2010 Oklahoma Epidemiological Profile

Epidemiology, the science of public health, provides vital information about disorders that threaten the health and well-being of populations. Epidemiological data identify problems, help determine what areas and who are affected by the problems—knowledge that is essential for effective intervention—and measure the success of interventions aimed at preventing or reducing these problems. Engagement in a thoughtful planning process that includes careful assessments of needs, resources, capacity, readiness, and contextual conditions—prior to selecting strategies—is essential to successful prevention efforts.

This data focus—collection, analysis, and use—is entrenched in each step of the SPF and continually informs the process. The formal assessment of contextual conditions, needs, resources, readiness, and capacity is used to identify priority issues in Step 1. In Step 2, data are shared to generate awareness, spur mobilization, and leverage resources. In Step 3, assessment data are used to drive the development of a strategic plan and guide the selection of evidence-based strategies. Data are used in Step 4 to inform (and, if necessary, revise) the implementation plan. And finally, data are collected to monitor progress toward outcomes, and findings are used to make adjustments and develop sustainable prevention efforts.

The Oklahoma State Epidemiological Outcomes Workgroup (SEOW) is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in the state. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma’s SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses the causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state.

To study the nature and extent of the problem of alcohol, tobacco, and other drug use in Oklahoma, the state’s SEOW utilized the CSAP model of consumption and consequence constructs and indicators. Table 1 provides a complete listing of alcohol, tobacco, and illicit and prescription drug consumption and consequence constructs. For each construct, one or more identifiable indicators (measures) were used to quantify consumption and substance-related consequences. Unlike the underlying constructs, these indicators are precisely defined and determined by specific data sources. Thus, while “alcohol-related mortality” is a relevant construct for monitoring trends of an important consequence of use, it does not provide a precise definition of how this construct can be measured. However, a number of indicators do provide specific measures of this construct (e.g., annual incidence rate of deaths attributable to alcohol-related chronic liver disease, suicide, homicide, or crash fatalities). A list of constructs and indicators for alcohol and illicit drug consumption and consequences appear in the epidemiological data tables on pages 54–59.

CSAP recommendations were not available for prescription drugs, so Oklahoma used the same data sources CSAP recommended for the other constructs and indicators.
Table 1. Alcohol, Tobacco, Illicit Drugs, and Prescription Drug Consumption and Consequence Constructs

<table>
<thead>
<tr>
<th>Consumption</th>
<th>Alcohol</th>
<th>Tobacco</th>
<th>Illicit Drugs</th>
<th>Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use</td>
<td></td>
<td></td>
<td>Current use</td>
<td>Current use</td>
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<tr>
<td>Current binge drinking</td>
<td></td>
<td></td>
<td>Age of initial use</td>
<td>Lifetime use</td>
</tr>
<tr>
<td>Heavy drinking</td>
<td></td>
<td></td>
<td>Tobacco use during pregnancy</td>
<td>Age of initial use</td>
</tr>
<tr>
<td>Age of initial use</td>
<td></td>
<td></td>
<td>Total cigarette use consumption per capita</td>
<td></td>
</tr>
<tr>
<td>Drinking and driving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use during pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apparent per capita alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consequence</td>
<td>Alcohol-related mortality</td>
<td>Tobacco-related mortality</td>
<td>Illicit drug-related mortality</td>
<td>Prescription opiate-related mortality</td>
</tr>
<tr>
<td>Alcohol-related motor vehicle crashes</td>
<td></td>
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<tr>
<td>Alcohol-related Crime</td>
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<tr>
<td>Dependence or abuse</td>
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</tbody>
</table>

The SEOW required data indicators for each substance to be readily available and accessible, with the measure available in disaggregated form at the State or lower geographic level. The method or means of collecting and organizing the data also had to be consistent over time; if for any reason the method of measurement had changed, reliable data had to be available to allow adjustment for differences resulting from data collection changes. In addition, research-based evidence had to support that the indicator accurately measured the specific construct and yielded a true representation of the phenomenon at the time of assessment, with data collected—preferably on an annual, or at minimum, a biennial basis—for the preceding 3 to 5 years. And each indicator had to be sufficiently sensitive to detect change over time that might be associated with changes in alcohol, tobacco, or illicit drug use.

Alcohol Consumption

According to Oklahoma’s Youth Risk Behavior Survey (YRBS), in 2009, 39.0 percent of students in grades 9–12 reported current alcohol consumption. That percentage is consistent with data collected by the National Survey on Drug Use and Health (NSDUH) for the population aged 12 and older, which showed 42.5 percent of respondents were current drinkers in 2007. NSDUH and YRBS data also showed between 21 and 28 percent of adolescents were binge drinkers at the time of the surveys. Although youth binge drinking is on the decline, with the exception of 2009, Oklahoma has been consistently above the national average for this behavior according to the YRBS. NSDUH data from 2007 indicated 37.4 percent of 18- to 25-year-olds and 9.0 percent of 12- to 17-year-olds were binge drinkers. The 2009 YRBS showed 19.4 percent of Oklahoma students in grades 9–12 reported early initiation of alcohol; a continued indication of a steady decline in that behavior since the 2003 YRBS report of 26.8 percent.

While adolescent drinking and driving is trending downward, Oklahoma continues to have percentages higher than the national average. In 2003, Oklahoma’s percentage of adolescent drunk driving was 17.5 percent, which was 45 percent higher than the national average. This dropped to 11.0 percent in 2009, which was 13 percent higher than the national average of 9.7 percent. [1]

Figure 1. YRBS 2003–2007 Percentage of Students in Grades 9–12 Who Reported Driving When They Had Been Drinking
Indicators from the 2009 Behavioral Risk Factor Surveillance System (BRFSS) show Oklahoma is lower than the national average in current alcohol consumption, heavy consumption, and binge drinking among adults. In 2009, 42.6 percent of Oklahoma adults reported current alcohol consumption, which was 27 percent lower than the national average of 54.3 percent.\[^2\]

Although lower than the national average, NSDUH data indicates Oklahoma’s percentage of binge drinking among persons 12 and older has increased from 2003-2007. The percentage was 19.01 in 2003 and 21.2 in 2007.\[^3\]

**Figure 2. BRFSS 2009 Alcohol Consumption Categories**

Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) show that alcohol use among pregnant women has been climbing in Oklahoma since 2003, when 2.5 percent of pregnant women had consumed alcohol during the last 3 months of their pregnancy. In 2007, the percentage had increased to 4.8 percent of pregnant women.\[^4\]

**Alcohol Consequences**

Oklahoma is consistently above the national average in alcohol-related mortality. Long-term alcohol consumption is associated with chronic liver disease. The relationship between alcohol use and suicide is also well documented, according to CSAP. Both chronic liver deaths and suicide deaths have been on the rise in Oklahoma since 2003.\[^5,6,7\]
Figure 3. 2003–2006 National Vital Statistics System (NVSS) Oklahoma Chronic Liver Disease and Suicide Mortality Data Deaths per 100,000

![Bar chart showing deaths from chronic liver disease and suicide from 2003 to 2006.]

According to the Uniform Crime Reports (UCR), Oklahoma has also been consistently above the national average in crimes related to alcohol use which include aggravated assaults, sexual assaults, and robberies. Since 2003, there has been an 18.1 percent increase.[8]

Figure 4. 2005–2008 UCR Number of Violent Crimes Reported to Police Per 100,000 Population

![Bar chart showing the number of violent crimes reported to police per 100,000 population from 2005 to 2008.]

Fatality Analysis Reporting System (FARS) data show that Oklahoma has maintained a steady rate of fatal crashes involving an alcohol-impaired driver. In 2003, Oklahoma’s alcohol-impaired driver fatality percent was 31.3, and in 2008, that figure remained relatively stable at 31.6 percent. National percentages for those years were 30.3 and 31.4, respectively.[9]

Tobacco Consumption

According to the 2007 NSDUH, 30.6 percent of Oklahomans aged 12 and older were current cigarette smokers, which was above the national average of 24.2 percent. Data from the 2009 BRFSS also showed Oklahomans’ daily cigarette smoking exceeding that of the United States population as a whole, at 25.4 percent vs. 17.9 percent, respectively.[2,3]

The YRBS shows indicators in tobacco use among adolescents have been falling in Oklahoma since 2003, with students who smoked their first cigarette before the age of 13 decreasing by half since that year.[1]
Figure 5. YRBS 2003–2009 Percentage of Students in Grades 9–12 Who Reported Smoking a Whole Cigarette for the First Time Before the Age of 13.

Smoking among pregnant women is climbing in Oklahoma according to PRAMS. In 2003, 16.2 percent of pregnant women reported they had smoked during the last 3 months of their pregnancy; in 2007, the most recent PRAMS for which data are currently available, the percentage of pregnant women who smoked during the last 3 months of pregnancy had jumped to 21.3.\(^4\)

**Tobacco Consequences**
National Vital Statistics System (NVSS) data show deaths from both chronic obstructive pulmonary disease (COPD) and emphysema for Oklahoma are above the national average.\(^10\)

**Figure 6. NVSS 2006 COPD/Emphysema and Lung Cancer Deaths Per 100,000**

Illicit Drug Consumption
The YRBS shows daily marijuana use for high school students in grades 9–12 is decreasing; 22.0 percent were daily users in 2003, while just 15.9 percent reported this behavior in 2007.\(^1\)

According to NSDUH, Oklahoma has been consistently above the national average among persons aged 12 and older reporting the use of any illicit drug other than marijuana. The percentages were 4.1 in 2004 and 4.6 in 2007. The national percentages for those same years were 3.4 and 3.7, respectively.\(^3\)
Although still above the national average, youth methamphetamine use continues to decline in Oklahoma according to the YRBS. Since 2003, the percentage of youth methamphetamine users has dropped by half.\textsuperscript{[1]}

**Figure 7. YRBS 2003-2009 Percentage of Oklahoma Students in Grades 9–12 Who Reported Ever Using Methamphetamines**

The YRBS also shows Oklahoma exceeds the national average in cocaine, ecstasy, steroid, and inhalant use. Although above the national average, cocaine use in Oklahoma has dropped from 9.2 percent in 2003 to 7.4 percent in 2009.\textsuperscript{[1]}

Although initially below the national average in years 2003–2007, adolescent use of inhalants is on a steady ascent. In 2009, 12.7 percent of Oklahoma adolescents reported inhalant use, surpassing the national average of 11.7 percent.\textsuperscript{[1]}

**Figure 8. 2003-2009 YRBS Percent of Students in Grades 9–12 Who Reported Ever Using Any Form of Inhalant**

**Illicit Drug Consequences**

The latest NVSS data show that Oklahoma exceeds the Nation in number of deaths due to drug-related behavior. In 2006, the rate per 100,000 was 17.3 for Oklahoma and 12.8 for the United States as a whole.\textsuperscript{[5]}
The number of drug-related crimes (larceny, burglary, motor vehicle theft) in Oklahoma also outstrips that of the Nation; in 2008, Oklahoma reported 3,442.4 per 100,000 compared to the national rate of 3,212.5 per 100,000. However, Oklahoma’s 2008 rate does represent a decline for the state, which reported drug-related crimes of 4042.0 per 100,000 in 2005.\(^8\)

**Prescription Drug Consumption**

According to data from the 2007 NSDUH, Oklahomans aged 12 and older exceeded the national average for the consumption of painkillers for nonmedical use by 232 percent. This is a 22 percent increase since 2004.\(^3\)

**Prescription Drug Consequences**

Although hospital inpatient discharge data were not indicators used in scoring, they were presented to the State Epidemiological Outcomes Workgroup (SEOW) due to the paucity of indicators regarding prescription drugs. Oklahoma hospital data associated with opiates have shown a 91 percent increase since 2003. Although this is a general category for opiates, for all practical purposes, heroin is the only illicit opiate taken into account.\(^11\)

NVSS data show there has been a 328 percent increase in opiate-related deaths in Oklahoma since 1999. In 2006, Oklahoma ranked 4\(^{th}\) in the Nation for opiate overdose deaths, exceeding the national average by 123 percent.\(^12\)

*Figure 9. NVSS 1999-2006 Opioid Overdose Deaths Per 100,000 Population*

![Opioid Overdose Deaths Per 100,000 Population](image)

**Mental and Emotional Disorders**

The Oklahoma SEOW intends to expand its scope to collect and analyze epidemiological data on the nature and extent of mental illness and related indicators in the state. The broadening of the SEOW’s scope of work is critical for Oklahoma to gain more understanding about opportunities for mental illness prevention and mental health promotion within the state. In addition, developing research supports the connection between mental and emotional disorders, their causal factors, and other behavioral health problems, including substance abuse. Therefore, it is imperative that Oklahoma apply the same
assessment standards integral to the SPF process for the prevention of mental and emotional disorders as has been done for substance abuse.

Mental disorders (brain dysfunction disorders) account for 25 percent of disability in the United States. About 22 percent of the U.S. adult population has one or more diagnosable disorders in a given year. Oklahoma currently ranks number one in the Nation for the prevalence of these disorders in adults.\[13\]

Mental illness can influence the onset, progression, and outcome of other illnesses. Anxiety, impulse control, and mood disorders often correlate with health risk behaviors such as substance abuse, tobacco use, and physical injury. Depression is a risk factor for such chronic illnesses as hypertension, cardiovascular disease, and diabetes. Mental illness and depression also increase the risk for suicide. Oklahoma has consistently had a higher number of suicide deaths compared to the rest of the Nation. In Oklahoma, suicide is the most common manner of violent death. The first quarter of 2010 has yielded a sharp increase in calls to Oklahoma’s suicide prevention hotline. In 2009, for example, there were 833 calls during the first quarter. In the first quarter of 2010 there has been a 53.0 percent increase, with 1,272 clients having called the hotline.\[14\]

From 2004–2007, the rate of suicide was 14.4 per 100,000 according to the Oklahoma Violent Death Reporting System (OVDRS). Data from OVDRS also show that suicide was the third-leading cause of death among 15- to 24-year-olds in 2007. The suicide rate reported by Oklahoma for this population was 13.5 percent higher than the national rate among the corresponding age group. And in fact, among all ages, Oklahoma’s reported suicide rate is higher than the national average. In 2006, Oklahoma’s rate per 100,000 was 15.0, compared to the national average of 10.9. Seventy-eight percent of suicides were males. Depression was the leading circumstance associated with suicide. Forty-six percent of suicides were the result of a depressed mood. Substance use also played a role in suicides according to OVDRS. Thirty percent of persons tested had a positive blood alcohol test, and 88 percent tested positive for other drugs.\[15\]

In 2007, NSDUH reported that 14.0 percent of Oklahomans aged 18 and older suffered from serious psychological distress. Table 2 shows several mental health indicators for which Oklahoma had some of the highest percentages in the Nation in 2006–2007. In addition, results from the 2009 BRFSS show 20.7 percent of Oklahoma adults had between 1 and 13 mentally unhealthy days in the last month, and 13.7 percent had between 14 and 30 such days.\[3\]

Table 2. NSDUH, 2006–2007 Annual Averages

<table>
<thead>
<tr>
<th>Mental Health Indicator</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious psychological distress in the past year (age 18 and older)</td>
<td>14.0</td>
</tr>
<tr>
<td>Serious psychological distress in the past year (age 26 and older)</td>
<td>13.2</td>
</tr>
<tr>
<td>Persons having at least one major depressive episode in the past year (age 18 and older)</td>
<td>9.1</td>
</tr>
<tr>
<td>Persons having at least one major depressive episode in the past year (age 18–25)</td>
<td>10.5</td>
</tr>
<tr>
<td>Persons having at least one major depressive episode in the past year (age 26 and older)</td>
<td>8.9</td>
</tr>
</tbody>
</table>
ODMHSAS reported 34,132 persons received ODMHSAS-funded mental health services for fiscal year 2004. In 2009, that number increased to 52,226. In 2009, the top three reasons clients sought services were emotional maladjustment/disturbance (38.9 percent), substance abuse disorders (29.0 percent), and depressive disorders (7.0 percent). The top drug of choice was alcohol. The age groups of clients that had the highest percentages of service were 25–34 (23.5 percent) and 35–44 (21.0 percent). The gender breakdown of clientele was virtually the same. Of the clients who were given a substance abuse screening, 57.0 percent tested positive. [16]

The number of children with serious emotional disturbance (SED) receiving ODMHSAS-funded mental health services increased 76 percent over a 5-year period, from 2,254 in 2004 to 3,959 in 2009. Persons with serious mental illness (SMI) receiving ODMHSAS-funded mental health services increased from 25,492 in 2004 to 38,222 in 2009—an increase of approximately 50 percent. [16]

Data from the YRBS show that, in 2009, 28.2 percent of students felt sad or hopeless everyday day for 2 weeks or more in a row to the extent that they stopped doing some usual activities during the past 12 months; this was slightly higher than the national average of 26.1 percent. [1] Oklahoma Systems of Care, a comprehensive spectrum of mental health and other support services for adolescents and their families with a serious emotional disturbance, has experienced a 73 percent increase in enrolled clients since fiscal year 2006—jumping from 456 in 2006 to 787 in 2010. The majority of clients are white, male, and diagnosed with conduct disorders. [17]

**Populations of Note**

**American Indian**

In 2000, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 266,801, comprising 8 percent of the state’s total population and ranking Oklahoma second among all states for AI/AN population. Alcohol and tobacco consumption is a significant problem in this population. According to data from the 2009 BRFSS, 14.2 percent of AI/AN adults reported binge drinking, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race. Smoking consumption was also highest among this group according to the BRFSS. In 2009, 31.9 percent AI/ANs reported current smoking compared to all other races (25.0 percent).

Data from the Oklahoma State Bureau of Investigation (OSBI) show Oklahoma’s AI/AN population had substantially greater alcohol-related arrests (i.e., driving under the influence, liquor law violations and drunkenness) at 44 percent; lower drug law violation arrests (i.e., all drug arrests reported as sale/manufacturing and possession) at 8 percent; and lower index crime arrests (i.e., murder, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft) at 10 percent, compared to all races combined (29 percent, 14 percent, and 13 percent, respectively).

From fiscal years (FYs) 2001–2008, Oklahoma’s AI/AN population had consistently high rates of persons served in substance abuse treatment facilities compared to Whites and people of all races combined. [18]

**Older Adults**

Older Oklahomans, aged 65 and above, are the fastest growing segment of the state’s population. In 2006, Oklahoma had the 19th-highest number of persons aged 65 and over, with 475,637 individuals falling into this category (U.S. Census Bureau, 2006). The population ages 60 and older increased by 18.2
percent from 1980 to 2000. This is substantially higher than the national average of 12.4 percent. In 2000, Oklahoma ranked 13th in terms of the percentage of the total population 60 years and older. This high growth rate among senior citizens outpaced Oklahoma’s overall growth rate of 14 percent for the same period. The very old (85 years and older) experienced the most notable growth rate of 61 percent from 1980 to 2000. It is estimated that while Oklahoma’s total population will grow at a relatively slow pace (10.2 percent), those 65 years and over will increase by over 60 percent between 2007 and 2030. Further, the state’s population ages 85 years and older is expected to increase by 50 percent during the same time period (U.S. Census Bureau, 2006).[13]

Figure 10.

According to Oklahoma’s 2009 BRFSS, 78.8 percent of persons aged 65–74 said that they always or usually received social and emotional support. This was down from 2005, when the percent was 83.1. Conversely, this among persons aged 75 and older, 77.6 percent always or usually received support in 2005 and 78.4 percent did in 2009. [13]

Another significant characteristic within the state’s older populations is grandparents raising grandchildren. Approximately 43,000 older Oklahomans are responsible for their grandchildren; of these, 16,200 have been responsible for the care of their grandchildren 5 years or longer. Grandparents living with grandchildren under 18 years of age for the population 30 years and over households are shown in the following table. [13]

<table>
<thead>
<tr>
<th>Household types</th>
<th>United States</th>
<th>Oklahoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-90</td>
<td>0.10</td>
<td>0.07</td>
</tr>
<tr>
<td>1980-2000</td>
<td>0.20</td>
<td>0.15</td>
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### Veterans and Military Families

In Oklahoma, 12.5 percent (333,358) of the state’s citizens are veterans, with 20.7 percent having served in the Gulf War, 35.1 percent having served in Vietnam Conflict, 12.7 percent having served in the Korean War, and 13 percent having served in World War II. The American Forces News Services reports that over 47,000 individuals based in Oklahoma are active in military operations and 24,500 have been deployed since American troops entered Afghanistan (www.usmilitary.about.com. 2008). In addition to other mental health disorders, 20 percent of returning veterans suffer posttraumatic stress disorder.\[^13\]

According to the OVDARS, 23 percent of suicide deaths between 2004 and 2007 were veterans, which represented 76 percent of all violent deaths among veterans.\[^15\] In addition, a comparison of mortality between Operation Enduring Freedom/Operation Iraqi Freedom Veterans and the general U.S. population (adjusted for age, sex, race, and calendar year) showed evidence of a 21 percent excess of suicides among veterans through 2007. Although the evidence is preliminary, it suggests decreased suicide rates since 2006 among veterans of both sexes aged 18–29 who have used Veterans Health Administration (VHA) health care services relative to veterans in the same age group who have not. This decrease in rates translates to approximately 250 lives per year. Finally, more than 60 percent of suicides among users of VHA services include patients with a known diagnosis of a mental health condition.\[^19\]

### Incarcerated Women

According to the Oklahoma Department of Corrections (ODOC), Oklahoma leads the Nation in the rate of female offender incarceration at 131 per 100,000 population, a significant departure from the national average of 69 per 100,000 population. As of 2006, 2,213 women were incarcerated in the State of Oklahoma, and the state’s female inmate population is growing more rapidly than its male inmate population. Analogous to this rise in incarcerated females is a rise in incarcerated female drug use (i.e., both personal use and drug-related crimes).

From 2001 to 2007, the number of female prison admissions per year increased by 136 (12 percent). Of the total female prison admissions during this time, 5,308 (61 percent) were White; 2,141 (24 percent) were Black; 998 (11 percent) were American Indian or Alaska Native; and 274 (3 percent) were Hispanic.

According to the Bureau of Justice Statistics (2002), 52 percent of the Nation’s female inmates were dependent on drugs or alcohol. Of all the offenses listed for incarcerated women between 2001 and 2007 in Oklahoma, approximately 70 percent were associated with a controlled substance (i.e., a drug or chemical substance whose possession and use are controlled by law), alcohol, or both.\[^18\]
Epidemiological Data Sources

**Alcohol Epidemiologic Data System (AEDS)** • AEDS is responsible for maintaining, and extending an alcohol-related epidemiologic databank. AEDS also compiles the Alcohol Epidemiologic Data Directory which is a current listing of surveys and other relevant data suitable for epidemiologic research on alcohol.

**Behavioral Risk Factor Surveillance Survey (BRFSS)** • Established in 1984 by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. Oklahoma has participated in BRFSS since 1995. This report focused on 2007 BRFSS data to give a current picture of substance use/abuse in Oklahoma. [http://www.cdc.gov/brfss/about.htm](http://www.cdc.gov/brfss/about.htm)

**Bureau of Justice** • The Bureau of Justice Statistics was first established on December 27, 1979 under the Justice Systems Improvement Act of 1979. The Bureau of Justice Statistics (BJS) is a component of the Office of Justice Programs in the U.S. Department of Justice.

**Center for Disease Control and Prevention (CDC)** • The CDC, a part of the U.S. Department of Health and Human Services, is the primary Federal agency for conducting and supporting public health activities in the United States. CDC’s focus is not only on scientific excellence but also on the essential spirit that is CDC – to protect the health of all people. CDC keeps humanity at the forefront of its mission to ensure health protection through promotion, prevention, and preparedness.

**Fatal Analysis Reporting System (FARS)** • FARS contains data on all fatal traffic crashes within the 50 states, the District of Columbia, and Puerto Rico. The data system was conceived, designed, and developed by the National Center for Statistics and Analysis (NCSA) to assist the traffic safety community in identifying traffic safety problems, developing and implementing vehicle and driver countermeasures, and evaluating motor vehicle safety standards and highway safety initiatives.

**National Survey on Drug Use and Health (NSDUH)** • The National Survey on Drug Use and Health (NSDUH) provides annual data on drug use in the United States. The NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service and a part of the Department of Health and Human Services (DHHS). The survey provides yearly national and state-level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use. Other health-related questions also appear from year to year, including questions about mental health. The NSDUH findings were used to evaluate substance use/abuse from the age of 12. This survey is not a school based survey so it provides a different perspective than the YRBS for youth. [https://nsduhweb.rti.org](https://nsduhweb.rti.org)

**National Vital Statistics System (NVSS)** • The National Vital Statistics System is the oldest and most successful example of inter-governmental data sharing in Public Health and the shared relationships, standards, and procedures form the mechanism by which NCHS collects and disseminates the Nation's
official vital statistics. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths.

**Oklahoma Bureau of Narcotics and Dangerous Drugs (OBN)** • The Oklahoma State Bureau of Narcotics and Dangerous Drugs Control is a law enforcement agency with a goal of minimizing the abuse of controlled substances through law enforcement measures directed primarily at drug trafficking, illicit drug manufacturing, and major suppliers of illicit drugs.

**Oklahoma Department of Corrections (ODOC)** • Following the enacting of the Oklahoma Corrections Act of 1967, the new Department of Corrections was created on July 1, 1967. The ODOC is a network of facilities comprised of 17 institutions, seven Community Corrections Centers, and 15 Community Work Centers. The incarcerated women data was obtained from the ODOC.

**Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)** • The ODMHSAS was established in 1953 and continues to evolve to meet the needs of all Oklahomans. Collaborating with leaders from multiple state agencies, advocacy organizations, consumers and family members, providers, community leaders and elected officials, the way has been paved for meaningful mental health and substance abuse services transformation in Oklahoma. The ODMHSAS is responsible for providing services to Oklahomans who are affected by mental illness and substance abuse.

**Oklahoma Prevention Needs Assessment Survey (OPNA)** • The Oklahoma Prevention Needs Assessment is a paper/pencil survey administered in opposite years of the YRBS in schools to 6th, 8th, 10th and 12th grade students. The survey is designed to assess students’ involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. In 2008, 60,720 students were surveyed from 686 schools across 74 of Oklahoma’s 77 counties.* The major limitation of this survey is that it is not a random sample; schools choose whether or not they participate, making it a convenience sample.

**Oklahoma State Bureau of Investigation (OSBI)** • The Oklahoma State Bureau of Investigation Uniform Crime Reporting (UCR) Program is part of a nationwide, cooperative statistical effort.

**Oklahoma State Department of Health (OSDH)** • The OSDH is a department of the government of Oklahoma responsible for protecting the health of all Oklahomans and providing other essential human services and through its system of local health services delivery, is ultimately responsible for protecting and improving the public’s health status through strategies that focus on preventing disease. The OSDH serves as the primary public health protection agency in the state.

**Oklahoma Tax Commission** • Since 1931, the Oklahoma Tax Commission has held the responsibility of the collection and administration of taxes, licenses and fees that impact every Oklahoman. Under the direction of the state legislature, the Tax Commission manages not only the collection of taxes and fees, but also the distribution and apportionment of revenues to various state funds. The collected revenues fuel such state projects as education, transportation, recreation, social welfare and a myriad of other services.
**Oklahoma Violent Death Reporting System (OKVDRS)** • Oklahoma and 16 other states (Massachusetts, Maryland, New Jersey, Oregon, South Carolina, North Carolina, Virginia, Alaska, Colorado, Georgia, Wisconsin, Rhode Island, Kentucky, Utah, New Mexico and California) participate in the National Violent Death Reporting System. Violent deaths include homicides, suicides, deaths from legal intervention, unintentional firearm deaths, deaths of undetermined manner and deaths from acts of terrorism. Data for OKVDRS are collected from death certificates, medical examiner reports, police reports, supplemental homicide reports and crime labs. Standardized methodology and coding are used to collect the data and enter into a database that is housed at the Oklahoma State Department of Health (OSDH). The OSDH partners with the Oklahoma State Bureau of Investigation and the Oklahoma Medical Examiner’s Office to collect the data.

**Oklahoma Youth Tobacco Survey (OYTS)** • Designed to provide comprehensive data for planning and evaluating progress toward reducing tobacco use among youth. Items measured as part of the OYTS survey include correlates of tobacco use such as demographics, minors’ access to tobacco, and exposure to secondhand smoke. It provides data representative of Oklahoma middle school and high school youth’s tobacco-related beliefs, attitudes and behaviors, and exposure to pro- and anti-tobacco influences such as curricula and media. The data can be compared to results from the National Youth Tobacco Survey and results from other states.

**Pacific Institute for Research and Evaluation (PIRE)** • PIRE is one of the Nation’s preeminent independent, nonprofit organizations focusing on individual and social problems associated with the use of alcohol and other drugs. PIRE is dedicated to merging scientific knowledge and proven practice to create solutions that improve the health, safety, and well-being of individuals, communities, nations, and the world.

**Pregnancy Risk Assessment Monitoring System (PRAMS)** • PRAMS was initiated in 1987 with a goal to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.

**Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)** • SAMMEC is an internet-based, computational application. SAMMEC calculates annual state- and national-level smoking-attributable deaths and years of potential life lost for adults and infants in the United States. The Adult application also calculates medical expenditures and productivity costs among adults. Likewise, Maternal and Child Health (MCH) SAMMEC estimates annual state- and national-level smoking-attributable deaths and years of potential life lost for infants.

**Substance Abuse and Mental Health Services Administration (SAMHSA)** • The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS), focuses attention, programs and funding on promoting a life in the community with jobs, homes and meaningful relationships with family and friends for people with or at risk for mental or
substance use disorders. The Agency is achieving that vision through an action-oriented, measurable mission of building resilience and facilitating recovery.

The Uniform Crime Report (UCR) • The UCR was conceived, developed, and implemented by law enforcement for the express purpose of serving as a tool for operational and administrative purposes. Under the auspices of the International Association of Chiefs of Police, the UCR Program was developed in 1930. Prior to that date, no comprehensive system of crime information on a national scale existed. The Oklahoma State Bureau of Investigation assumed the statewide administration of the UCR Program on September 1, 1973. Statistical information was collected and compiled through the year 2007 with a comparative analysis of the years 2006 and 2005.

United States Census Bureau • The Census Bureau serves as the leading source of quality data about the Nation’s people and economy. The bureau of the Commerce Department, responsible for taking the census, provides demographic information and analyses about the population of the United States. Census data was used for all Oklahoma demographics. http://www.census.gov/main/www/aboutus.html

Youth Risk Factor Behavioral Survey (YRBS) • The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults, including behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infections; unhealthy dietary behaviors; and physical inactivity. YRBSS includes a national school-based survey conducted by CDC and state and local school-based surveys conducted by state and local education and health agencies. Oklahoma has participated in the YRBS since 2003.
References

2. CDC. Behavioral Risk Factor Surveillance System Survey Data [2003-2009]. Atlanta, Georgia: CDC.