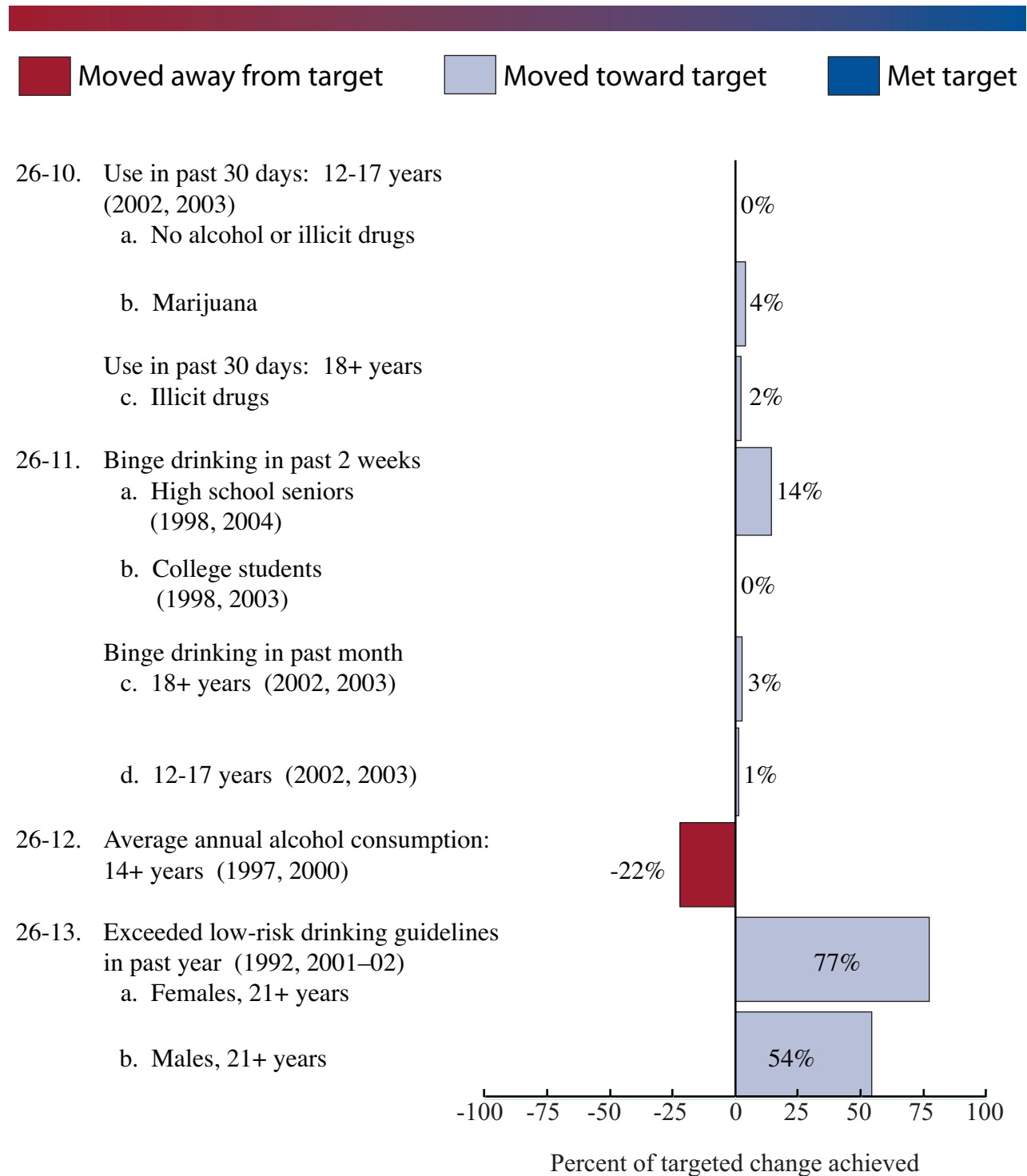
In addition to illicit and controlled substance use, a recent national study identified an emerging trend in the abuse of prescription and over-the-counter drugs.<sup>32</sup> Hydrocodone, oxycodone, methylphenidate, and amphetamines are among the most abused drugs.<sup>32</sup> Research on the treatment protocols of methamphetamine continues to improve. These efforts are part of a larger strategic prevention framework being implemented nationwide through collaboration with State, local, and community-based organizations. Healthy People 2010 substance abuse objectives will continue to guide States in implementing policy and programs that address substance prevention and treatment.

**Figure 26-1. Progress Quotient Chart for Focus Area 26: Substance Abuse**



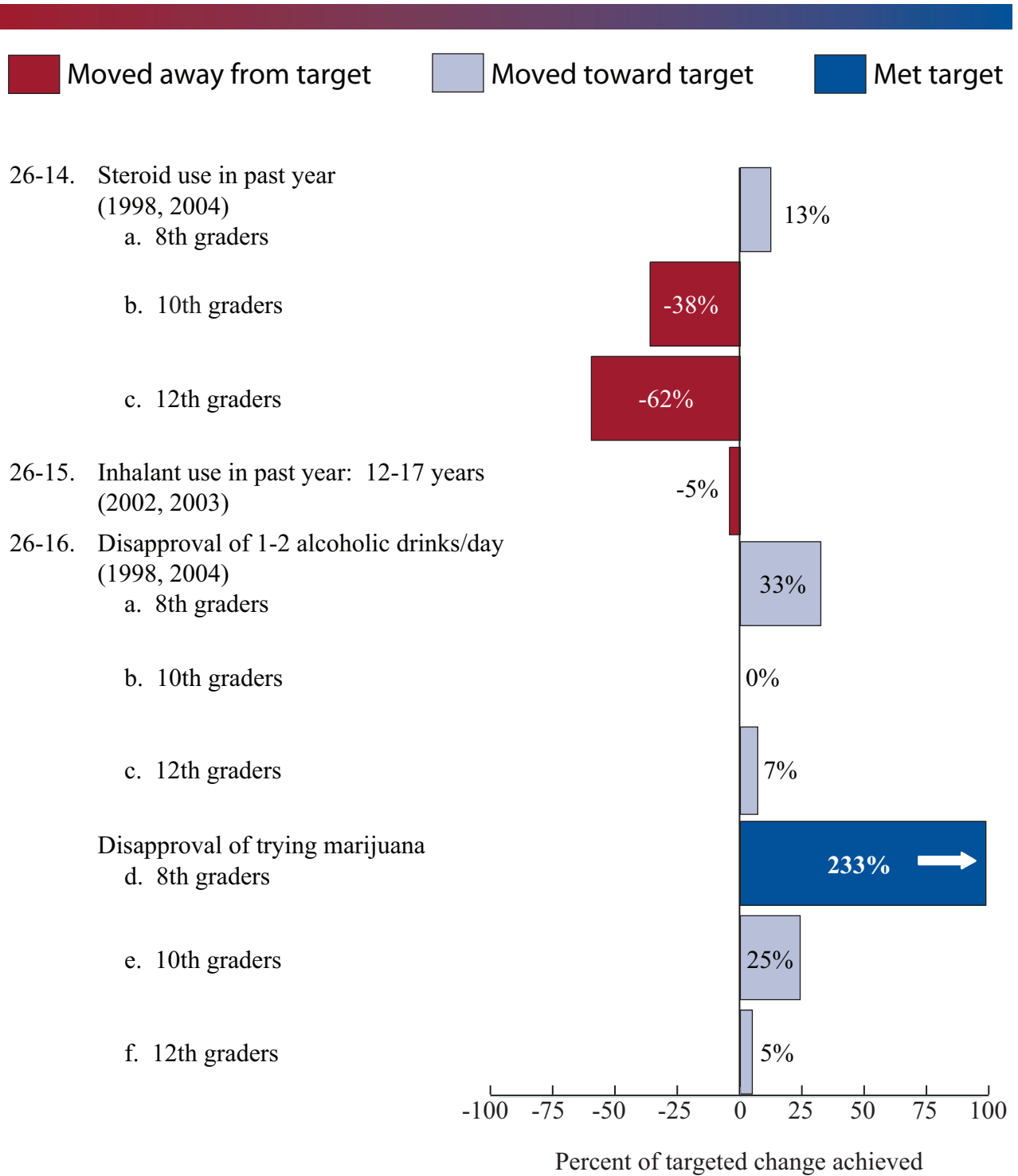
See notes at end of chart. (continued)

Figure 26-1. (continued)



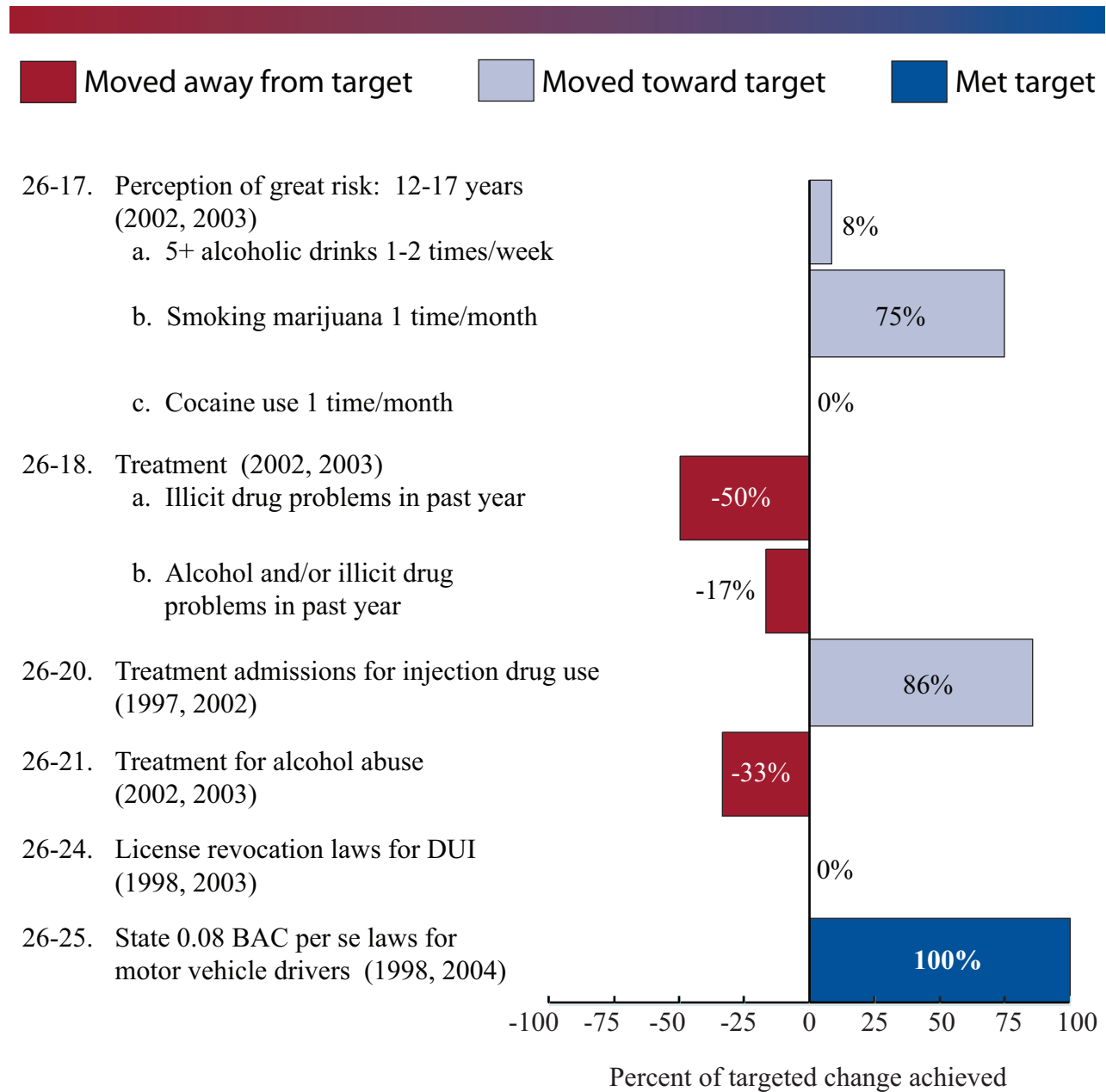
See notes at end of chart. (continued)

Figure 26-1. (continued)



See notes at end of chart. (continued)

Figure 26-1. (continued)



**Notes:** Tracking data for objectives 26-5, 26-7, 26-8a and b, 26-19, 26-22, and 26-23 are unavailable. Objectives 26-1b, c, and d were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left( \frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}} \right) \times 100$$

**Figure 26-2. Disparities Table for Focus Area 26: Substance Abuse**

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

	Characteristics																	
	Race and ethnicity							Gender		Education			Income					
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Female	Male	Less than high school	High school graduate	At least some college	Summary index	Poor	Near poor	Middle/high income	Summary index
<b>Population-based objectives</b>																		
26-1a. Alcohol-related motor vehicle crash deaths (1998) † <sup>1</sup>		B <sup>2</sup>				3	3		B									
26-2. Cirrhosis deaths (1999, 2002) *		B <sup>2</sup>					↑		B	↓		↑	B					
26-3. Drug-induced deaths (1999, 2002) *		B <sup>2</sup>					↑↑		B	↓	↓		B					
26-6. Riding in past 30 days with a driver who has been drinking: grades 9-12 (1999, 2003) *							B		B									
26-9a. Average age at first use of alcohol: 12-17 years (2002, 2003) *			B						B						4	4	B <sup>4</sup>	
26-9b. Average age at first use of marijuana: 12-17 years (2002, 2003) *		B							B						4	4	B <sup>4</sup>	
26-9c. Never used alcohol: high school seniors (1998, 2004) †						B <sup>3</sup>	3		B									
26-9d. Never used illicit drugs: high school seniors (1998, 2004) †						B <sup>3</sup>	3		B									
26-10a. No alcohol or illicit drugs in the past 30 days: 12-17 years (2002, 2003) *		b				B			B					B				
26-10b. Used marijuana in the past 30 days: 12-17 years (2002, 2003) *		b				B			B								B	
26-10c. Used illicit drugs in the past 30 days: 18+ years (2002, 2003) *		b			B				B									
26-11a. Binge drinking in the past 2 weeks: high school seniors (1998, 2004) †						B <sup>3</sup>	↓ <sup>3</sup>		B	↓								
26-11b. Binge drinking in the past 2 weeks: college students (1998, 2003) †									B	↓								
26-11c. Binge drinking in the past 30 days: 18+ years (2002, 2003) *		B	↑↑						B					B <sup>4</sup>	4	4		
26-11d. Binge drinking in the past 30 days: 12-17 years (2002, 2003) *		b			B	b			B					B <sup>4</sup>	4	4		
26-13a. Exceeded low-risk drinking guidelines in past year: females 21+ years (1992, 2001-02) †	↑	B			↑		↑				B							
26-13b. Exceeded low-risk drinking guidelines in past year: males 21+ years (1992, 2001-02) †	↑	B			↑↑							B						
26-14a. Steroid use in the past year: 8th graders (1998, 2004) †					↓	B <sup>3</sup>	↓ <sup>3</sup>	↓	B	↓↓								
26-14b. Steroid use in the past year: 10th graders (1998, 2004) †					↓	B <sup>3</sup>	3		B	↓↓								
26-14c. Steroid use in the past year: 12th graders (1998, 2004) †					↓↓	B <sup>3</sup>	↑ <sup>3</sup>	↓	B	↓↓								

(continued)

Figure 26-2. (continued)

Population-based objectives	Characteristics																	
	Race and ethnicity							Gender		Education level			Income level					
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Female	Male	Less than high school	High school graduate	At least some college	Summary index	Poor	Near poor	Middle/high income	Summary index
26-15. Inhalant use in the past year: 12-17 years (2002, 2003) *									B						4	B <sup>4</sup>	4	
26-16a. Disapproval of 1-2 drinks/day: 8th graders (1998, 2004) †					↓	3	B <sup>3</sup>		B	↓								
26-16b. Disapproval of 1-2 drinks/day: 10th graders (1998, 2004) †						B <sup>3</sup>	↓ <sup>3</sup>	↓	B									
26-16c. Disapproval of 1-2 drinks/day: 12th graders (1998, 2004) †					↑	B <sup>3</sup>	↑ <sup>3</sup>	↑	B	↓								
26-16d. Disapproval of trying marijuana: 8th graders (1998, 2004) †						↑ <sup>3</sup>	B <sup>3</sup>	↑	B									
26-16e. Disapproval of trying marijuana: 10th graders (1998, 2004) †					B	3	↓ <sup>3</sup>		B									
26-16f. Disapproval of trying marijuana: 12th graders (1998, 2004) †						B <sup>3</sup>	3		B									
26-17a. Perception of risk of 5+ drinks 1-2 times/week: 12-17 years (2002, 2003) *						B			B						B <sup>4</sup>	4	4	
26-17b. Perception of risk of smoking marijuana once a month: 12-17 years (2002, 2003) *		B							B						B <sup>4</sup>	4	4	
26-17c. Perception of risk of using cocaine once a month: 12-17 years (2002, 2003) *						B			B						B <sup>4</sup>	4	4	
26-18a. Treatment for illicit drug problems in the past year (2002, 2003) *						B			B									
26-18b. Treatment for alcohol and/or illicit drug problems in the past year (2002, 2003) †						B			B						B <sup>4</sup>	4	4	
26-21. Treatment for alcohol abuse (2002, 2003) *						B			B						B <sup>4</sup>	4	4	

**Notes:** Data for objectives 26-4, 26-5, 26-7, 26-8a and b, 26-12, 26-19, 26-20, and 26-22 through 26-25 are unavailable or not applicable. Objectives 26-1b, c, and d were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

(continued)



**Figure 26-2. (continued)**

The <b>best group rate</b> at the most recent data point.	<input type="checkbox"/> B	The group with the best rate for specified characteristic.	<input type="checkbox"/> b	Most favorable group rate for specified characteristic, but reliability criterion not met.	<input type="checkbox"/>	Best group rate reliability criterion not met.		
<b>Percent difference from the best group rate</b>								
<b>Disparity from the best group rate</b> at the most recent data point.	<input type="checkbox"/>	Less than 10 percent or not statistically significant	<input type="checkbox"/>	10-49 percent	<input type="checkbox"/>	50-99 percent	<input type="checkbox"/>	100 percent or more
<b>Increase in disparity (percentage points)</b>								
Changes in <b>disparity</b> over time are shown when the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available.	↑ 10-49		↑↑ 50-99		↑↑↑ 100 or more			
	<b>Decrease in disparity (percentage points)</b>							
	↓ 10-49		↓↓ 50-99		↓↓↓ 100 or more			
	<b>Availability of data.</b>							
	<input type="checkbox"/>	Data not available.	<input type="checkbox"/>	Characteristic not selected for this objective.				

\* The variability of best group rates was assessed, and disparities of  $\geq 10\%$  are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

<sup>1</sup> Baseline data by race and ethnicity are for 1995.

<sup>2</sup> Data are for Asians or Pacific Islanders.

<sup>3</sup> Data include persons of Hispanic origin.

<sup>4</sup> Family income level: \$0-\$19,999, \$20,000-\$35,000, \$35,000+.

## Objectives and Subobjectives for Focus Area 26: Substance Abuse

---

**Goal:** Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010*.

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.<sup>1</sup>

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

---

<sup>1</sup> See Technical Appendix for more information on baseline and target revisions.

## Adverse Consequences of Substance Use and Abuse

### ORIGINAL OBJECTIVE

#### 26-1. Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.

##### Target and baseline:

Objective	Reduction in Consequences of Motor Vehicle Crashes	1998 Baseline	2010 Target
		<i>Per 100,000 Population</i>	
<b>26-1a.</b>	Alcohol-related deaths	5.3 <sup>1</sup>	4.8 <sup>2</sup>
<b>26-1b.</b>	Alcohol-related injuries	113	65
<b>26-1c.</b>	Drug-related deaths	Developmental	
<b>26-1d.</b>	Drug-related injuries	Developmental	

**Target setting method:** Consistent with the U.S. Department of Transportation for 26-1a; 47 percent improvement for 26-1b.

**Data sources:** Fatality Analysis Reporting System (FARS), DOT, NHTSA; General Estimates System (GES), DOT.

<sup>1</sup> Baseline revised from 5.9 after November 2000 publication.

<sup>2</sup> Target revised from 4 because of baseline revision after November 2000 publication.

### OBJECTIVE WITH REVISIONS (Including subobjectives deleted)

#### 26-1. Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.

##### Target and baseline:

Objective*	Reduction in Consequences of Motor Vehicle Crashes	1998 Baseline	2010 Target
		<i>Per 100,000 Population</i>	
<b>26-1a.</b>	Alcohol-related <u>motor vehicle crash</u> deaths	5.3 <sup>1</sup>	4.8 <sup>2</sup>
<b>26-1b.</b>	<i>(Subobjective deleted due to lack of data source)*</i> Alcohol-related injuries	113	65
<b>26-1c.</b>	<i>(Subobjective deleted due to lack of data source)*</i> Drug-related deaths	Developmental	
<b>26-1d.</b>	<i>(Subobjective deleted due to lack of data source)*</i> Drug-related injuries	Developmental	

\* For data control purposes, subobjectives are not renumbered.

**OBJECTIVE WITH REVISIONS (continued)  
(Including subobjectives deleted)**

**Target setting method:** Consistent with the U.S. Department of Transportation.

**Data source:** Fatality Analysis Reporting System (FARS), DOT, NHTSA.

<sup>1</sup> Baseline revised from 5.9 after November 2000 publication.

<sup>2</sup> Target revised from 4 because of baseline revision after November 2000 publication.

**REVISED OBJECTIVE**

**26-1. Reduce deaths caused by alcohol-related motor vehicle crashes.**

**Target and baseline:**

Objective*	Reduction in Deaths	1998 Baseline	2010 Target
		<i>Per 100,000 Population</i>	
<b>26-1a.</b>	Alcohol-related motor vehicle crash deaths	5.3 <sup>1</sup>	4.8 <sup>2</sup>

\* For data control purposes, subobjectives are not renumbered.

**Target setting method:** Consistent with the U.S. Department of Transportation.

**Data source:** Fatality Analysis Reporting System (FARS), DOT, NHTSA.

<sup>1</sup> Baseline revised from 5.9 after November 2000 publication.

<sup>2</sup> Target revised from 4 because of baseline revision after November 2000 publication.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**26-2. Reduce cirrhosis deaths.**

**Target:** 3.2<sup>1</sup> deaths per 100,000 population.

**Baseline:** 9.6<sup>2</sup> cirrhosis deaths per 100,000 population occurred in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 3.0 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 9.5 and 1998 after November 2000 publication.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**26-3. Reduce drug-induced deaths.**

**Target:** 1.2<sup>1</sup> deaths per 100,000 population.

**Baseline:** 6.8<sup>2</sup> drug-induced deaths per 100,000 population occurred in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 1.0 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 6.3 and 1998 after November 2000 publication.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**26-4. Reduce drug-related hospital emergency department visits.**

**Target:** 349,810<sup>1</sup> visits per year.

**Baseline:** 542,250<sup>2</sup> hospital emergency department visits by patients aged 6 to 97 years were drug-related in 1998.

**Target setting method:** 35 percent improvement.

**Data source:** Drug Abuse Warning Network (DAWN), SAMHSA.

<sup>1</sup> Target revised from 350,000 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline revised from 542,544 after November 2000 publication.

**NO CHANGE IN OBJECTIVE**

**26-5. (Developmental) Reduce alcohol-related hospital emergency department visits.**

**Potential data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

**NO CHANGE IN OBJECTIVE**

**26-6. Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.**

**Target:** 30 percent.

### NO CHANGE IN OBJECTIVE *(continued)*

**Baseline:** 33 percent of students in grades 9 through 12 reported riding during the previous 30 days with a driver who had been drinking alcohol in 1999.

**Target setting method:** Better than the best.

**Data source:** Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

### NO CHANGE IN OBJECTIVE

**26-7. (Developmental) Reduce intentional injuries resulting from alcohol- and illicit drug-related violence.**

**Potential data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

### ORIGINAL OBJECTIVE

**26-8. (Developmental) Reduce the cost of lost productivity in the workplace due to alcohol and drug use.**

**Potential data source:** Periodic estimates of economic costs of alcohol and drug use, NIH, NIAAA and NIDA.

### OBJECTIVE WITH REVISIONS

**26-8. (Developmental) Reduce the cost of lost productivity in the workplace due to alcohol and drug use.**

**Target and baseline:**

Objective	Reduction in the Cost of Lost Productivity in the Workplace	1998 Baseline	2010 Target
		<i>Dollars per Capita</i>	
<b>26-8a.</b>	Due to alcohol abuse	\$468	\$435
<b>26-8b.</b>	Due to drug abuse	\$360	\$335

**Target setting method:** 7 percent improvement.

**Potential data sources:** Office of National Drug Control Policy (ONDCP); Periodic estimates of economic costs of alcohol and drug use, NIH, NIAAA and NIDA.

### REVISED OBJECTIVE

**26-8. Reduce the cost of lost productivity in the workplace due to alcohol and drug use.**

### REVISED OBJECTIVE (continued)

**Target and baseline:**

Objective	Reduction in the Cost of Lost Productivity in the Workplace	1998 Baseline	2010 Target
		<i>Dollars per Capita</i>	
<b>26-8a.</b>	Due to alcohol abuse	\$468	\$435
<b>26-8b.</b>	Due to drug abuse	\$360	\$335

**Target setting method:** 7 percent improvement.

**Data sources:** Office of National Drug Control Policy (ONDCP); NIH, NIAAA.

### Substance Use and Abuse

### ORIGINAL OBJECTIVE

**26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.**

**Target and baseline:**

Objective	Increase in Average Age of First Use in Adolescents Aged 12 to 17 Years	1998 Baseline	2010 Target
		<i>Average Age in Years</i>	
<b>26-9a.</b>	Alcohol	13.1	16.1
<b>26-9b.</b>	Marijuana	13.7	17.4

**Target setting method:** Better than the best for alcohol use; consistent with Office of National Drug Control Policy for marijuana use.

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

**Target and baseline:**

Objective	Increase in High School Seniors Never Using Substances	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-9c.</b>	Alcoholic beverages	19	29
<b>26-9d.</b>	Illicit drugs	46	56

**Target setting method:** Better than the best.

**Data source:** Monitoring the Future Study, NIH, NIDA.

## OBJECTIVE WITH REVISIONS

**26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.**

**Target and baseline:**

Objective	Increase in Average Age of First Use in Adolescents Aged 12 to 17 Years	<del>1998</del> 2002 Baseline	2010 Target
		<i>Average Age in Years</i>	
<b>26-9a.</b>	Alcohol	13.0 <del>1</del>	16.1
<b>26-9b.</b>	Marijuana	13.7 <del>6</del>	17.4

**Target setting method:** ~~Better than the best for alcohol use; consistent with Office of National Drug Control Policy for marijuana use.~~

**Data sources:** ~~National Household Survey on Drug Abuse and Health (NSDUHSDA); SAMHSA.~~

**Target and baseline:**

Objective	Increase in High School Seniors Never Using Substances	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-9c.</b>	Alcoholic beverages	19	29
<b>26-9d.</b>	Illicit drugs	46	56

**Target Setting Method:** Better than the best.

**Data sources:** National Survey on Drug Use and Health (NSDUH), SAMHSA; Monitoring the Future Study, NIH, NIDA.

## REVISED OBJECTIVE

**26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.**

**Target and baseline:**

Objective	Increase in Average Age of First Use in Adolescents Aged 12 to 17 Years	2002 Baseline	2010 Target
		<i>Average Age in Years</i>	
<b>26-9a.</b>	Alcohol	13.0	16.1
<b>26-9b.</b>	Marijuana	13.6	17.4

**Target and baseline:**

Objective	Increase in High School Seniors Never Using Substances	1998 Baseline	2010 Target



## REVISED OBJECTIVE (continued)

		Percent	
26-9c.	Alcoholic beverages	19	29
26-9d.	Illicit drugs	46	56

**Target setting method:** Better than the best.

**Data sources:** National Survey on Drug Use and Health (NSDUH), SAMHSA; Monitoring the Future Study, NIH, NIDA.

## ORIGINAL OBJECTIVE

### 26-10. Reduce past-month use of illicit substances.

**26-10a.** Increase the proportion of adolescents not using alcohol or any illicit drug during the past 30 days.

**Target:** 89 percent.

**Baseline:** 79 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in 1998.

**Target setting method:** Better than the best.

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

**26-10b.** Reduce the proportion of adolescents reporting use of marijuana during the past 30 days.

**Target:** 0.7 percent.

**Baseline:** 8.3 percent of adolescents aged 12 to 17 years reported marijuana use in the past 30 days in 1998.

**Target setting method:** Better than the best (consistent with the Office of National Drug Control Policy).

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

**26-10c.** Reduce the proportion of adults using any illicit drug during the past 30 days.

**Target:** 2.0 percent.

## ORIGINAL OBJECTIVE (*continued*)

**Baseline:** 5.8 percent of adults aged 18 years and older used any illicit drug during the past 30 days in 1998.

**Target setting method:** Better than the best (consistent with Office of National Drug Control Policy).

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

## OBJECTIVE WITH REVISIONS

### 26-10. Reduce past-month use of illicit substances.

**26-10a.** Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

**Target:** 9189 percent.

**Baseline:** 798 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in ~~1998~~2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH)~~National Household Survey on Drug Abuse (NHSDA)~~, SAMHSA.

**26-10b.** Reduce the proportion of adolescents reporting use of marijuana during the past 30 days.

**Target:** 0.7 percent.

**Baseline:** 8.32 percent of adolescents aged 12 to 17 years reported marijuana use in the past 30 days in ~~1998~~2002.

**Target setting method:** ~~Better than the best (consistent with the Office of National Drug Control Policy).~~

**Data source:** ~~National Household Survey on Drug Abuse (NHSDA)~~National Survey on Drug Use and Health (NSDUH), SAMHSA.

**26-10c.** Reduce the proportion of adults using any illicit drug during the past 30 days.

**Target:** ~~2.0~~3.2 percent.

**Baseline:** ~~5.8~~7.9 percent of adults aged 18 years and older used any illicit drug during the past 30 days in ~~1998~~2002.

## OBJECTIVE WITH REVISIONS (*continued*)

**Target setting method:** Better than the best (~~consistent with Office of National Drug Control Policy~~).

**Data source:** ~~National Survey on Drug Use and Health (NSDUH)~~ National Household Survey on Drug Abuse (NHSDA), SAMHSA.

## REVISED OBJECTIVE

### 26-10. Reduce past-month use of illicit substances.

**26-10a.** Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

**Target:** 91 percent.

**Baseline:** 78 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in 2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

**26-10b.** Reduce the proportion of adolescents reporting use of marijuana during the past 30 days.

**Target:** 0.7 percent.

**Baseline:** 8.2 percent of adolescents aged 12 to 17 years reported marijuana use in the past 30 days in 2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

**26-10c.** Reduce the proportion of adults using any illicit drug during the past 30 days.

**Target:** 3.2 percent.

**Baseline:** 7.9 percent of adults aged 18 years and older used any illicit drug during the past 30 days in 2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

## ORIGINAL OBJECTIVE

**26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.**

**Target and baseline:**

Objective	Reduction in Students Engaging in Binge Drinking During Past 2 Weeks	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11a.</b>	High school seniors	32	11
<b>26-11b.</b>	College students	39	20

**Target setting method:** Better than the best for 26-11a; 49 percent improvement for 26-11b. (Better than the best will be used when data are available.)

**Data source:** Monitoring the Future Study, NIH, NIDA.

**Target and baseline:**

Objective	Reduction in Adults and Adolescents Engaging in Binge Drinking During Past Month	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11c.</b>	Adults aged 18 years and older	16.6	6.0
<b>26-11d.</b>	Adolescents aged 12 to 17 years	7.7	2.0

**Target setting method:** Better than the best.

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

## OBJECTIVE WITH REVISIONS

**26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.**

**Target and baseline:**

Objective	Reduction in Students Engaging in Binge Drinking During <u>the</u> Past 2 Weeks	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11a.</b>	High school seniors	32	11
<b>26-11b.</b>	College students	39	20

**Target setting method:** Better than the best for 26-11a; 49 percent improvement for 26-11b. (Better than the best will be used when data are available.)

**Data source:** Monitoring the Future Study, NIH, NIDA.

## OBJECTIVE WITH REVISIONS *(continued)*

**Target and baseline:**

Objective	Reduction in Adults and Adolescents Engaging in Binge Drinking During the Past Month	1998 2002 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11c.</b>	Adults aged 18 years and older	16.6 24.3	6.0 13.4
<b>26-11d.</b>	Adolescents aged 12 to 17 years	7.7 10.7	2.0 3.1

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH) National Household Survey on Drug Abuse (NHSDA), SAMHSA.

## REVISED OBJECTIVE

**26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.**

**Target and baseline:**

Objective	Reduction in Students Engaging in Binge Drinking During the Past 2 Weeks	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11a.</b>	High school seniors	32	11
<b>26-11b.</b>	College students	39	20

**Target setting method:** Better than the best for 26-11a; 49 percent improvement for 26-11b. (Better than the best will be used when data are available.)

**Data source:** Monitoring the Future Study, NIH, NIDA.

**Target and baseline:**

Objective	Reduction in Adults and Adolescents Engaging in Binge Drinking During the Past Month	2002 Baseline	2010 Target
		<i>Percent</i>	
<b>26-11c.</b>	Adults aged 18 years and older	24.3	13.4
<b>26-11d.</b>	Adolescents aged 12 to 17 years	10.7	3.1

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**26-12. Reduce average annual alcohol consumption.**

**Target:** 1.96<sup>1</sup> gallons.

**Baseline:** 2.14<sup>2</sup> gallons of ethanol per person aged 14 years and older were consumed in 1997.

**Target setting method:** 8.3<sup>3</sup> percent improvement.

**Data source:** Alcohol Epidemiologic Data System (AEDS), NIH, NIAAA.

<sup>1</sup> Target revised from 2 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline revised from 2.18 after November 2000 publication.

<sup>3</sup> Target setting method corrected after November 2000 publication.

**NO CHANGE IN OBJECTIVE**

**26-13. Reduce the proportion of adults who exceed guidelines for low-risk drinking.**

**Target and baseline:**

Objective	Reduction in Adults Aged 21 Years and Older Exceeding Guidelines for Low-Risk Drinking	1992 Baseline	2010 Target
		<i>Percent</i>	
<b>26-13a.</b>	Females	72	50
<b>26-13b.</b>	Males	74	50

**Target setting method:** Better than the best.

**Data source:** National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), NIH, NIAAA.

**NO CHANGE IN OBJECTIVE**

**26-14. Reduce steroid use among adolescents.**

**Target and baseline:**

Objective	Reduction in Steroid Use Among Adolescents in Past Year	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-14a.</b>	8th graders	1.2	0.4
<b>26-14b.</b>	10th graders	1.2	0.4

### NO CHANGE IN OBJECTIVE (continued)

26-14c.	12th graders	1.7	0.4
---------	--------------	-----	-----

**Target setting method:** Better than the best.

**Data source:** Monitoring the Future Study, NIH, NIDA.

### ORIGINAL OBJECTIVE

**26-15. Reduce the proportion of adolescents who use inhalants.**

**Target:** 0.7 percent.

**Baseline:** 2.9 percent of adolescents aged 12 to 17 years used inhalants in the past year in 1998.

**Target setting method:** Better than the best.

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### OBJECTIVE WITH REVISIONS

**26-15. Reduce the proportion of adolescents who use inhalants.**

**Target:** ~~0.7~~2.2 percent.

**Baseline:** ~~2.9~~4.49 percent of adolescents aged 12 to 17 years used inhalants in the past year in ~~1998~~2002.

**Target setting method:** Better than the best.

**Data source:** ~~National Survey on Drug Use and Health (NSDUH)~~National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### REVISED OBJECTIVE

**26-15. Reduce the proportion of adolescents who use inhalants.**

**Target:** 2.2 percent.

**Baseline:** 4.4 percent of adolescents aged 12 to 17 years used inhalants in the past year in 2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

## Risk of Substance Use and Abuse

### NO CHANGE IN OBJECTIVE

#### 26-16. Increase the proportion of adolescents who disapprove of substance abuse.

##### Target and baseline:

Objective	Increase in Adolescents Who Disapprove of Having One or Two Alcoholic Drinks Nearly Every Day	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-16a.</b>	8th graders	77	83
<b>26-16b.</b>	10th graders	75	83
<b>26-16c.</b>	12th graders	69	83

**Target setting method:** Better than the best.

**Data source:** Monitoring the Future Study, NIH, NIDA.

##### Target and baseline:

Objective	Increase in Adolescents Who Disapprove of Trying Marijuana or Hashish Once or Twice	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-16d.</b>	8th graders	69	72
<b>26-16e.</b>	10th graders	56	72
<b>26-16f.</b>	12th graders	52	72

**Target setting method:** Better than the best.

**Data source:** Monitoring the Future Study, NIH, NIDA.

### ORIGINAL OBJECTIVE

#### 26-17. Increase the proportion of adolescents who perceive great risk associated with substance abuse.

##### Target and baseline:

Objective	Increase in Adolescents Aged 12 to 17 Years Perceiving Great Risk Associated With Substance Abuse	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>26-17a.</b>	Consuming five or more alcoholic drinks at a single occasion once or twice a week	47	80
<b>26-17b.</b>	Smoking marijuana once per month	31	80
<b>26-17c.</b>	Using cocaine once per month	54	80



### ORIGINAL OBJECTIVE *(continued)*

**Target setting method:** Better than the best (consistent with Office of National Drug Control Policy).

**Data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### OBJECTIVE WITH REVISIONS

**26-17. Increase the proportion of adolescents who perceive great risk associated with substance abuse.**

**Target and baseline:**

Objective	Increase in Adolescents Aged 12 to 17 Years Perceiving Great Risk Associated With Substance Abuse	<del>1998</del> <u>2002</u> Baseline	2010 Target
		<i>Percent</i>	
<b>26-17a.</b>	Consuming five or more alcoholic drinks at a single occasion once or twice a week	<del>47</del> <u>38</u>	<del>80</del> <u>50</u>
<b>26-17b.</b>	Smoking marijuana once per month	<del>31</del> <u>32</u>	<del>80</del> <u>36</u>
<b>26-17c.</b>	Using cocaine once per month	<del>54</del> <u>51</u>	<del>80</del> <u>57</u>

**Target setting method:** Better than the best (~~consistent with Office of National Drug Control Policy~~).

**Data source:** ~~National Survey on Drug Use and Health (NSDUH)~~National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### REVISED OBJECTIVE

**26-17. Increase the proportion of adolescents who perceive great risk associated with substance abuse.**

**Target and baseline:**

Objective	Increase in Adolescents Aged 12 to 17 Years Perceiving Great Risk Associated With Substance Abuse	2002 Baseline	2010 Target
		<i>Percent</i>	
<b>26-17a.</b>	Consuming five or more alcoholic drinks at a single occasion once or twice a week	38	50
<b>26-17b.</b>	Smoking marijuana once per month	32	36
<b>26-17c.</b>	Using cocaine once per month	51	57

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

## Treatment for Substance Abuse

### ORIGINAL OBJECTIVE

**26-18. (Developmental) Reduce the treatment gap for illicit drugs in the general population.**

**Potential data source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### OBJECTIVE WITH REVISIONS

**26-18. (Developmental) Reduce the treatment gap for illicit drugs in the general population. Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.**

**Target and baseline:**

Objective	Increase in Persons Aged 12 Years and Older Who Need Alcohol or Illicit Drug Treatment and Received Specialty Treatment for Abuse or Dependence in the Past Year	2002 Baseline	2010 Target
		<i>Percent</i>	
<b>26-18a.</b>	Illicit drug treatment	18	24
<b>26-18b.</b>	Alcohol and illicit drug treatment	10	16

**Target setting method:** Better than the best.

**Potential data source:** National Survey on Drug Use and Health (NSDUH), National Household Survey on Drug Abuse (NHSDA), SAMHSA.

### REVISED OBJECTIVE

**26-18. Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.**

**Target and baseline:**

Objective	Increase in Persons Aged 12 Years and Older Who Need Alcohol or Illicit Drug Treatment and Received Specialty Treatment for Abuse or Dependence in the Past Year	2002 Baseline	2010 Target
		<i>Percent</i>	
<b>26-18a.</b>	Illicit drug treatment	18	24
<b>26-18b.</b>	Alcohol and illicit drug treatment	10	16

### REVISED OBJECTIVE *(continued)*

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

### ORIGINAL OBJECTIVE

**26-19. (Developmental) Increase the proportion of inmates receiving substance abuse treatment in correctional institutions.**

**Potential data source:** Uniform Facilities Data Set Survey of Correctional Facilities, SAMHSA, OAS.

### OBJECTIVE WITH REVISIONS

**26-19. (Developmental) Increase the proportion of inmates receiving substance abuse treatment in correctional institutions.**

**Potential data source:** ~~Uniform Facilities Data Set Survey of Correctional Facilities, OAS, SAMHSA~~ Survey of Inmates in State and Federal Correctional Facilities and Survey of Inmates in Local Jails, Department of Justice, Bureau of Justice Statistics.

### REVISED OBJECTIVE

**26-19. (Developmental) Increase the proportion of inmates receiving substance abuse treatment in correctional institutions.**

**Potential data source:** Survey of Inmates in State and Federal Correctional Facilities and Survey of Inmates in Local Jails, Department of Justice, Bureau of Justice Statistics.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

**26-20. Increase the number of admissions to substance abuse treatment for injection drug use.**

**Target:** 256,680<sup>1</sup> admissions.

**Baseline:** 215,560<sup>2</sup> admissions for injection drug use were reported in 1997.

**Target setting method:** 19 percent improvement.

**Data source:** Treatment Episodes Data System, SAMHSA, OAS.

<sup>1</sup> Target revised from 200,000 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline revised from 167,960 after November 2000 publication.

### ORIGINAL OBJECTIVE

**26-21. (Developmental) Reduce the treatment gap for alcohol problems.**

**Potential data source:** National Household Survey on Drug Abuse, SAMHSA.

### OBJECTIVE WITH REVISIONS

**26-21. (Developmental) ~~Reduce the treatment gap for alcohol problems~~ Increase the proportion of persons who needed and received specialty treatment for alcohol abuse or dependence in the past year.**

**Target:** 11.9 percent.

**Baseline:** 8.3 percent of persons aged 12 years and older received specialty treatment for alcohol abuse or dependence in 2002.

**Target setting method:** Better than the best.

**Potential dData source:** National Survey on Drug Use and Health (NSDUH) ~~National Household Survey on Drug Abuse, SAMHSA.~~

### REVISED OBJECTIVE

**26-21. Increase the proportion of persons who needed and received specialty treatment for alcohol abuse or dependence in the past year.**

**Target:** 11.9 percent.

**Baseline:** 8.3 percent of persons aged 12 years and older received specialty treatment for alcohol abuse or dependence in 2002.

**Target setting method:** Better than the best.

**Data source:** National Survey on Drug Use and Health (NSDUH), SAMHSA.

## State and Local Efforts

### ORIGINAL OBJECTIVE

**26-22. (Developmental) Increase the proportion of persons who are referred for followup care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department.**

**Potential data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

### OBJECTIVE WITH REVISIONS

**26-22. (Developmental) Increase the proportion of persons who are referred for followup care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department.**

26-22a. Increase in the proportion of persons who are referred for followup care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department.

26-22b. Increase in the proportion of persons who are referred for followup care for suicide attempts after diagnosis or treatment in a hospital emergency department.

**Potential data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

### REVISED OBJECTIVE

**26-22. (Developmental) Increase the proportion of persons who are referred for followup care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department.**

26-22a. Increase in the proportion of persons who are referred for followup care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department.

26-22b. Increase in the proportion of persons who are referred for followup care for suicide attempts after diagnosis or treatment in a hospital emergency department.

**Potential data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

### NO CHANGE IN OBJECTIVE

**26-23. (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.**

**Potential data source:** Community Partnerships Data, SAMHSA.

### NO CHANGE IN OBJECTIVE

**26-24. Extend administrative license revocation laws, or programs of equal effectiveness, for persons who drive under the influence of intoxicants.**

**Target:** All States and the District of Columbia.

**Baseline:** 41 States and the District of Columbia had administrative license revocation laws for persons who drive under the influence of intoxicants in 1998.

### NO CHANGE IN OBJECTIVE *(continued)*

**Target setting method:** Total coverage.

**Data source:** DOT, NHTSA.

### NO CHANGE IN OBJECTIVE

**26-25. Extend legal requirements for maximum blood alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older.**

**Target:** All States and the District of Columbia.

**Baseline:** 16 States had legal requirements for maximum blood alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older in 1998.

**Target setting method:** Total coverage.

**Data source:** DOT, NHTSA.

## References

---

- <sup>1</sup> The term “problem” is defined as meeting the diagnostic criteria for treatment for the abuse of or dependence on alcohol and illicit drugs. This definition includes the nonmedical use of prescription drugs and also includes adolescents who meet the diagnostic criteria.
- <sup>2</sup> Substance Abuse and Mental Health Services Administration (SAMHSA). *Results from the 2004 National Survey on Drug Use and Health: National Findings*. NSDUH Series H-28. U.S. Department of Health and Human Services (HHS) Publication No. SMA 05-4062. Rockville, MD: SAMHSA, Office of Applied Studies.
- <sup>3</sup> DWI is the preferred term at the level of Federal policy. However, States and local jurisdictions use a range of terms, including driving under the influence (DUI), driving while impaired, and operating under the influence.
- <sup>4</sup> Shults, R.A., et al. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American Journal of Preventive Medicine* 21(4 Suppl 1):66–88, 2001.
- <sup>5</sup> Hingson, R., and Sleet, D.A. Modifying alcohol use to reduce motor vehicle injury. In Gielen, A.C., et al., eds. *Injury and Violence Prevention: Behavioral Science Theories, Methods, and Applications*. San Francisco, CA: Jossey-Bass, 2006, 234–256.
- <sup>6</sup> More information available at [www.nhtsa.gov/portal/site/nhtsa/menuitem.18e416bf1b09b6bbbf30811060008a0c/](http://www.nhtsa.gov/portal/site/nhtsa/menuitem.18e416bf1b09b6bbbf30811060008a0c/); accessed October 31, 2006.
- <sup>7</sup> Senate Report 109-103, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2006. *Childhood Drinking*. More information available at [http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp109jlfKK&refer=&r\\_n=sr103.109&db\\_id=109&item=&sel=TOC\\_701922&](http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp109jlfKK&refer=&r_n=sr103.109&db_id=109&item=&sel=TOC_701922&); accessed October 31, 2006.
- <sup>8</sup> HHS. Teen Drug Use Declines 2003–2004. [News release.] More information available at [www.hhs.gov/news/press/2004pres/20041221.html](http://www.hhs.gov/news/press/2004pres/20041221.html); accessed October 31, 2006.
- <sup>9</sup> Grant, B.F., and Dawson, D.A. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse* 9:103–110, 1997.
- <sup>10</sup> Kreek, M.J., and Vocci, F. History and current status of opioid maintenance treatments: Blending conference session. *Journal of Substance Abuse Treatment* 23:93–105, 2002.
- <sup>11</sup> More information available at <http://buprenorphine.samhsa.gov>; accessed October 31, 2006.
- <sup>12</sup> Watts-Davis, B. Prevention Fellows. [Slide presentation.] March 16, 2006. More information available at <http://captus.samhsa.gov/western/resources/documents/5-BWD-PreventionFellows-Mar16-2006.ppt>; accessed October 31, 2006.

- 
- <sup>13</sup> SAMHSA. \$54.6 Million for Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment. More information available at [www.samhsa.gov/news/newsreleases/061011\\_SBirt.aspx](http://www.samhsa.gov/news/newsreleases/061011_SBirt.aspx); accessed October 31, 2006.
- <sup>14</sup> SAMHSA. *Notice of Funding Availability. Grants to Expand Substance Abuse Treatment Capacity in Targeted Areas of Need*. More information available at [www.samhsa.gov/grants/2005/nofa/ti05003\\_TCE.aspx](http://www.samhsa.gov/grants/2005/nofa/ti05003_TCE.aspx); accessed October 31, 2006.
- <sup>15</sup> National Institute on Drug Abuse (NIDA). *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*. 2nd ed. NIH Publication No. 04-4212. Bethesda, MD: NIDA, October 2003.
- <sup>16</sup> National Highway Traffic Safety Administration. Traffic Safety Facts: Laws: “Administrative License Revocation.” Vol. 2. No. 1. March 2004. More information available at [www.nhtsa.dot.gov/people/injury/new-fact-sheet03/fact-sheets04/Laws-ALR.pdf](http://www.nhtsa.dot.gov/people/injury/new-fact-sheet03/fact-sheets04/Laws-ALR.pdf); accessed October 31, 2006.
- <sup>17</sup> Greenfield, T.K., and Kerr, W.C. Tracking alcohol consumption over time. *Alcohol Research & Health* 27(1):2003. More information available at <http://pubs.niaaa.nih.gov/publications/arh27-1/30-38.htm>; accessed October 31, 2006.
- <sup>18</sup> National Association of State Alcohol and Drug Abuse Directors. Policy Position Paper: Recommendations Related to Closing the Treatment Gap. June 2003. More information available at [www.nasadad.org/resource.php?base\\_id=37](http://www.nasadad.org/resource.php?base_id=37); accessed October 31, 2006.
- <sup>19</sup> Otto-Salaj, L.L., and Stevenson, L.Y. Influence of psychiatric diagnoses and symptoms on HIV risk behavior in adults with serious mental illness. *AIDS Reader* 11(4):197–204, 206–208, 2001.
- <sup>20</sup> Murphy, E.L., et al. Risk factors for hepatitis C virus infection in United States blood donors. NHLBI Retrovirus Epidemiology Donor Study (REDS). *Hepatology* 31(3):756–762, 2000.
- <sup>21</sup> Centers for Disease Control and Prevention (CDC). Drug-Associated HIV Transmission Continues in the United States. [Fact sheet.] May 2002. More information available at [www.cdc.gov/hiv/resources/factsheets/print/idu.htm](http://www.cdc.gov/hiv/resources/factsheets/print/idu.htm); accessed October 31, 2006.
- <sup>22</sup> Massimo, R., et al., for Italian Study Group on Mother-to-Infant Hepatitis C Virus Transmission. Maternal drug use is a preeminent risk factor for mother-to-child hepatitis C virus transmission: Results from a multicenter study of 1372 mother-infant pairs. *Journal of Infectious Diseases* 185:567–572, 2002.
- <sup>23</sup> More information available at [www.nida.nih.gov/about/organization/CEWG/CEWGHome.html](http://www.nida.nih.gov/about/organization/CEWG/CEWGHome.html); accessed October 31, 2006.
- <sup>24</sup> Using State Epidemiology Workgroups to Change Policy and Drive Funding. [Slide presentation.] More information available at [www.fasdcenter.samhsa.gov/documents/BFSS2006\\_Ammie\\_Bonsu\\_Presentation.ppt](http://www.fasdcenter.samhsa.gov/documents/BFSS2006_Ammie_Bonsu_Presentation.ppt); accessed October 31, 2006.



- 
- <sup>25</sup> Hingson, R., et al. Magnitude of alcohol-related mortality and morbidity among U.S. college students ages 18–24: Changes from 1998 to 2001. *Annual Review of Public Health* 26:259–279, 2005.
- <sup>26</sup> Task Force on the National Advisory Council on Alcohol Abuse and Alcoholism. *A Call to Action: Changing the Culture of Drinking at U.S. Colleges*. NIH Publication No. 02-5010. Bethesda, MD: The Task Force, October 2002.
- <sup>27</sup> Volkow, N.D. Exploring the why's of adolescent drug abuse. [Electronic version.] *NIDA Notes*. 19(3):1–2, September 2004. More information available at [www.nida.nih.gov/NIDA\\_notes/NNvol19N3/DirRepVol19N3.html](http://www.nida.nih.gov/NIDA_notes/NNvol19N3/DirRepVol19N3.html); accessed October 31, 2006.
- <sup>28</sup> National Institute on Alcohol Abuse and Alcoholism. Alcohol and development in youth: A multidisciplinary overview. *Alcohol Research & Health* 28(3):105–176, 2004–2005.
- <sup>29</sup> Brecht, M.L., et al. Methamphetamine use behaviors and gender differences. *Addictive Behaviors* 29(1):89–106, 2004.
- <sup>30</sup> National Drug Intelligence Center. *National Drug Threat Assessment 2007*. October 2006. More information available at [www.usdoj.gov/ndic/pubs21/21137/index.htm](http://www.usdoj.gov/ndic/pubs21/21137/index.htm); accessed October 31, 2006.
- <sup>31</sup> CDC. *Public Health Consequences Among First Responders to Emergency Events Associated With Illicit Methamphetamine Laboratories—Selected States, 1996–1999*. November 2000. More information available at [www.cdc.gov/mmwr/preview/mmwrhtml/mm4945a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4945a1.htm), accessed October 31, 2006.
- <sup>32</sup> Partnership for a Drug-Free America. *Prescription Medicine Abuse: A Growing Problem*. More information available at [www.drugfree.org/Parent/Resources/Prescription\\_Medicine\\_Misuse](http://www.drugfree.org/Parent/Resources/Prescription_Medicine_Misuse); accessed October 31, 2006.

## Related Objectives From Other Focus Areas

---

### 1. Access to Quality Health Services

- 1-1. Persons with health insurance
- 1-3. Counseling about health behaviors
- 1-4. Source of ongoing care
- 1-5. Usual primary care provider
- 1-6. Difficulties or delays in obtaining needed health care
- 1-7. Core competencies in health profession training
- 1-8. Racial and ethnic representation in the health professions
- 1-10. Delay or difficulty in getting emergency care
- 1-11. Rapid prehospital emergency care
- 1-12. Single toll-free number for poison control centers
- 1-13. Trauma care systems
- 1-14. Special needs of children

### 3. Cancer

- 3-10. Provider counseling about cancer prevention

### 6. Disability and Secondary Conditions

- 6-2. Feelings and depression among children with disabilities

### 7. Educational and Community-Based Programs

- 7-1. High school completion
- 7-2. School health education
- 7-3. Health-risk behavior information for college and university students
- 7-4. School nurse-to-student ratio
- 7-5. Worksite health promotion programs
- 7-6. Participation in employer-sponsored health promotion activities
- 7-10. Community health promotion programs
- 7-11. Culturally appropriate and linguistically competent community health promotion programs
- 7-12. Older adult participation in community health promotion activities

### 9. Family Planning

- 9-8. Abstinence before age 15 years
- 9-9. Abstinence among adolescents aged 15 to 17 years
- 9-10. Pregnancy prevention and sexually transmitted disease (STD) protection
- 9-11. Reproductive health education
- 9-12. Problems in becoming pregnant and maintaining a pregnancy

### 13. HIV

- 13-3. AIDS among persons who inject drugs
- 13-4. AIDS among men who have sex with men and who inject drugs
- 13-8. HIV counseling and education for persons in substance abuse treatment
- 13-13. Treatment according to guidelines

## **14. Immunization and Infectious Diseases**

- 14-28. Hepatitis B vaccination among high-risk groups

## **15. Injury and Violence Prevention**

- 15-12. Emergency department visits
- 15-13. Deaths from unintentional injuries
- 15-14. Emergency department visits for nonfatal intentional injuries
- 15-15. Deaths from motor vehicle crashes
- 15-16. Pedestrian deaths
- 15-17. Nonfatal motor vehicle injuries
- 15-18. Nonfatal pedestrian injuries
- 15-29. Drownings
- 15-32. Homicides
- 15-37. Physical assaults

## **16. Maternal, Infant, and Child Health**

- 16-17. Prenatal substance exposure
- 16-18. Fetal alcohol syndrome

## **18. Mental Health and Mental Disorders**

- 18-6. Primary care facilities providing treatment
- 18-10. Treatment for co-occurring disorders
- 18-13. State plans addressing cultural competence

## **23. Public Health Infrastructure**

- 23-2. Public access to information and surveillance data
- 23-3. Use of geocoding in health data systems
- 23-4. Data for all population groups
- 23-6. National tracking of Healthy People 2010 objectives
- 23-7. Timely release of data on objectives
- 23-8. Competencies for public health workers
- 23-9. Training in essential public health services
- 23-10. Continuing education for public health personnel
- 23-11. Performance standards for essential public health services
- 23-12. Health improvement plans
- 23-14. Access to epidemiology services
- 23-15. Review and evaluation of public health laws
- 23-17. Population-based prevention research

## **25. Sexually Transmitted Diseases**

- 25-11. Responsible adolescent sexual behavior
- 25-13. Hepatitis B vaccine services in STD clinics

## **27. Tobacco Use**

- 27-1. Adult tobacco use
- 27-2. Adolescent tobacco use
- 27-3. Initiation of tobacco use
- 27-4. Age at first tobacco use
- 27-5. Smoking cessation by adults
- 27-6. Smoking cessation during pregnancy
- 27-7. Smoking cessation by adolescents
- 27-8. Insurance coverage of cessation treatment
- 27-9. Exposure to tobacco smoke at home among children
- 27-10. Exposure to environmental tobacco smoke
- 27-11. Smoke-free and tobacco-free schools
- 27-12. Worksite smoking policies
- 27-13. Smoke-free indoor air laws
- 27-14. Enforcement of illegal tobacco sales to minors laws
- 27-15. Retail license suspension for sales to minors
- 27-16. Tobacco advertising and promotion targeting adolescents and young adults
- 27-17. Adolescent disapproval of smoking
- 27-18. Tobacco control programs
- 27-19. Preemptive tobacco control laws
- 27-20. Tobacco product regulation
- 27-21. Tobacco tax