

Substance Abuse

Young people, whites and males had higher rates of binge drinking compared to the county overall.

- Nearly 11% of Contra Costa adults were current smokers
- Among illicit drugs, marijuana was the most commonly used

Substance abuse has been defined as “the overindulgence in and dependence on an addictive substance, especially alcohol or a narcotic drug”.¹ While there is a wide variety of addictive substances, this section is a brief summary of three key forms of substance abuse: smoking tobacco, binge drinking and use of illicit drugs.

Smoking Tobacco

In 2007, there were an estimated 83,000 current adult smokers in Contra Costa. This amounted to 10.7% of the county population 18 years and older. Contra Costa’s adult smoking prevalence (10.7%) was not significantly different from that of the greater Bay Area (12.4%) or California (14.4%).

Table 1 ■ Current smoking
Adults 18 and older, 2007

	Smokers	Prevalence
California	3,869,000	14.4%
Greater Bay Area	671,000	12.4%
Contra Costa	83,000	10.7%

These estimates are not age-adjusted.



Editor’s note: Analyses of Contra Costa current smoking data by race/ethnicity, gender and age were not possible due to small sample size, but we can look at the greater Bay Area overall for an indication of the prevalence of smoking in these subgroups.

Whites had the greatest number of adult smokers (321,000) in the greater Bay Area followed by Latinos (141,000), Asians/Pacific Islanders (118,000) and African Americans (58,000).

Table 2 ■ Current smoking by race/ethnicity

Greater Bay Area adults 18 and older, 2007

	Smokers	Percent	Prevalence
White	321,000	47.8%	11.8%
Latino	141,000	21.0%	13.7%
Asian/Pacific Islander	118,000	17.6%	10.0%
African American	58,000	8.6%	17.1%
Total	671,000	100.0%	12.4%

These estimates are not age-adjusted.

Total includes racial/ethnic groups not listed above.

More men (408,000) were current smokers than women (263,000) in the greater Bay Area. Men also had a significantly higher current smoking prevalence (15.3%) compared to women (9.6%).

Table 3 ■ Current smoking by gender

Greater Bay Area adults 18 and older, 2007

	Smokers	Percent	Prevalence
Men	408,000	60.8%	15.3%*
Women	263,000	39.2%	9.6%
Total	671,000	100.0%	12.4%

These estimates are not age-adjusted.

* Significantly higher than women.

People 80 years and older had the lowest smoking prevalence (2.4%), lower than adults in the greater Bay Area (12.4%) overall and all other age groups. Adults ages 65-79 also had a lower smoking prevalence (6.9%) than adults in the greater Bay Area overall.

Table 4 ■ Current smoking by age group

Greater Bay Area adults 18 and older, 2007

	Smokers	Percent	Prevalence
18-24 years	101,000	15.1%	16.3%
25-39 years	209,000	31.1%	13.7%
40-64 years	315,000	46.9%	12.9%
65-79 years	41,000	6.1%	6.9%**
80 years and older	5,000	0.7%	2.4%**
Total	671,000	100.0%	12.4%

These estimates are age-specific.

** Significantly lower rate compared to the greater Bay Area overall

Youth smoking is also an important indicator of this problem. According to data from the California Health Interview Survey, 14.5% of 15 to 17 year olds in the greater Bay Area were current smokers in 2007. Sample sizes were too small to develop a stable estimate of smoking prevalence among 12–14 year olds in the greater Bay Area.

Why is tobacco use important?

Cigarette smoking remains the leading preventable cause of death in the United States, accounting for approximately one of every five deaths each year.²

Smoking is the strongest environmental risk factor for lung cancer and pancreatic cancer.³ Exposure to tobacco smoke is also closely associated with several other diseases including cancer of the larynx, chronic bronchitis, emphysema, coronary artery disease and hypertensive heart disease.

Tobacco smoke contains respiratory irritants, poisons (including nicotine) and cancer-causing compounds (carcinogens).⁴ It can worsen the health effects of air pollution and other inhaled irritants. Half of all smokers who keep smoking will end up dying from a smoking-related illness.

The adult smoking rate in California in 2006 was 13.3%.⁵

Who is more likely to smoke?

Educational attainment is closely linked to cigarette use. National surveys have found that adults with less than a high school education were three times as likely to smoke as those with a bachelor's degree or more education. Cigarette smoking also varied by race, ethnicity and gender, with the highest prevalence found among African American men and American Indian and Alaska Native men.⁶

In 2006, the smoking rate was 6.1% among California middle school students and 15.4% among California high school students. Despite an increase in California's youth smoking rate, the percentage of California youths who smoke is still far below the national average.⁵

Preventing smoking among teenagers and young adults is essential because smoking usually begins in adolescence.⁶

What can we do about smoking?

Smoking cessation

No matter how old someone is or how long they have smoked, quitting can help them live longer and be healthier. People who stop smoking before age 50 cut their risk of dying in the next 15 years in half compared with those who continue smoking.⁷ Quitting smoking also reduces the risk of lung cancer for other residents by decreasing secondhand smoke. Every year in the United States, 3,400 non-smoking adults die of lung cancer as a result of breathing smoke from other people's cigarettes.⁸

Nationally, an estimated 69.5% of current adult smokers want to quit smoking. An estimated 70.7% of African American adults who are current smokers want to quit, as do 70.3% of white, 68.8% of Asian American and 61.5% of Hispanic current adult smokers.⁹

Tobacco dependence is a chronic condition that often requires repeated interventions, but effective treatments and helpful resources exist. Smokers can and do quit smoking. Today, in the United States there are more former smokers than current smokers.²

Tobacco prevention

The goal of the *California Tobacco Control Program* is to change the broad social norms around the use of tobacco by “indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable and less accessible.”¹⁰

State and local tobacco-control policies have proven to be very effective in reducing smoking. Since the 1988 passage of the *California Tobacco Tax*, per capita cigarette consumption in California declined by 59.0%. During the same period, per capita cigarette consumption in the rest of the nation declined by only 35.0%. The greater decline in California is a result of activities of the *California Tobacco Control Program* along with the higher price of cigarettes in California.¹¹

Unfortunately, there are still approximately 4 million smokers in California (3.6 million adults and 300,000 youths).¹²

Binge Drinking

In 2007, an estimated 224,000 adults 18 and older in Contra Costa reported binge drinking in the past year. This amounted to 28.8% of the adult population. This overall prevalence was not different from that of the greater Bay Area (29.5%) or California (29.7%).

Table 5 ■ Binge drinking

Adults 18 and older, 2007

	Cases	Prevalence
California	7,973,000	29.7%
Greater Bay Area	1,592,000	29.5%
Contra Costa	224,000	28.8%

Binge drinking involves consuming more drinks on the same occasion than is considered healthy or safe by experts. In this section, binge drinking is defined for males as having five or more drinks on a single occasion and for females as having four or more drinks on a single occasion.

These estimates are not age-adjusted.



Editor’s note: Analyses of Contra Costa binge drinking by race/ethnicity, gender or age were not possible due to small numbers, but we can look at the greater Bay Area overall for an indication of the prevalence of binge drinking in these subgroups.

The greatest number of binge drinking reports in the greater Bay Area was among whites (935,000) followed by Latinos (343,000), Asians/Pacific Islanders (207,000), African Americans (56,000) and American Indian/Alaska Natives (12,000). In the greater Bay Area, 1,592,000 adults reported binge drinking in the past year.

Whites (34.3%) had a binge drinking prevalence that was significantly higher than the rate of the greater Bay Area overall (29.5%). Asians/Pacific Islanders (17.5%) and African Americans (16.4%) had lower prevalence than the greater Bay Area as a whole.

Table 6 ■ Binge drinking by race/ethnicity

Greater Bay Area adults 18 and older, 2007

	Cases	Percent	Prevalence
White	935,000	58.7%	34.3%*
Latino	343,000	21.5%	33.4%
Asian/Pacific Islander	207,000	12.5%	17.5%**
African American	56,000	3.5%	16.4%**
American Indian/Alaska Native	12,000	0.8%	43.8%
Total	1,592,000	100.0%	29.5%

These estimates are not age-adjusted.

Total includes racial/ethnic groups not listed above.

* Significantly higher rate compared to the greater Bay Area overall.

** Significantly lower rate compared to the greater Bay Area overall.

Men and women were different when it came to binge drinking. More men (941,000) than women (652,000) had engaged in binge drinking in the past year. Men (35.4%) also had a significantly higher prevalence of binge drinking compared to women (23.8%).

Table 7 ■ Binge drinking by gender

Greater Bay Area adults 18 and older, 2007

	Cases	Percent	Prevalence
Men	941,000	59.1%	35.4%*
Women	652,000	41.0%	23.8%
Total	1,592,000	100.0%	29.5%

These estimates are not age-adjusted.

* Significantly higher rate compared to women

Most Bay Area adults (95.0%) who engaged in binge drinking were younger than 65 years.

Young adults had higher prevalence of binge drinking. Adults aged 18–24 (45.5%) and 25–39 (39.1%) years had significantly higher prevalence of binge drinking than the greater Bay Area overall (29.5%). Adults 65–79 years had a significantly lower prevalence (11.5%) of binge drinking compared to the

greater Bay Area (29.5%). Adults 80 years and older had the lowest prevalence (5.4%); significantly lower than the greater Bay Area and all other age groups.

Table 8 ■ Binge drinking by age group

Greater Bay Area adults 18 And older, 2007

	Cases	Percent	Prevalence
18–24 years	282,000	17.7%	45.5%*
25–39 years	596,000	37.4%	39.1%*
40–64 years	635,000	39.9%	26.0%
65–79 years	68,000	4.3%	11.5%**
80 years and older	12,000	0.8%	5.4%**
Total	1,592,000	100.0%	29.5%

These estimates are age-specific.

* Significantly higher rate compared to the greater Bay Area overall.

** Significantly lower rate compared to the greater Bay Area overall.

What is binge drinking?

Binge drinking involves consuming more drinks on the same occasion than is considered healthy or safe by experts. In this section, binge drinking is defined for males as having five or more drinks on a single occasion and for females as having four or more drinks on a single occasion.

Binge drinking is considered "alcohol abuse," a pattern of problematic drinking that continues despite recurrent adverse consequences, such as harm to one's health, interpersonal relationships or the ability to work.¹³ Binge drinking differs from alcoholism, also known as "alcohol dependence," which is recognized as a chronic disease that includes the following four symptoms: craving, loss of control, physical dependence and tolerance (i.e., the need to drink greater amounts of alcohol to get "high.")¹³ Most people who binge drink are not alcohol dependent.¹⁴

Why is binge drinking important?

Alcohol use is very common in our society. Drinking alcohol has immediate effects that can increase the risk of many harmful health conditions. Alcohol use poses additional problems for underage drinkers. Alcohol use is the third leading lifestyle-related cause of death for people in the United States each year.¹⁵

About 75% of the alcohol consumed by adults in the United States is in the form of binge drinks.¹⁶ Approximately 92% of U.S. adults who drink excessively report binge drinking in the past 30 days.¹⁷

Binge drinking is associated with risk-taking behaviors that can lead to a number of health issues, including unintentional injuries (e.g., car crashes, falls, burns, drowning), intentional injuries (e.g., firearm injuries, sexual assault, domestic violence), alcohol poisoning, sexually transmitted diseases (e.g. HIV/AIDS, hepatitis C), and unintended pregnancy. Over-consumption of alcohol can also result in children born with fetal alcohol spectrum disorders.¹³

Who is risk of developing alcohol problems?

Although men are more likely to drink alcohol and drink in larger amounts, gender differences in body structure and chemistry cause women to absorb more alcohol, and take longer to break it down and remove it from their bodies (i.e., to metabolize it). In other words, upon drinking equal amounts, women have higher alcohol levels in their blood than men, and the immediate effects occur more quickly and last longer. These differences also make women more vulnerable to alcohol's long-term effects on their health.¹⁸

Nationally, alcohol abuse is more prevalent among whites than among Hispanics, blacks and Asians. Alcohol dependence is more prevalent among Native Americans, Hispanics and whites than among Asians.¹⁹

Research also shows that people who start drinking at an early age—for example, at age 14 or younger—are at much higher risk of developing alcohol problems at some point in their lives compared to someone who starts drinking at age 21 or after.¹³ About 90% of the alcohol consumed by youths younger than 21 years in the United States is in the form of binge drinks.¹⁶

Drinking alcohol can be especially harmful to adolescents whose growing bodies and brain are in a critical stage of development. Drinking under the age of 21 is against the law and is typically called underage drinking. Adolescents are more vulnerable to the harmful effects of alcohol than adults, and underage drinking puts them at a higher risk of becoming alcoholics at a later age. Because drinking is part of our culture, teenagers receive messages leading them to believe that drinking is acceptable. In Contra Costa County, 41% of 11th-grade students reported drinking alcohol in the past 30 days. This is twice the reported use for marijuana (18%) or any other drug, and higher than the state rate (37%).²⁰ In Contra Costa County, 22% of 11th-graders report binge drinking in the past 30 days and 10% report binge drinking three or more days in the past month, suggesting a pattern of risky behavior.²⁰

What can we do about binge drinking?

Beer accounted for most alcohol consumed by binge drinkers and most alcohol consumed by those at greatest risk of causing or incurring alcohol-related harm. Lower excise taxes and relatively permissive sales and marketing practices for beer as compared with other beverage types may account for some of these research findings. Establishing alcohol-control policies/taxes at more stringent levels would be an effective way to prevent excessive drinking.²¹

Evidence-based prevention efforts include interventions aimed at the general public (all drinkers) and those that prioritize underage drinkers:

- Limit the number of retail alcohol outlets in a given area and limit the days and hours of alcohol sale.
- Increase alcoholic beverage costs and alcohol taxes.
- Consistently enforce laws and policies intended to prohibit adults from furnishing alcohol to minors.
- Join a local coalition and support community efforts to limit the availability of alcohol to young people.
- Work toward shifting community norms regarding underage drinking and creating a new attitude for unsafe and unhealthy alcohol promotion

Illicit Drug Use

Current illicit drug use refers to the use of illegal drugs (including marijuana or hashish, cocaine, inhalants, hallucinogens, lysergic acid diethylamide (LSD), Ecstasy (MDMA), heroin and prescription-type psychotherapeutics used non-medically) in the last month.

Nationally, 20.1 million people (8.0%) of the population ages 12 years or older reported being current (within the past month) illicit drug users in 2008. Of those who used illicit drugs, most used marijuana or marijuana in combination with other drugs (15.2 million).²²

Table 9 ■ Current illicit drug use

U.S. residents 12 and older, 2008

	Prevalence	Estimated number of users (in millions)
Marijuana	6.1%	15.2
Prescription-type psychotherapeutics used nonmedically	2.5%	6.2
Cocaine	0.7%	1.9
Hallucinogens	0.4%	1.1
Total	8.0%	20.1

Total includes drugs not listed above.
Drug groups are not mutually exclusive.

The following were the key findings of the 2008 National Survey on Drug Use and Health produced by the U.S. Department of Health and Human Services.²²

- The rate of illicit drug use in 2008 (8.0%) was the same as the rate in 2007 (8.0%)
- The rate of past month marijuana use in 2008 (6.1%) was similar to the rate in 2007 (5.8%)
- There were an estimated 1.9 million cocaine users nationwide (0.7% of the population aged 12 and above) and 1.1 million hallucinogen users (0.4% of the population), including 555,000 who had used Ecstasy.
- There were an estimated 6.2 million people aged 12 and over who used prescription-type psychotherapeutic drugs non-medically. These drugs include pain-relievers, tranquilizers, stimulants and sedatives.
- There were an estimated 10 million people (4.0% of those 12 and older) who reported driving under the influence of illicit drugs in the past year.
- An estimated 22.2 million people were classified with substance dependence or abuse in the past year. Of these:
 - 3.1 million were dependent or abused both alcohol and illicit drugs
 - 3.9 million were dependent or abused illicit drugs but not alcohol
 - 15.2 million abused alcohol but not illicit drugs

If the national pattern of illicit drug use in 2008 were applied to Contra Costa County, there would have been more than 71,000 users of these drugs.

Table 10 ■ Estimated illicit drug use
 Contra Costa County Residents 12 and Older, 2008

	Estimated number of users
Marijuana	54,377
Prescription-type psychotherapeutics used nonmedically	22,286
Cocaine	6,240
Hallucinogens	3,566
Total	71,314

Total includes drugs not listed above
 Drug groups are not mutually exclusive

Substance-abuse treatment admissions suggest that methamphetamine use may be particularly important within Contra Costa County. In 2009, there were 4,201 admissions to licensed or publicly funded facilities for substance-abuse treatment in Contra Costa. More people were admitted for methamphetamine-abuse treatment (1,297) than any other drug group. Alcohol was the second most common reason for admission (1,046), followed by marijuana (659).²³

What is drug addiction?

Drug addiction is a chronic, often relapsing condition that causes compulsive drug seeking and use despite harmful consequences to the individual who is addicted and to those around them.

Although the initial decision to take drugs is often voluntary, over time drug abuse can lead to structural and functional changes in the brain that can affect self-control, hinder sound decision-making and result in intense impulses to take drugs.²⁴

Why is drug addiction important?

With continued drug use, there is a danger of a fatal or non-fatal overdose. In health statistics, intentional drug overdoses are counted as suicides and unintentional (accidental) overdoses are documented as drug “poisonings.” (See this report’s Injury sections for statistics.)

Beyond the harmful consequences for the addicted person, drug abuse can cause serious health problems for others. Drug abuse can contribute to the spread of serious infectious diseases in several ways.

Injection of drugs such as heroin, cocaine and methamphetamine can facilitate the spread of HIV/AIDS and hepatitis C.²⁵

Drug use can also interfere with a person’s judgment, increasing the likelihood of engaging in risky sexual behaviors that can contribute to the spread of HIV/AIDS, hepatitis B, and other sexually transmitted diseases. (See this report’s HIV/AIDS and STD sections for more information.)

Who is at risk for drug addiction?

No single factor can predict whether or not a person will become addicted to drugs. Risk for addiction is influenced by a person’s biology, social environment, and age or stage of development. The more risk factors an individual has, the greater the chance that taking drugs can lead to addiction.

For example:

Biology. The genes that people are born with—in combination with environmental influences—account for about half of their addiction vulnerability. Additionally, gender, ethnicity and the presence of other mental disorders may influence risk for drug abuse and addiction.

Environment. Peer pressure, physical and sexual abuse, stress, poverty and limited parental involvement can greatly influence the course of drug abuse and addiction in a person’s life.

Development. Genetic and environmental factors interact at critical developmental stages in a person’s life to affect addiction vulnerability. Although taking drugs at any age can lead to addiction, the earlier drug use begins, the more likely it is to progress to more serious abuse. And because adolescents’ brains are still developing in the areas that govern decision-making, judgment and self-control, they are especially prone to risk-taking behaviors, including trying drugs.²⁴

What can we do about drug addiction?

Drug addiction is a preventable disease. Results from NIDA-funded research have shown that prevention programs families, schools, communities and the media are effective in reducing drug abuse. Although many events and cultural factors affect drug-abuse trends, when youths perceive drug abuse as harmful, they reduce their drug use. It is necessary, therefore, to help youth and the general public understand the risks of drug abuse.²⁴

Research has shown the key risk periods for drug abuse in youths are during major transitions in children’s lives. Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.²⁶

The impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent. Because risks appear at every life transition, prevention

planners need to choose prevention programs that strengthen protective factors across the life course.

Parents can use information on risk and protection to help them develop positive preventive actions (e.g., talking about family rules) before problems occur.

Educators can strengthen learning and bonding to school by addressing aggressive behaviors and poor concentration—associated with later onset of drug abuse and related problems.

Community Leaders can assess community risks and protective factors associated with drug problems to best target prevention services.²⁵

Research has shown programs that reach youths through multiple settings can strongly impact community norms.

Data Sources: Substance Abuse

TEXT

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TABLES

Tables 1-8: Data presented for Latinos include Latino residents of any race. Data presented for whites, Asians/Pacific Islanders and African Americans include non-Latino residents. Not all race/ethnicities are shown but all are included in Contra Costa, greater Bay Area and California totals.

Tables 1-4: Local data about tobacco use comes from the California Health Interview Survey's AskCHIS data query system, copyright© 2007 the Regents of the University of California, all rights reserved, available online at: <http://askchis.com/main/default.asp>. Data analysis performed in April 2010. Current smoking prevalence refers to the percent of respondents who report that they now smoke based on a series of smoking related questions. In Table 4, data for American Indians/Alaska Natives was excluded due to small numbers. AskCHIS data are generated from a telephone survey that asks questions to a randomly selected group of residents in Contra Costa and other counties in California. Responses are then weighted to represent the county, region and state as whole. The Greater Bay Area includes the counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma.

Tables 5-8: Local data about binge drinking from the California Health Interview Survey's AskCHIS data query system, copyright© 2007 the Regents of the University of California, all rights reserved, available online at: <http://askchis.com/main/default.asp>. Data analysis performed in April 2010. Respondents were asked a series of questions

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concerning their alcohol consumption in the past year to determine binge drinking. AskCHIS data are generated from a telephone survey that asks questions to a randomly selected group of residents in Contra Costa and other counties in California. Responses are then weighted to represent the county, region, and state as whole. The greater Bay Area includes the counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma.

Table 9: National data from the *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD. Available at: <http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm>

Table 10: Local estimates for illicit drug use among Contra Costa residents ages 12 years and older were created by the Community Health Assessment Planning and Evaluation (CHAPE) Unit of Contra Costa Health Services by applying national estimates of the percent of people 12 years and older using illicit drugs from the 2008 National Survey on Drug Use and Health to 2008 population projections for Contra Costa County residents ages 12 years and older from the *State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050*. Sacramento, CA, July 2007.