Results from the 2005 National Survey on Drug Use and Health: National Findings

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Office of Applied Studies

Acknowledgments

This report was prepared by the Division of Population Surveys, Office of Applied Studies, SAMHSA, and by RTI International, a trade name of Research Triangle Institute, Research Triangle Park, North Carolina. Work by RTI was performed under Contract No. 283-2004-00022. Contributors and reviewers at RTI listed alphabetically include Jeremy Aldworth, Ellen Bishop, Walter R. Boyle, Patrick Chen, James R. Chromy, Andrew Clarke, Elizabeth Copello, David B. Cunningham, Lanting Dai, Teresa R. Davis, Steven L. Emrich, Ralph E. Folsom, Jr., Misty Foster, Peter Frechtel, G. G. Frick, Julia Gable, Jody M. Greene, David C. Heller, Erica Hirsch, Susan Hunter, B. Kathleen Jordan, Larry A. Kroutil, Bing Liu, Mary Ellen Marsden, Katherine B. Morton, Breda Munoz, Scott Novak, Lisa E. Packer, Lanny Piper, Jeremy Porter, Tania Robbins, Jill Ruppenkamp, Kathryn Spagnola, Paul Tillman, Thomas G. Virag (Project Director), Michael Vorburger, and Jiantong Wang. Contributors at SAMHSA listed alphabetically, with chapter authorship noted, include Peggy Barker (Chapter 8), James Colliver, Joan Epstein (Chapter 7), Joseph Gfroerer (Chapters 1, 2, 5, and 9), Joe Gustin, Arthur Hughes (Project Officer), Joel Kennet (Chapters 3 and 4), Sharon Larson (Chapter 8), Pradip Muhuri, Dicy Painter, and Doug Wright (Chapter 6). At RTI, Kathleen B. Mohar was the publication coordinator; Richard S. Straw edited the report; Diane G. Eckard and Danny Occoquan prepared the graphics; Brenda K. Porter formatted the tables; Joyce Clay-Brooks formatted and word processed the report; and Pamela Couch Prevatt, Teresa F. Gurley, Kim Cone, and Shari B. Lambert prepared its press and Web versions. Final report production was provided by Beatrice Rouse, Coleen Sanderson, and Jane Feldmann at SAMHSA.

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Originating Office

SAMHSA, Office of Applied Studies
1 Choke Cherry Road, Room 7-1044
Rockville, MD 20857

September 2006

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Highlights

This report presents the first information from the 2005 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year. Unless otherwise noted, all comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Illicit Drug Use

- In 2005, an estimated 19.7 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.1 percent of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

- The rate of current illicit drug use among persons aged 12 or older in 2005 (8.1 percent) was similar to the rate in 2004 (7.9 percent), 2003 (8.2 percent), and 2002 (8.3 percent).

- Marijuana was the most commonly used illicit drug (14.6 million past month users). Among persons aged 12 or older, the rate of past month marijuana use was about the same in 2005 (6.0 percent) as in 2004 (6.1 percent), 2003 (6.2 percent), and 2002 (6.2 percent).

- In 2005, there were 2.4 million current cocaine users aged 12 or older, which is more than in 2004 when the number was 2.0 million. However, the change in the rate of current use of cocaine between 2005 and 2004 (1.0 and 0.8 percent, respectively) was not statistically significant.

- Hallucinogens were used in the past month by 1.1 million persons (0.4 percent) aged 12 or older in 2005, including 502,000 (0.2 percent) who had used Ecstasy. These estimates are similar to the corresponding estimates for 2004.

- There were 6.4 million (2.6 percent) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. Of these, 4.7 million used pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants (including 512,000 using methamphetamine), and 272,000 used sedatives. Each of these estimates is similar to the corresponding estimate for 2004.

- The rates for past month and past year methamphetamine use did not change between 2004 and 2005, but the lifetime rate declined from 4.9 to 4.3 percent. From 2002 to 2005, decreases were seen in lifetime (5.3 to 4.3 percent) and past year (0.7 to 0.5 percent) use, but not past month use (0.3 percent in 2002 vs. 0.2 percent in 2005). Although the number of past month users has remained steady since 2002, the number of methamphetamine users who were dependent on or abused some illicit drug did rise significantly during this period, from 164,000 in 2002 to 257,000 in 2005.

- The rate of current illicit drug use among youths aged 12 to 17 in 2005 was similar to the rate in 2004, but significantly lower than in 2002. The rates were 11.6 percent in 2002, 11.2 percent in 2003, 10.6 percent in 2004, and 9.9 percent in 2005.

- The rate of current marijuana use among youths aged 12 to 17 declined from 7.6 percent in 2004 to 6.8 percent in 2005. The rate of current marijuana use has declined significantly from 8.2 percent in 2002.

- There were no significant changes in past month use of any illicit drugs among young adults aged 18 to 25 between 2004 and 2005, except for cocaine use, which increased from 2.1 to 2.6 percent.

- Past month nonmedical use of prescription-type drugs among young adults aged 18 to 25 increased from 5.4 percent in 2002 to 6.3 percent in 2005. This was primarily due to an increase in pain reliever use, which was 4.1 percent in 2002 and 4.7 percent in 2003, 2004, and 2005.

- Among unemployed adults aged 18 or older in 2005, 17.1 percent were current illicit drug users, which was higher than the 8.2 percent of those employed full time and 10.4 percent of those employed part time. However, most drug users were employed. Of the 17.2 million current illicit drug users aged 18 or older in 2005, 12.9 million (74.8 percent) were employed either full or part time.

- In 2005, there were 10.5 million persons aged 12 or older who reported driving under the influence of an illicit drug during the past year. This corresponds to 4.3 percent of the population aged 12 or older, similar to the rates in 2003 (4.6 percent) and 2004 (4.4 percent), but lower than the rate in 2002 (4.7 percent). In 2005, the rate was highest among young adults aged 18 to 25 (13.4 percent).

- NSDUH includes questions for nonmedical users of prescription-type psychotherapeutic drugs regarding how they obtained the drugs they recently used nonmedically. In 2005, the most prevalent source from which recently used drugs were obtained among nonmedical users of prescription-type drugs was "from a friend or relative for free."

- Among persons aged 12 or older who used pain relievers nonmedically in the past 12 months, 59.8 percent reported that the source of the drug the most recent time they used was from a friend or relative for free. Another 16.8 percent reported they got the drug from one doctor. Only 4.3 percent got the pain relievers from a drug dealer or other stranger, and only 0.8 percent reported buying the drug on the Internet.

Alcohol Use

- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in the 2005 survey (51.8 percent). This translates to an estimated 126 million people, which is higher than the 2004 estimate of 121 million people (50.3 percent).

- More than one fifth (22.7 percent) of persons aged 12 or older participated in binge drinking (having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey) in 2005. This translates to about 55 million people, comparable with the estimate in 2004.

- In 2005, heavy drinking was reported by 6.6 percent of the population aged 12 or older, or 16 million people. This rate is similar to the rate of heavy drinking in 2004 (6.9 percent). Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.

- In 2005, among young adults aged 18 to 25, the rate of binge drinking was 41.9 percent, and the rate of heavy drinking was 15.3 percent. These rates are similar to the rates in 2002, 2003, and 2004.

- The rate of current alcohol use among youths aged 12 to 17 declined from 17.6 percent in 2004 to 16.5 percent in 2005. Youth binge drinking also declined during that period, from 11.1 to 9.9 percent, but heavy drinking did not change significantly (2.7 percent in 2004 and 2.4 percent in 2005).

- Although there were declines in past month and binge alcohol use among youths aged 12 to 17 between 2004 and 2005, overall underage (persons aged 12 to 20) past month and binge drinking rates have remained essentially unchanged since 2002. In 2005, about 10.8 million persons aged 12 to 20 (28.2 percent of this age group) reported drinking alcohol in the past month. Nearly 7.2 million (18.8 percent) were binge drinkers, and 2.3 million (6.0 percent) were heavy drinkers.

- Among persons aged 12 to 20, past month alcohol use rates were 12.0 percent among Native Hawaiians or Other Pacific Islanders, 15.5 percent among Asians, 19.0 percent among blacks, 21.7 percent among American Indians or Alaska Natives, 24.0 percent among those reporting two or more races, 25.9 percent among Hispanics, and 32.3 percent among whites.

- In 2005, an estimated 13.0 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage has dropped since 2002, when it was 14.2 percent. The 2005 estimate corresponds to 31.7 million persons.

Tobacco Use

- In 2005, an estimated 71.5 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 29.4 percent of the population in that age range. In addition, 60.5 million persons (24.9 percent of the population) were current cigarette smokers; 13.6 million (5.6 percent) smoked cigars; 7.7 million (3.2 percent) used smokeless tobacco; and 2.2 million (0.9 percent) smoked tobacco in pipes.

- The rates of current use of cigarettes, smokeless tobacco, cigars, and pipe tobacco were unchanged between 2004 and 2005 among persons aged 12 or older. However, between 2002 and 2005, past month use of a tobacco product declined from 30.4 to 29.4 percent, and past month cigarette use decreased from 26.0 to 24.9 percent.

- The rate of past month cigarette use among 12 to 17 year olds declined from 13.0 percent in 2002 to 10.8 percent in 2005. Cigar use in the past month declined to 4.2 percent of youths in 2005 from the 2004 estimate of 4.8 percent. Past month smokeless tobacco use was reported by 2.1 percent of youths in 2005, similar to estimates since 2002.

- Among pregnant women aged 15 to 44, combined data for 2004 and 2005 indicated that the rate of past month cigarette use was 16.6 percent. The rate was higher among women in that age group who were not pregnant (29.6 percent).

Initiation of Substance Use (Incidence, or First-Time Use)

- The illicit drug categories with the largest number of recent initiates among persons aged 12 or older were nonmedical use of pain relievers (2.2 million) and marijuana use (2.1 million). These estimates are not significantly different from the numbers in 2004.

- In 2005, there were 877,000 persons aged 12 or older who had used inhalants for the first time within the past 12 months; 72.3 percent were under age 18 when they first used. There was no significant change in the number of inhalant initiates from 2002 to 2005.

- The number of recent new users of methamphetamine taken nonmedically among persons aged 12 or older was 192,000 in 2005. Between 2002 and 2004, the number of methamphetamine initiates remained steady at around 300,000 per year, but there was a decline from 2004 (318,000 initiates) to 2005.

- Most (88.9 percent) of the 4.3 million recent alcohol initiates were younger than 21 at the time of initiation.

- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.3 million in 2005, which was significantly greater than the estimate for 2002 (1.9 million). Most new smokers in 2005 were under age 18 when they first smoked cigarettes (63.4 percent).

Youth Prevention-Related Measures

- Perceived risk is measured by NSDUH as the percentage reporting that there is great risk in the substance use behavior. Among youths aged 12 to 17, there were no changes in the perceived risk of marijuana, cocaine, heroin, or LSD use between 2004 and 2005. However, between 2002 and 2005, there were increases in the perceived risk of smoking marijuana once a month (from 32.4 to 34.0 percent) and smoking marijuana once or twice a week (from 51.5 to 55.0 percent). On the other hand, the percentage of youths who perceived that trying heroin once or twice is a great risk declined from 58.5 percent in 2002 to 56.5 percent in 2005, and those who perceived that using cocaine once a month is a great risk declined from 50.5 to 48.8 percent.

- The proportion of youths aged 12 to 17 who reported perceiving great risk from smoking one or more packs of cigarettes per day increased from 63.1 percent in 2002 to 68.3 percent in 2005.

- Over half (51.0 percent) of youths aged 12 to 17 reported in 2005 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some. Around one quarter reported it would be easy to get cocaine (24.9 percent) or crack (25.3 percent). One in seven (14.0 percent) indicated that heroin would be "fairly" or "very" easily available, and about one in six (15.7 percent) said it would be easy for them to get LSD if they wanted some.

- The perceived availability among youths decreased between 2002 and 2005 for marijuana (from 55.0 to 51.0 percent), crack (from 26.5 to 25.3 percent), heroin (from 15.8 to 14.0 percent), and LSD (from 19.4 to 15.7 percent). However, the percentage reporting that it would be easy to obtain cocaine showed no decline over this period (25.0 percent in 2002 and 24.9 percent in 2005).

- A majority of youths (90.2 percent) reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice. Current marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.6 vs. 27.0 percent).

- Almost four fifths (77.9 percent) of youths aged 12 to 17 enrolled in school reported in 2005 they had seen or heard drug or alcohol prevention messages at school in the past year, a percentage similar to the 2004 estimate of 78.2 percent. Past month use of an illicit drug was lower for youths exposed to such messages in school (9.2 percent) than for youths not reporting such exposure (13.2 percent).

Substance Dependence, Abuse, and Treatment

- In 2005, an estimated 22.2 million persons (9.1 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). Of these, 3.3 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.6 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs.

- Between 2002 and 2005, there was no change in the number of persons with substance dependence or abuse (22.0 million in 2002, 21.6 million in 2003, 22.5 million in 2004, and 22.2 million in 2005).

- The specific illicit drugs that had the highest levels of past year dependence or abuse in 2005 were marijuana (4.1 million), followed by cocaine (1.5 million) and pain relievers (1.5 million).

- Adults aged 21 or older who had first used alcohol before age 21 were more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (9.6 vs. 2.1 percent).

- There were 3.9 million persons aged 12 or older (1.6 percent of the population) who received some kind of treatment for a problem related to the use of alcohol or illicit drugs in 2005. More than half (2.1 million) received treatment at a self-help group. There were 1.5 million persons who received treatment at a rehabilitation facility as an outpatient, 1.1 million at a rehabilitation facility as an inpatient, 1.0 million at a mental health center as an outpatient, 773,000 at a hospital as an inpatient, 460,000 at a private doctor's office, 399,000 at an emergency room, and 344,000 at a prison or jail. None of these estimates changed significantly between 2004 and 2005.

- More than half (2.5 million) of the 3.9 million persons who received treatment for a substance use problem in the past year received treatment for alcohol use during their most recent treatment. There were 1.1 million persons who received treatment for marijuana use during their most recent treatment. Estimates for other drugs were 797,000 persons for cocaine, 466,000 for pain relievers, 358,000 for hallucinogens, 351,000 for stimulants, and 326,000 for heroin. (Note that respondents could indicate that they received treatment for more than one substance during their most recent treatment.)

- In 2005, the number of persons aged 12 or older needing treatment for an illicit drug or alcohol use problem was 23.2 million (9.5 percent of the population aged 12 or older). Of these, 2.3 million (0.9 percent of persons aged 12 or older and 10.0 percent of those who needed treatment) received treatment at a specialty facility. Thus, there were 20.9 million persons (8.6 percent of the population aged 12 or older) who needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year.

- Of the 20.9 million people in 2005 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1.2 million persons (5.6 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem. Of these 1.2 million persons who felt they needed treatment, 296,000 (25.5 percent) reported that they made an effort to get treatment, and 865,000 (74.5 percent) reported making no effort to get treatment.

- The number of people who felt they needed treatment and made an effort to get it among those who needed but did not receive treatment was not statistically different in 2005 (296,000) from the number reported in 2004 (441,000).

Prevalence and Treatment of Mental Health Problems

- Serious psychological distress (SPD) is an overall indicator of past year nonspecific psychological distress that is constructed from the K6 scale administered to adults aged 18 or older in NSDUH. The data related to SPD in this report are not comparable with data in previous reports due to changes in the survey administration of this instrument.

- In 2005, there were an estimated 24.6 million adults aged 18 or older in the United States with SPD in the past year. This represents 11.3 percent of all adults in this country, a significantly lower rate than in 2004 (12.2 percent).

- Rates of SPD in 2005 were highest for adults aged 18 to 25 (18.6 percent) and lowest for adults aged 50 or older (7.1 percent).

- The prevalence of SPD among women aged 18 or older (14.0 percent) was higher than that among men in that age group (8.4 percent).

- SPD in the past year was associated with past year substance dependence or abuse in 2005. Among adults with SPD in 2005, 21.3 percent (5.2 million) were dependent on or abused illicit drugs or alcohol. The rate among adults without SPD was 7.7 percent (14.9 million).

- Among the 24.6 million adults with SPD in 2005, 11.1 million (45.3 percent) received treatment for a mental health problem in the past year. This was a higher proportion than in 2004 (41.6 percent). Among adults with SPD, 39.4 percent received a prescription medication, 28.5 percent received outpatient treatment, and 4.6 percent received inpatient treatment for a mental health problem in the past year.

- Among the 5.2 million adults with both SPD and substance dependence or abuse (i.e., a substance use disorder) in 2005, about half (47.0 percent) received mental health treatment or substance use treatment at a specialty facility: 8.5 percent received both treatment for mental health problems and specialty substance use treatment, 34.3 percent received only treatment for mental health problems, and 4.1 percent received only specialty substance use treatment.

- In 2005, there were 30.8 million adults (14.2 percent of persons aged 18 or older) who had at least one major depressive episode (MDE) in their lifetime, and 15.8 million adults (7.3 percent of persons aged 18 or older) had at least one MDE in the past year. In 2004, there were 17.1 million adults (8.0 percent) who had MDE during the past year. This represents a statistically significant decline in the rate of past year MDE between 2004 and 2005.

- Having MDE in the past year was associated with past year substance dependence or abuse in 2005. Among adults who had MDE in 2005, 19.9 percent were dependent on or abused alcohol or illicit drugs, while among persons without MDE only 8.4 percent were dependent on or abused alcohol or illicit drugs. Persons with MDE were more likely than those without MDE to be dependent on or abuse illicit drugs (8.3 vs. 2.1 percent) and alcohol (14.8 vs. 7.4 percent).

- Among adults aged 18 or older who had MDE in the past year, 65.6 percent received treatment (i.e., saw or talked to a medical doctor or other professional or used prescription medication) for depression in the same time period.

- Among adults aged 18 or older with MDE in the past year in 2005, women were more likely than men to receive treatment for depression in the past year (70.9 vs. 55.6 percent).

- In 2005, there were 3.4 million youths aged 12 to 17 years (13.7 percent of the population aged 12 to 17 years old) who had at least one MDE in their lifetime and 2.2 million youths (8.8 percent) who had MDE during the past year.

- The rate of MDE in the past year was higher for adolescent females (13.3 percent) than for adolescent males (4.5 percent).

- The occurrence of MDE in the past year among youths aged 12 to 17 was associated with a higher prevalence of illicit drug or alcohol dependence or abuse (19.8 percent). Among youths who did not report past year MDE, 6.9 percent had illicit drug or alcohol dependence or abuse during the same period.

- In 2005, 37.8 percent of youths aged 12 to 17 with past year MDE received treatment for depression (saw or talked to a medical doctor or other professional or used prescription medication).

1. Introduction

This report presents the first information from the 2005 National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. Prior to 2002, the survey name was the National Household Survey on Drug Abuse (NHSDA). This initial report on the 2005 data presents national estimates of rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco products. Measures related to mental health problems also are presented, including data on depression and on the co-occurrence of substance use and mental health problems. Estimates from NSDUH for States and areas within States will be presented in separate reports.

A major focus of this report is a comparison of substance use prevalence estimates between 2004 and 2005. Trends since 2002 also are discussed for some measures. Because of improvements to the survey in 2002, the 2002 data constitute a new baseline for tracking trends in substance use and other measures. Therefore, estimates from the 2002 through 2005 NSDUHs should not be compared with estimates from the 2001 and earlier surveys in the series to assess changes in substance use and mental health problems over time.

1.1. Summary of NSDUH

NSDUH is the primary source of statistical information on the use of illegal drugs by the U.S. population. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent's place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, and is planned and managed by SAMHSA's Office of Applied Studies (OAS). Data collection is conducted under contract with RTI International, Research Triangle Park, North Carolina.[1] This section briefly describes the survey methodology; a more complete description is provided in Appendix A.

NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. Appendix D describes surveys that cover populations outside the NSDUH target population.

Since 1999, the NSDUH interview has been carried out using computer-assisted interviewing (CAI). Most of the questions are administered with audio computer-assisted self-interviewing (ACASI). ACASI is designed to provide the respondent with a highly private and confidential means of responding to questions to increase the level of honest reporting of illicit drug use and other sensitive behaviors. Less sensitive items are administered by interviewers using computer-assisted personal interviewing (CAPI).

[1] RTI International is a trade name of Research Triangle Institute.

The 2005 NSDUH employed a State-based design with an independent, multistage area probability sample within each State and the District of Columbia. The eight States with the largest population (which together account for 48 percent of the total U.S. population aged 12 or older) were designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas). For these States, the design provided a sample sufficient to support direct State estimates. For the remaining 42 States and the District of Columbia, smaller, but adequate, samples support State estimates using small area estimation (SAE) techniques. The design oversampled youths and young adults, so that each State's sample was approximately equally distributed among three age groups: 12 to 17 years, 18 to 25 years, and 26 years or older.

Nationally, 134,055 addresses were screened for the 2005 survey, and 68,308 completed interviews were obtained. The survey was conducted from January through December 2005. Weighted response rates for household screening and for interviewing were 91.3 and 76.2 percent, respectively. See Appendix B for more information on NSDUH response rates.

1.2. Trend Measurement

Although the design of the 2002 through 2005 NSDUHs is similar to the design of the 1999 through 2001 surveys, there are important methodological differences that affect the comparability of the 2002-2005 estimates with estimates from prior surveys. In addition to the name change, each NSDUH respondent completing the interview is now given an incentive payment of $30. These changes, implemented in 2002 and continued subsequently, resulted in an improvement in the response rate, but also affected respondents' reporting of items that are the basis of prevalence measures produced each year. Comparability also may be affected by improved data collection quality control procedures that were introduced beginning in 2001 and by the incorporation of new population data from the 2000 decennial census into NSDUH sample weighting procedures. **Analyses of the effects of these factors on NSDUH estimates have shown that 2002 and later data should not be compared with 2001 and earlier data from the survey series to assess changes over time. Appendix C of the 2004 NSDUH report on national findings discusses this issue in more detail (see OAS, 2005).**

1.3. Format of Report and Explanation of Tables

This report has separate chapters that discuss the national findings on seven topics: use of illicit drugs; use of alcohol; use of tobacco products; initiation of substance use; prevention-related issues; substance dependence, abuse, and treatment; and mental health problems and treatment. A final chapter summarizes the results and discusses key findings in relation to other research and survey results. Technical appendices describe the survey (Appendix A), provide technical details on the statistical methods and measurement (Appendix B), offer key NSDUH definitions (Appendix C), discuss other sources of related data (Appendix D), list the references cited in the report (as well as other relevant references) (Appendix E), and present selected tabulations of estimates (Appendices F and G).

Tables, text, and figures present prevalence measures for the population in terms of both the number of persons and the percentage of the population. Substance use tables show prevalence estimates by lifetime (i.e., ever used), past year, and past month use. Analyses focus primarily on past month use, which also is referred to as "current use." Tables and figures in

which estimates are presented by year have footnotes indicating whether the 2005 estimates are significantly different from 2004 or earlier estimates.

Statistical tests have been conducted for all statements appearing in the text of the report that compare estimates between years or subgroups of the population. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level. Statistically significant differences are described using terms such as "higher," "lower," "increased," and "decreased." Statements that use terms such as "similar," "no difference," "same," or "remained steady" to describe the relationship between estimates denote that a difference is not statistically significant. In addition, a set of estimates for survey years or population subgroups may be presented without a statement of comparison, in which case a statistically significant difference between these estimates is not implied and testing was not conducted.

All estimates presented in the report have met the criteria for statistical reliability (see Section B.2.2 of Appendix B). Estimates that do not meet these criteria are suppressed and do not appear in tables, figures, or text. Also, subgroups with suppressed estimates are not included in statistical tests of comparisons. For example, a statement that "whites had the highest prevalence" means that the rate among whites was higher than the rate among all nonsuppressed racial/ethnic subgroups, but not necessarily higher than the rate among a subgroup for which the estimate was suppressed.

Data are presented for racial/ethnic groups based on current guidelines for collecting and reporting race and ethnicity data (Office of Management and Budget [OMB], 1997). Because respondents were allowed to choose more than one racial group, a "two or more races" category is presented that includes persons who reported more than one category among the basic groups listed in the survey question (white, black or African American, American Indian or Alaska Native, Native Hawaiian, Other Pacific Islander, Asian, Other). Respondents choosing both Native Hawaiian and Other Pacific Islander but no other categories mentioned above are classified in the combined "Native Hawaiian or Other Pacific Islander" category instead of the "two or more race" category. It should be noted that, except for the "Hispanic or Latino" group, the racial/ethnic groups discussed in this report include only non-Hispanics. The category "Hispanic or Latino" includes Hispanics of any race.

Data also are presented for four U.S. geographic regions and nine geographic divisions within these regions. These regions and divisions, defined by the U.S. Census Bureau, consist of the following groups of States:

> ***Northeast Region*** - *New England Division:* Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; *Middle Atlantic Division:* New Jersey, New York, Pennsylvania.
>
> ***Midwest Region*** - *East North Central Division:* Illinois, Indiana, Michigan, Ohio, Wisconsin; *West North Central Division:* Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota.

South Region - *South Atlantic Division:* Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; *East South Central Division:* Alabama, Kentucky, Mississippi, Tennessee; *West South Central Division:* Arkansas, Louisiana, Oklahoma, Texas.

West Region - *Mountain Division:* Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; *Pacific Division:* Alaska, California, Hawaii, Oregon, Washington.

Geographic comparisons also are made based on county type, a variable that reflects different levels of urbanicity and metropolitan area inclusion of counties, based on metropolitan area definitions issued by the OMB in June 2003 (OMB, 2003). For this purpose, counties are grouped based on the 2003 rural-urban continuum codes. These codes were originally developed by the U.S. Department of Agriculture (Butler & Beale, 1994). Each county is either inside or outside a metropolitan statistical area (MSA), as defined by the OMB.

Large metropolitan areas have a population of 1 million or more. Small metropolitan areas have a population of fewer than 1 million. Small metropolitan areas are further classified based on whether they have a population of 250,000 or more. Nonmetropolitan areas are areas outside MSAs. Counties in nonmetropolitan areas are further classified based on the number of people in the county who live in an urbanized area, as defined by the Census Bureau at the subcounty level. "Urbanized" counties have a population of 20,000 or more in urbanized areas, "less urbanized" counties have at least 2,500 but fewer than 20,000 population in urbanized areas, and "completely rural" counties have fewer than 2,500 population in urbanized areas.

1.4. Other NSDUH Reports and Data

Other reports focusing on specific topics of interest will be produced using the 2005 NSDUH data and made available on SAMHSA's website. A report on State-level estimates for 2004-2005 will be available in early 2007.

In addition to the tables in Appendices F and G, a more extensive set of tables, including standard errors, is available upon request from OAS or through the Internet at http://www.oas.samhsa.gov. Tables in Appendices F and G can be mapped back to these detailed tables by using the table number in parentheses in the upper left corner of each table (e.g., Table F.1 in Appendix F is Table 9.1N in the detailed tables). Additional methodological information on NSDUH, including the questionnaire, is available electronically at the same Web address. Brief descriptive reports and in-depth analytic reports focusing on specific issues or population groups also are produced by OAS. A complete listing of previously published reports from NSDUH and other data sources is available from OAS. Most of these reports also are available through the Internet (http://www.oas.samhsa.gov). In addition, OAS makes public use data files available to researchers through the Substance Abuse and Mental Health Data Archive (SAMHDA, 2006) at http://www.icpsr.umich.edu/SAMHDA/index.html. Currently, files are available from the 1979 to 2004 surveys. The 2005 NSDUH public use file will be available by the end of 2006.

2. Illicit Drug Use

The National Survey on Drug Use and Health (NSDUH) obtains information on nine different categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants; and the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives. In these categories, hashish is included with marijuana, and crack is considered a form of cocaine. Several drugs are grouped under the hallucinogens category, including LSD, PCP, peyote, mescaline, mushrooms, and "Ecstasy" (MDMA). Inhalants include a variety of substances, such as amyl nitrite, cleaning fluids, gasoline, paint, and glue. The four categories of prescription-type drugs (pain relievers, tranquilizers, stimulants, and sedatives) cover numerous drugs available through prescriptions as well as drugs within these groupings that may be manufactured illegally, such as methamphetamine, which is included under stimulants. Respondents are asked to report only uses of drugs that were not prescribed for them or drugs they took only for the experience or feeling they caused; therefore, over-the-counter drugs and legitimate uses of prescription drugs are not included. NSDUH reports combine the four prescription-type drug groups into a category referred to as "psychotherapeutics."

Because of concerns that methamphetamine use is underestimated in NSDUH due to its inclusion within the prescription-type drug questions, new questions regarding methamphetamine use were added to NSDUH in 2005. Preliminary analysis of these new data showed that underestimation is occurring, and additional questions may be needed to make it possible to estimate correctly the actual prevalence rate for methamphetamine use. Additional questions were included in the 2006 NSDUH. A discussion of these analyses, including preliminary data from the new 2006 questions, is provided in Section B.4.6 in Appendix B. Estimates of methamphetamine use in this chapter and in the tables in Appendix G are based on the same "core" NSDUH questions that were used in the 2004 survey and are therefore comparable with estimates from previous years.

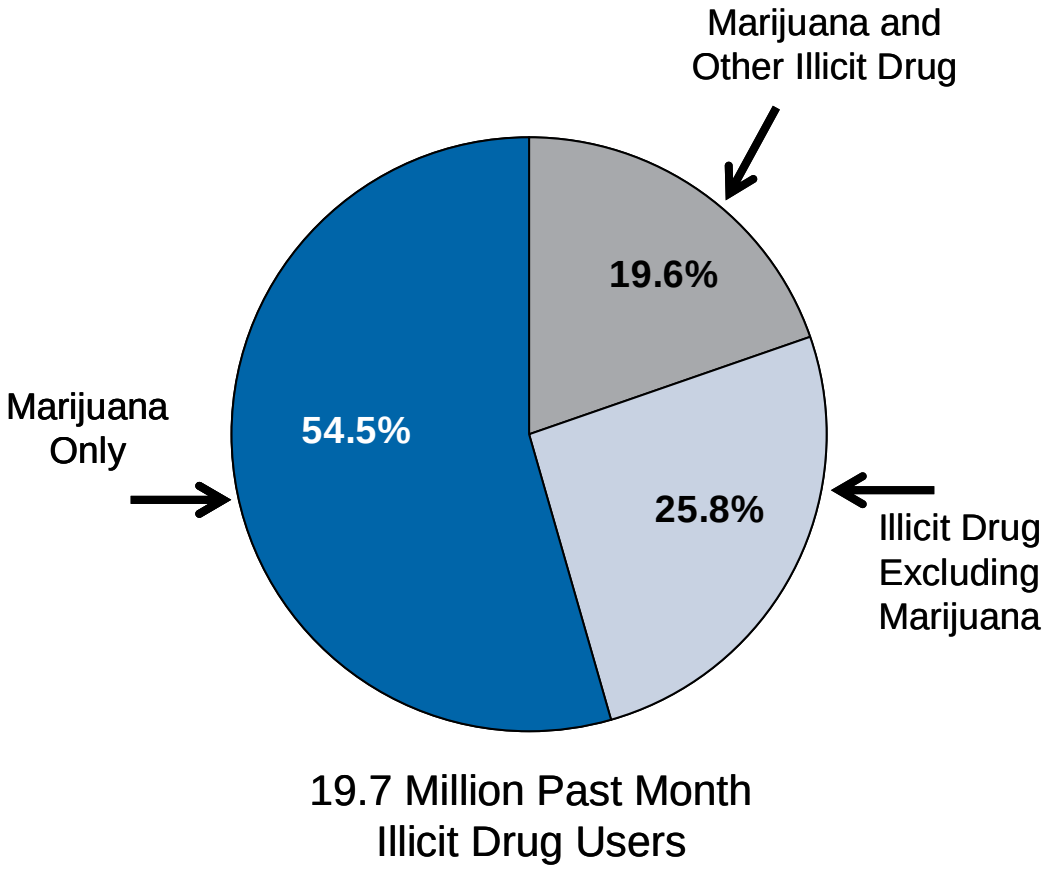
Estimates of "illicit drug use" reported from NSDUH reflect the use of any of the nine drug categories listed above. Use of alcohol and tobacco products, while illegal for youths, is not included in these estimates, but is discussed in Chapters 3 and 4.

- In 2005, an estimated 19.7 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.1 percent of the population aged 12 years old or older.

- The overall rate of current illicit drug use among persons aged 12 or older in 2005 (8.1 percent) was similar to the rate in 2004 (7.9 percent), 2003 (8.2 percent), and 2002 (8.3 percent).

- Marijuana was the most commonly used illicit drug (14.6 million past month users). In 2005, it was used by 74.2 percent of current illicit drug users. Among current illicit drug users, 54.5 percent used only marijuana, 19.6 percent used marijuana and another illicit drug, and the remaining 25.8 percent used only an illicit drug other than marijuana in the past month (Figure 2.1).

Figure 2.1 Types of Drugs Used by Past Month Illicit Drug Users Aged 12 or Older: 2005



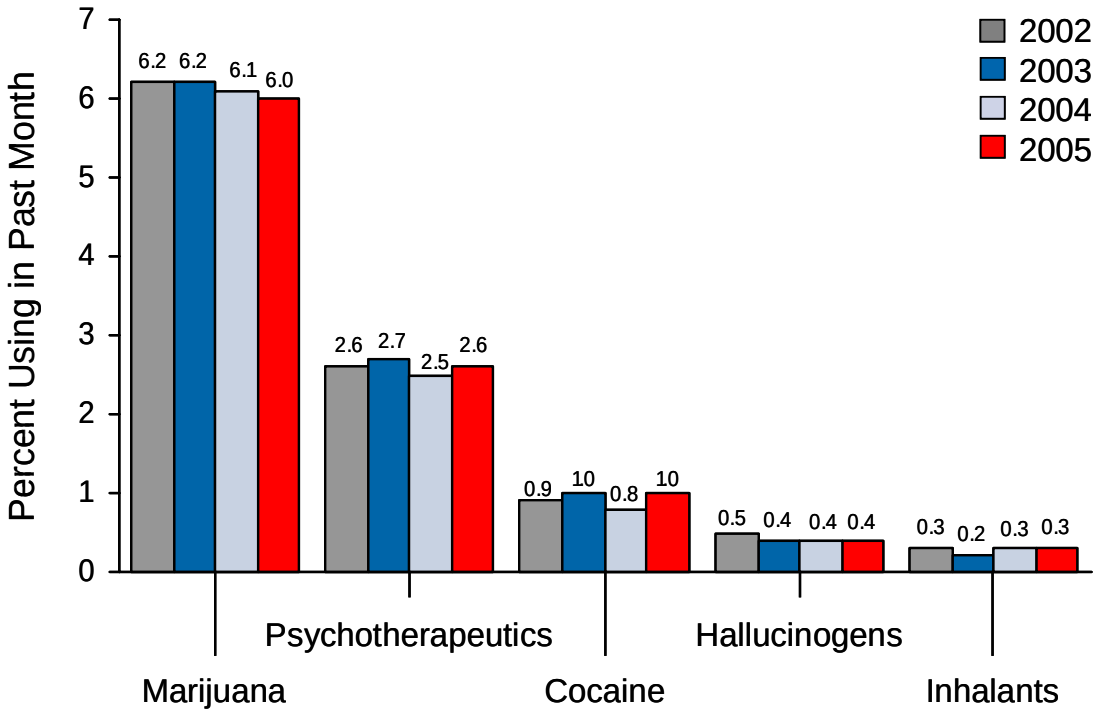
- Among persons aged 12 or older, the overall rate of past month marijuana use was about the same in 2005 (6.0 percent) as it was in 2004 (6.1 percent), 2003 (6.2 percent), and 2002 (6.2 percent) (Figure 2.2).

- In 2005, there were 2.4 million persons who were current cocaine users, which is more than in 2004 when the number was 2.0 million. However, the change in the rate of current use of cocaine between 2005 and 2004 (1.0 and 0.8 percent, respectively) was not statistically significant.

- Similarly, the number of current crack users increased from 467,000 in 2004 to 682,000 in 2005. However, the change in the rate of current use of crack between 2004 and 2005 (0.2 and 0.3 percent, respectively) was not statistically significant.

- Hallucinogens were used in the past month by 1.1 million persons (0.4 percent) in 2005, including 502,000 (0.2 percent) who had used Ecstasy. These estimates are similar to the corresponding estimates for 2004.

Figure 2.2 Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

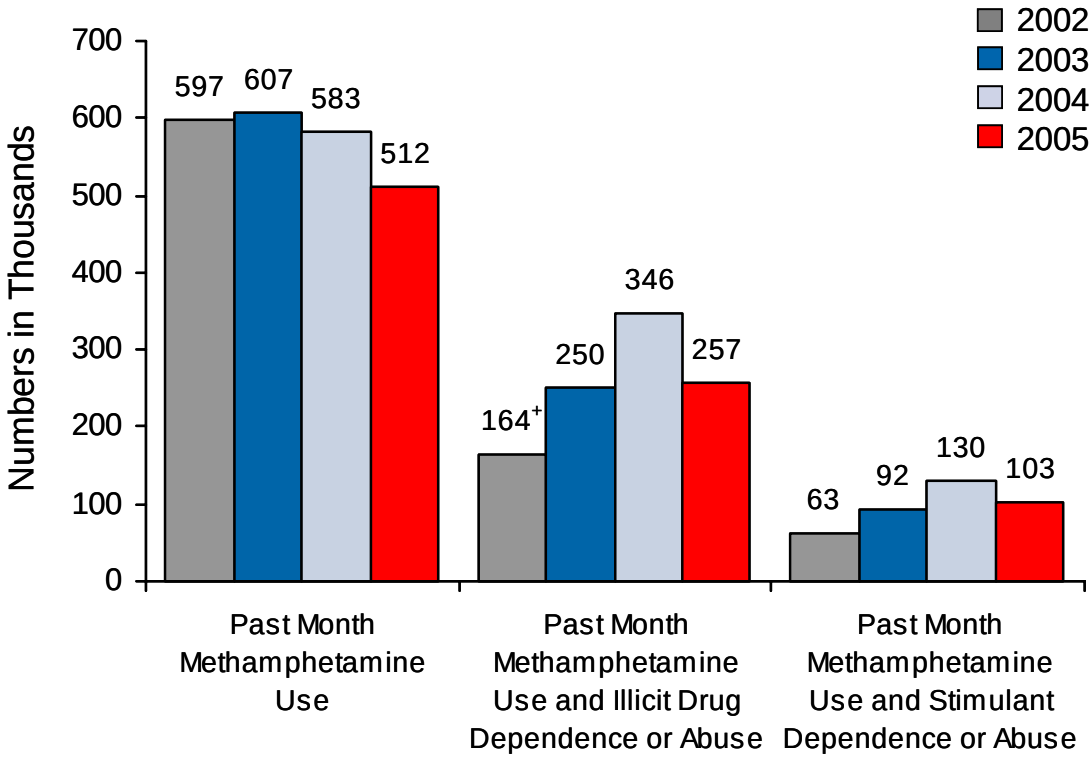
- There was no significant change in the number of current heroin users in 2005 (136,000), nor in the rate of heroin use (0.1 percent), compared with estimates from 2004.

- There were 9.0 million people aged 12 or older (3.7 percent) who were current users of illicit drugs other than marijuana in 2005. Most (6.4 million, 2.6 percent) used psychotherapeutic drugs nonmedically. Of these, 4.7 million used pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants (including 512,000 using methamphetamine), and 272,000 used sedatives. Each of these estimates is similar to the corresponding estimate for 2004.

- The rate of current use of sedatives declined from 0.2 percent in 2002 to 0.1 percent in 2005, but there were no significant changes in current nonmedical use of other categories of psychotherapeutics during that period.

- The rates for past month and past year methamphetamine use did not change between 2004 and 2005, but the lifetime rate declined from 4.9 to 4.3 percent. From 2002 to 2005, decreases were seen in lifetime (5.3 to 4.3 percent) and past year (0.7 to 0.5 percent) use, but not past month use (0.3 percent in 2002 vs. 0.2 percent in 2005). Although the number of past month users has remained steady since 2002, the number of methamphetamine users who were dependent on or abused some illicit drug did rise significantly during this period, from 164,000 in 2002 to 257,000 in 2005 (Figure 2.3).

Figure 2.3 Past Month Methamphetamine Use and Illicit Drug or Stimulant Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Year: 2002-2005

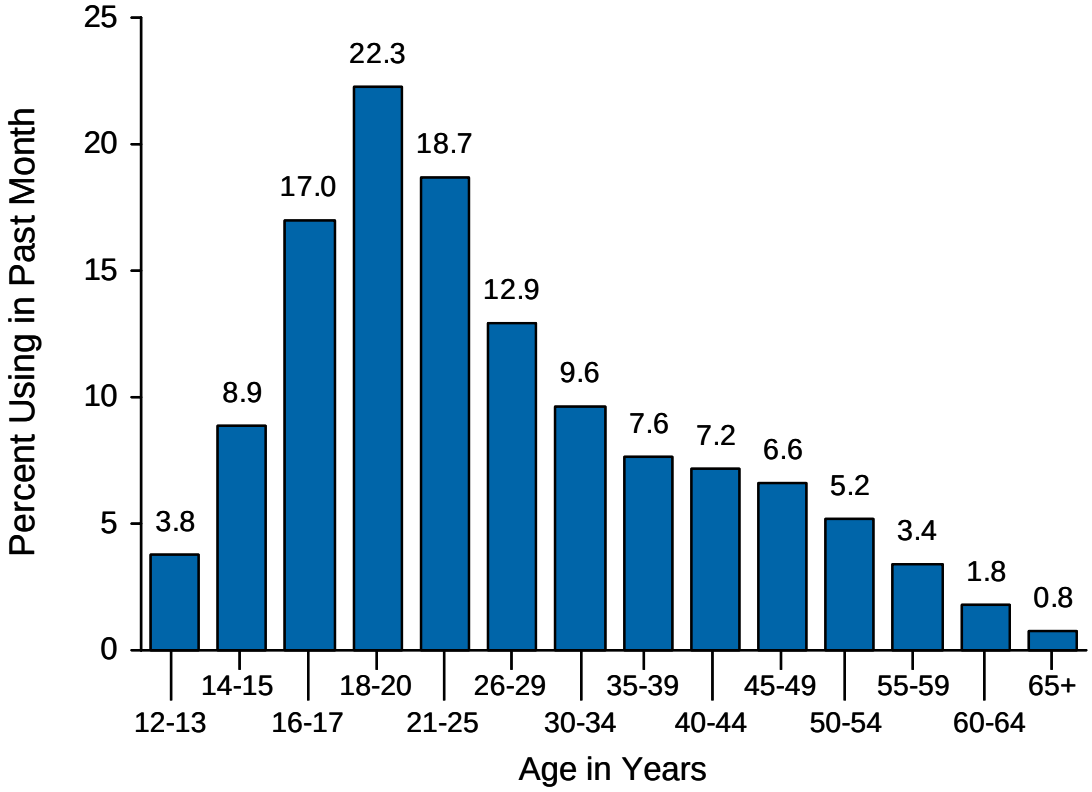


+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Age

- Rates of drug use are associated with age. Among youths aged 12 to 17, the rates of current illicit drug use increased with age: 3.8 percent at ages 12 or 13, 8.9 percent at ages 14 or 15, and 17.0 percent at ages 16 or 17 (Figure 2.4). The highest rate was among persons aged 18 to 20 (22.3 percent). The rate was 18.7 percent among those aged 21 to 25 and declined with increasing age among older adults.

Figure 2.4 Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2005

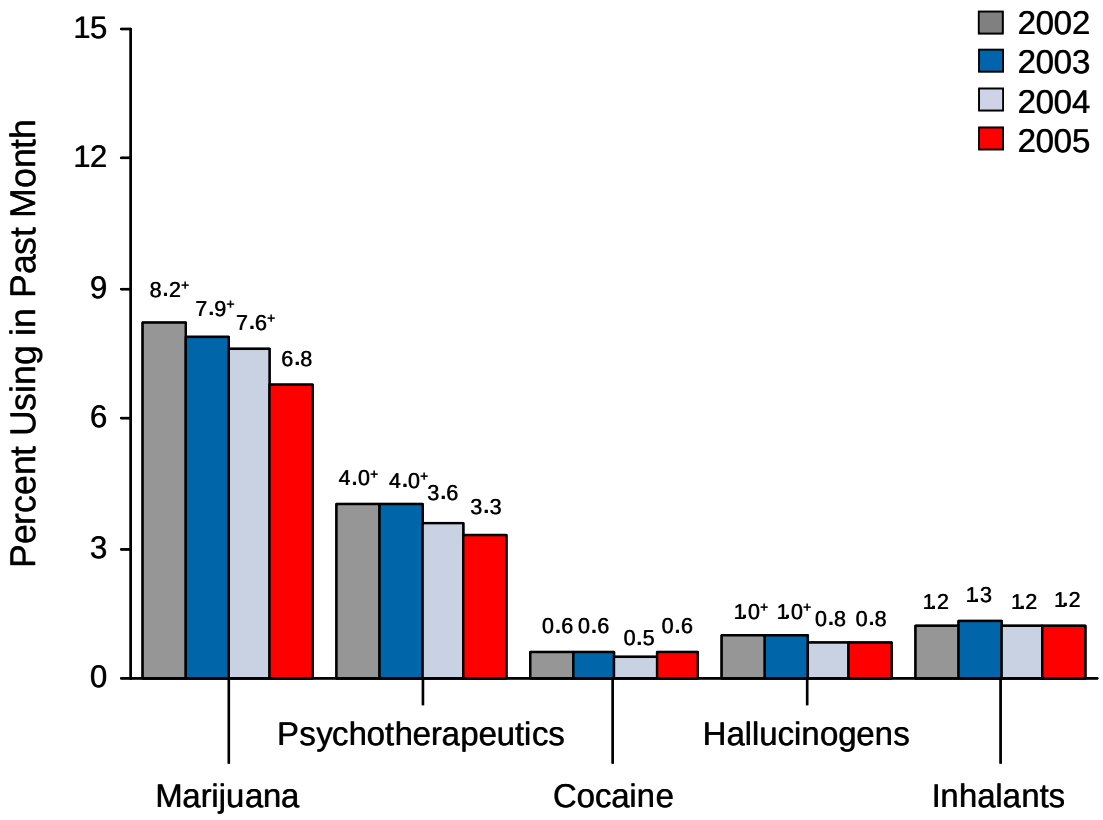


Youths Aged 12 to 17

- Among youths, different age groups engaged in the use of different types of illicit drugs in the past month. Among 12 or 13 year olds, 1.7 percent used prescription-type drugs nonmedically, 1.5 percent used inhalants, and 0.9 percent used marijuana. Among 14 or 15 year olds, marijuana was the dominant drug used (5.9 percent), followed by prescription-type drugs used nonmedically (2.8 percent) and inhalants (1.2 percent). Marijuana also was the most commonly used drug among 16 or 17 year olds (13.6 percent), followed by prescription-type drugs used nonmedically (5.4 percent), hallucinogens (1.7 percent), cocaine (1.2 percent), and inhalants (1.0 percent).

- In 2005, 9.9 percent of youths aged 12 to 17 were current illicit drug users: 6.8 percent used marijuana, 3.3 percent used prescription-type drugs nonmedically, 1.2 percent used inhalants, 0.8 percent used hallucinogens, and 0.6 percent used cocaine (Figure 2.5).

Figure 2.5 Past Month Use of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2005

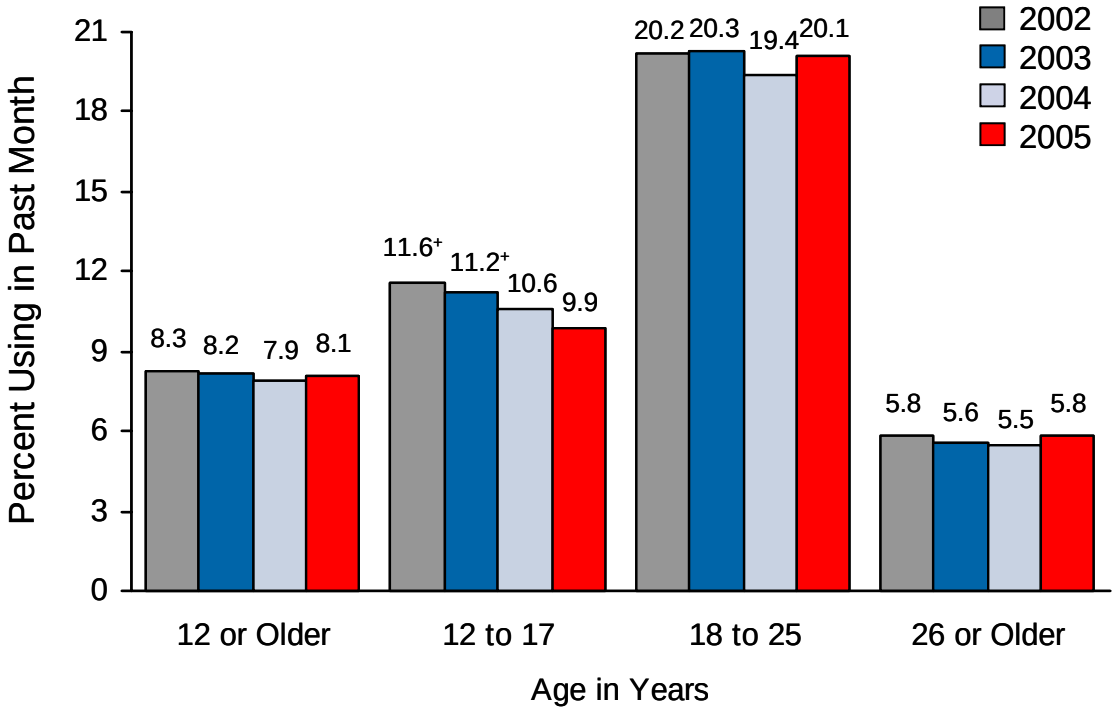


+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- The rate of current illicit drug use among youths aged 12 to 17 in 2005 was significantly lower than in 2002 (Figure 2.6). The rates were 11.6 percent in 2002, 11.2 percent in 2003, 10.6 percent in 2004, and 9.9 percent in 2005.

- The rate of current marijuana use among youths aged 12 to 17 declined from 7.6 percent in 2004 to 6.8 percent in 2005. There were also significant declines in past year use (14.5 to 13.3 percent) and lifetime use (19.0 to 17.4 percent). The rate of current marijuana use has declined significantly from 8.2 in 2002 to 6.8 percent in 2005. Significant declines were also evident between 2002 and 2005 for past year use (from 15.8 to 13.3 percent) and lifetime use (from 20.6 to 17.4 percent).

Figure 2.6 Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Young Adults Aged 18 to 25

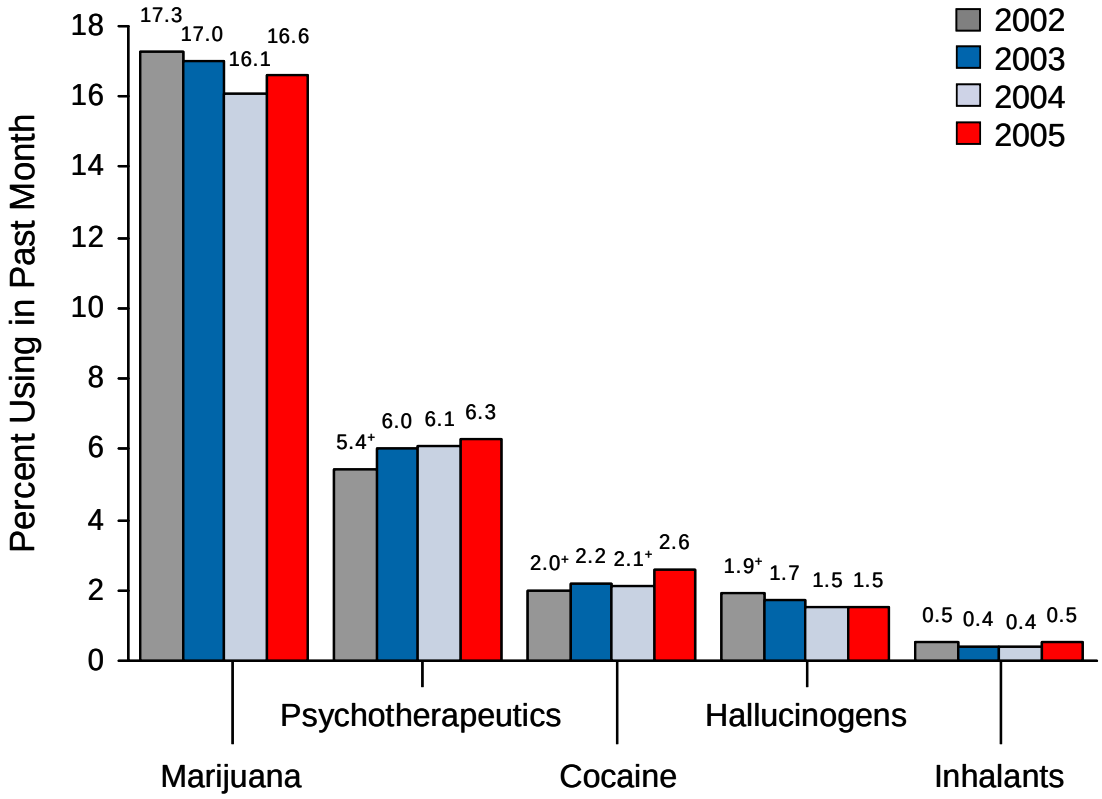
- Rates of current use of illicit drugs were higher for young adults aged 18 to 25 (20.1 percent) than for youths aged 12 to 17 and adults aged 26 or older, with 16.6 percent using marijuana, 6.3 percent using prescription-type drugs nonmedically, 2.6 percent using cocaine, and 1.5 percent using hallucinogens (Figure 2.7).

- There were no significant changes in past month use of any drugs among young adults between 2004 and 2005, except for cocaine use, which increased from 2.1 to 2.6 percent.

- Past year use of Ecstasy among young adults declined from 5.8 percent in 2002 to 3.7 percent in 2003 and to 3.1 percent in both 2004 and 2005.

- Past month nonmedical use of prescription-type drugs among young adults increased from 5.4 percent in 2002 to 6.3 percent in 2005. This was primarily due to an increase in pain reliever use, which was 4.1 percent in 2002 and 4.7 percent in 2003, 2004, and 2005.

Figure 2.7 Past Month Use of Selected Illicit Drugs among Young Adults Aged 18 to 25: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Adults Aged 26 or Older

- Among adults aged 26 or older, 5.8 percent reported current illicit drug use in 2005. In this age group, 4.1 percent used marijuana, and 1.9 percent used prescription-type drugs. Moreover, fewer than 1 percent used cocaine (0.8 percent), hallucinogens (0.2 percent), and inhalants (0.1 percent). Rates of lifetime, past year, and past month illicit drug use among adults aged 26 or older were unchanged between 2004 and 2005.

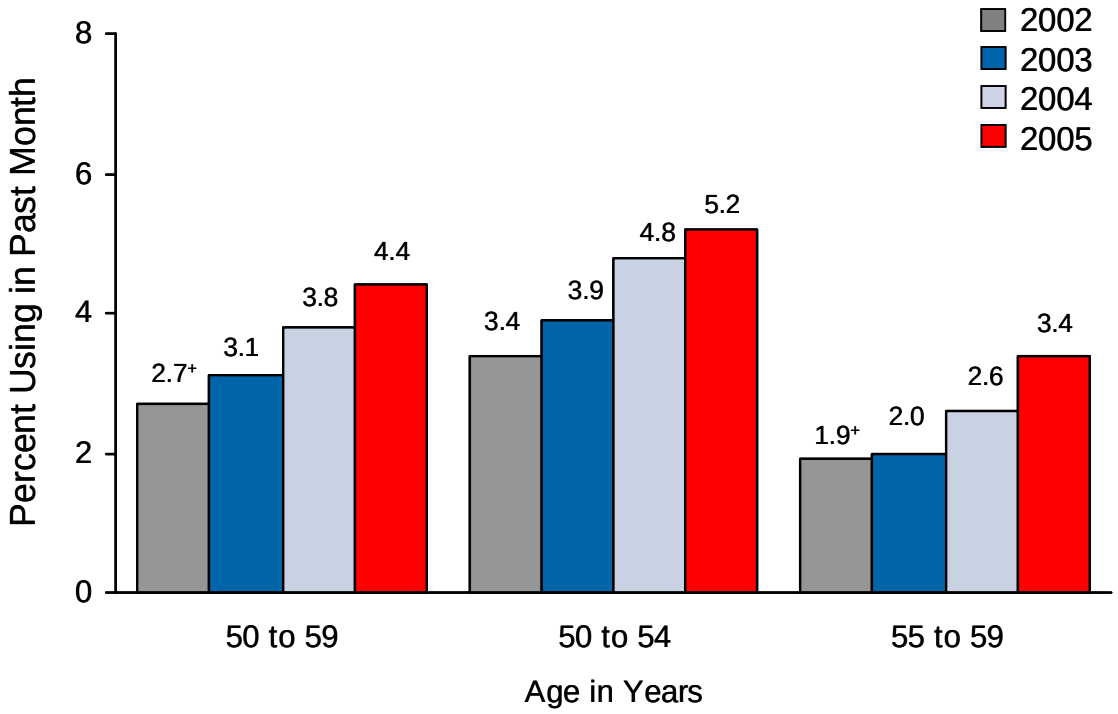
- Among adults aged 50 to 59, the rate of current illicit drug use increased between 2002 and 2005 (Figure 2.8). For those aged 50 to 54, the rate increased from 3.4 to 5.2 percent, but this increase was not statistically significant. Among those aged 55 to 59, the rate increased significantly from 1.9 to 3.4 percent. This may reflect the aging into these age groups of the baby boom cohort, which has a relatively higher rate of lifetime illicit drug use than older cohorts have.

Gender

- As in prior years, males were more likely in 2005 to report current illicit drug use than females (10.2 vs. 6.1 percent, respectively). Males were about twice as likely to use marijuana as females (8.2 vs. 4.0 percent). However, the rates of nonmedical use of prescription-type psychotherapeutics were similar for both males (2.8 percent) and females (2.5 percent).

- Among youths aged 12 to 17, the rate of current illicit drug use was similar for boys (10.1 percent) and girls (9.7 percent). While boys aged 12 to 17 had a higher rate of marijuana use than girls (7.5 vs. 6.2 percent), the rate for nonmedical use of prescription-type psychotherapeutics was similar for boys and girls (3.1 and 3.6 percent, respectively).

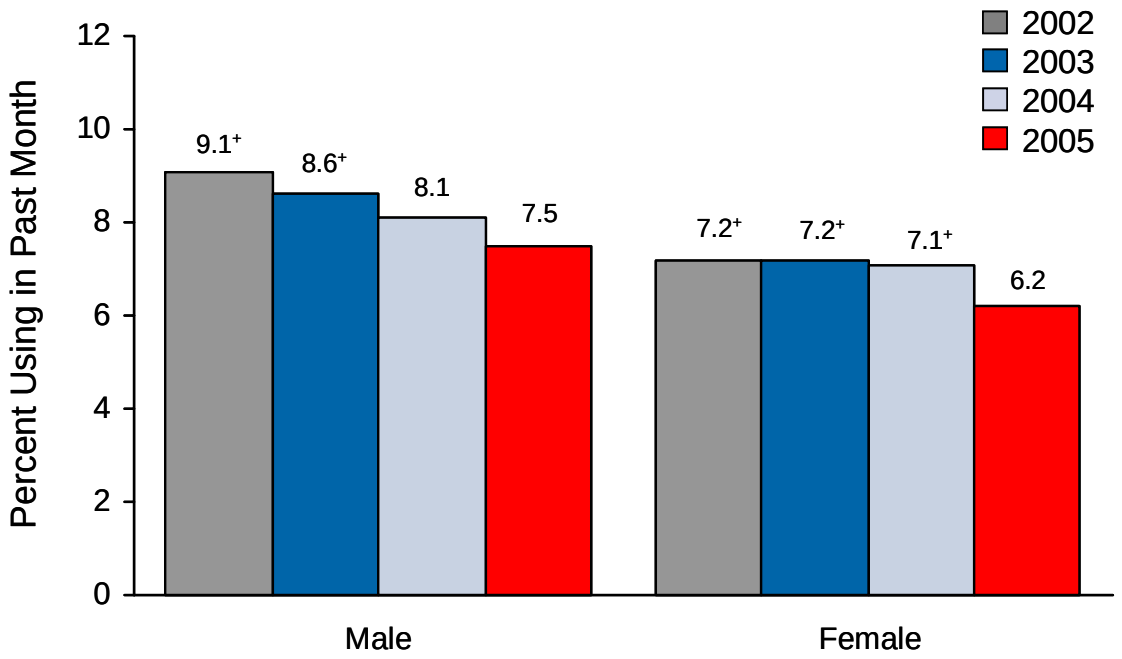
Figure 2.8 Past Month Illicit Drug Use among Adults Aged 50 to 59: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- Past month marijuana use declined from 2002 to 2005 for both male youths (9.1 to 7.5 percent) and female youths (7.2 to 6.2 percent) (Figure 2.9).

Figure 2.9 Past Month Marijuana Use among Youths Aged 12 to 17, by Gender: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Pregnant Women

- Among pregnant women aged 15 to 44 years, 3.9 percent reported using illicit drugs in the past month based on combined 2004 and 2005 NSDUH data. This rate was significantly lower than the rate among women aged 15 to 44 who were not pregnant (9.9 percent). The 2002-2003 combined rate of current illicit drug use among pregnant women (4.3 percent) was not significantly different from the 2004-2005 combined rate.

Race/Ethnicity

- Current illicit drug use was associated with race/ethnicity in 2005. The rate was lowest among Asians (3.1 percent). Rates were 12.8 percent for American Indians or Alaska Natives, 12.2 percent for persons reporting two or more races, 9.7 percent for blacks, 8.7 percent for Native Hawaiians or Other Pacific Islanders, 8.1 percent for whites, and 7.6 percent for Hispanics.

- Among youths aged 12 to 17 in 2005, the rate of current illicit drug use was highest among American Indians or Alaska Natives, about twice the overall rate among youths (19.2 vs. 9.9 percent, respectively). The rates for other groups were 11.0 percent among blacks, 10.1 percent among whites, 9.7 percent among those reporting two or more races, 9.4 percent among Hispanics, and 3.3 percent among Asians.

- There were no statistically significant changes between 2004 and 2005 in the rate of current illicit drug use for any racial/ethnic subgroup among persons aged 12 or older. For youths aged 12 to 17, there was a decline among whites from 11.1 to 10.1 percent.

Education

- Illicit drug use in 2005 was associated with educational status. Among adults aged 18 or older, the rate of current illicit drug use was lower among college graduates (5.0 percent) compared with those who did not graduate from high school (9.8 percent), high school graduates (8.6 percent), and those with some college (8.9 percent). However, adults who had graduated from college were more likely to have tried illicit drugs in their lifetime when compared with adults who had not completed high school (51.7 vs. 37.7 percent).

College Students

- In the college-aged population (persons aged 18 to 22 years old), the rate of current illicit drug use was similar among full-time college students (21.2 percent) and among other persons aged 18 to 22 years, which includes part-time college students, students in other grades, and nonstudents (21.8 percent). Current illicit drug use among college students and other 18 to 22 year olds did not change between 2004 and 2005.

- There was a significant increase in methamphetamine use among full-time college students aged 18 to 22 from 0.2 percent in 2004 to 0.5 percent in 2005. The rate was unchanged among other persons in that age group (1.0 percent in 2004 vs. 0.8 percent in 2005).

Employment

- Current employment status was associated with illicit drug use in 2005. Among unemployed adults aged 18 or older, 17.1 percent were current illicit drug users, which was higher than the 8.2 percent of those employed full time and 10.4 percent of those employed part time. These rates were all similar to the corresponding rates in 2004.

- Although the rate of past month illicit drug use was higher among unemployed persons compared with those from other employment groups, most drug users were employed. Of the 17.2 million current illicit drug users aged 18 or older in 2005, 12.9 million (74.8 percent) were employed either full or part time.

Geographic Area

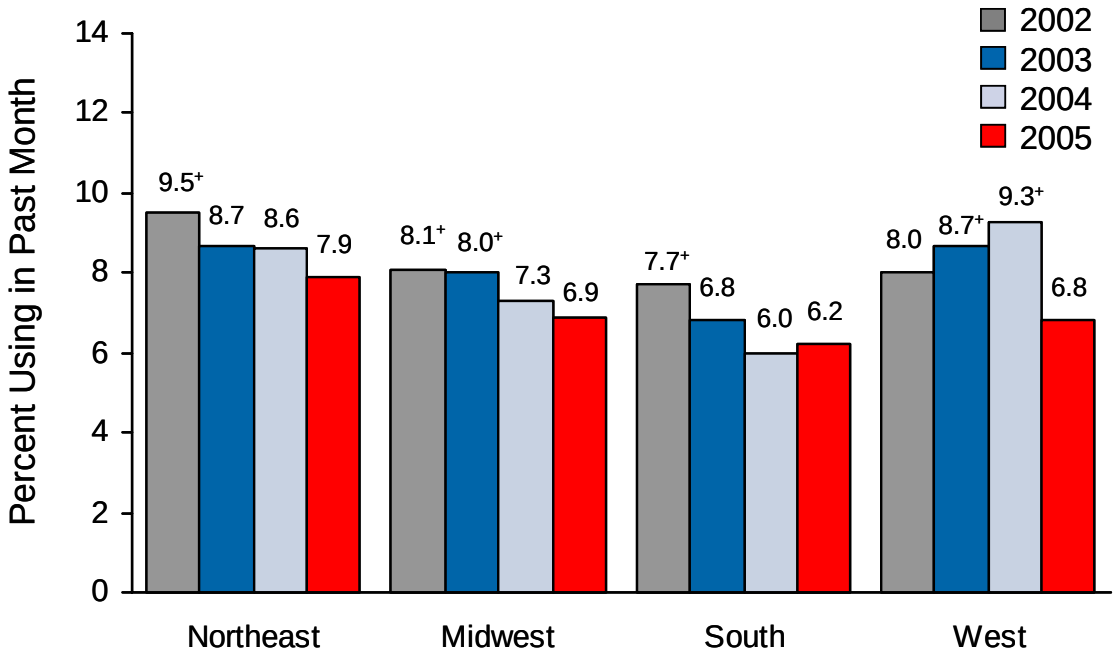
- Among persons aged 12 or older, the rate of current illicit drug use in 2005 was 9.0 percent in the West, 8.9 percent in the Northeast, 7.5 percent in the South, and 7.5 percent in the Midwest.

- The rate of current illicit drug use in metropolitan areas was higher than the rate in nonmetropolitan areas in 2005. The rates were 8.4 percent in large metropolitan counties, 8.4 percent in small metropolitan counties, and 6.9 percent in nonmetropolitan counties as a group. Within nonmetropolitan areas, counties that were urbanized had a rate of 7.8 percent, less urbanized counties had a rate of 6.5 percent, while completely rural counties had a rate of 5.1 percent.

- The rate of current illicit drug use in completely rural counties had declined between 2002 and 2003, from 6.7 to 3.1 percent, but then increased to 5.1 percent in 2005. The rate in 2005 was not significantly different from the rate in 2004 (4.6 percent).

- Among youths aged 12 to 17, there was evidence of regional differences in trends of marijuana use between 2002 and 2005. Current marijuana use rates declined in the Northeast, Midwest, and South between 2002 and 2005. In the West, the rates were steady between 2002 and 2004 (8.0 percent in 2002, 8.7 percent in 2003, and 9.3 percent in 2004) and then declined to 6.8 percent in 2005 (Figure 2.10).

Figure 2.10 Past Month Marijuana Use among Youths Aged 12 to 17, by Geographic Region: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Criminal Justice Populations

- In 2005, among the 1.6 million adults aged 18 or older on parole or other supervised release from prison during the past year, 26.3 percent were current illicit drug users, higher than the 7.7 percent among adults not on parole or supervised release.

- Among the 4.7 million adults on probation at some time in the past year, 29.2 percent reported current illicit drug use in 2005. This is higher than the rate of 7.4 percent among adults not on probation in 2005.

Frequency of Use

- In 2005, among past year marijuana users aged 12 or older, 13.3 percent used marijuana on 300 or more days within the past 12 months. This translates into 3.4 million persons using marijuana on a daily or almost daily basis over a 12-month period, similar to the estimate in 2004.

- Among past month marijuana users aged 12 or older, 34.8 percent (5.1 million) used the drug on 20 or more days in the past month. The percentage of past month marijuana users aged 12 to 17 who used on 20 or more days in the past month declined from 28.1 percent (536,000) in 2004 to 23.1 percent (400,000) in 2005.

Association with Cigarette and Alcohol Use

- In 2005, the rate of current illicit drug use was approximately 8 times higher among youths aged 12 to 17 who smoked cigarettes in the past month (46.7 percent) than it was among youths who did not smoke cigarettes in the past month (5.5 percent).

- Past month illicit drug use also was associated with the level of past month alcohol use. Among youths aged 12 to 17 in 2005 who were heavy drinkers (i.e., drank five or more drinks on the same occasion [i.e., at the same time or within a couple of hours of each other] on each of 5 or more days in the past 30 days), 59.9 percent also were current illicit drug users, which was higher than among nondrinkers (5.0 percent).

- Among youths aged 12 to 17 who were both smokers and heavy drinkers in the past month in 2005, 70.9 percent used illicit drugs in the past month, higher than the 3.5 percent among youths who did not drink or smoke in the past month.

Driving Under the Influence of Illicit Drugs

- In 2005, there were 10.5 million persons aged 12 or older who reported driving under the influence of an illicit drug during the past year. This corresponds to 4.3 percent of the population aged 12 or older, similar to the rates in 2003 (4.6 percent) and 2004 (4.4 percent), but lower than the rate in 2002 (4.7 percent). In 2005, the rate was highest among young adults aged 18 to 25 (13.4 percent).

Source of Prescription Drugs

- NSDUH includes questions for nonmedical users of prescription-type psychotherapeutic drugs regarding how they obtained the drugs they recently used nonmedically. In 2005, the most prevalent source from which recently used drugs were obtained among nonmedical users of prescription-type drugs was "from a friend or relative for free."

- Among persons aged 12 or older who used pain relievers nonmedically in the past 12 months, 59.8 percent reported that the source of the drug the most recent time they used was from a friend or relative for free. Another 16.8 percent reported they got the drug from one doctor. Only 4.3 percent got the pain relievers from a drug dealer or other stranger, and only 0.8 percent reported buying the drug on the Internet.

- Over half (57.6 percent) of past year nonmedical users of stimulants aged 12 or older reported getting the drug from a friend or relative for free. Also, 6.5 percent bought the drug from a drug dealer or other stranger, and 7.2 percent bought it on the Internet. However, compared with overall stimulant users, methamphetamine users were less likely to purchase this stimulant on the Internet (1.5 percent) and more likely to purchase it from a drug dealer or other stranger (17.1 percent). Nearly half (47.7 percent) of past year methamphetamine users reported obtaining the drug from a friend or relative for free.

3. Alcohol Use

The National Survey on Drug Use and Health (NSDUH) includes questions about the recency and frequency of consumption of alcoholic beverages, such as beer, wine, whiskey, brandy, and mixed drinks. An extensive list of examples of the kinds of beverages covered is given to respondents prior to the question administration. A "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Times when the respondent only had a sip or two from a drink are not considered to be consumption. For this report, estimates for the prevalence of alcohol use are reported primarily at three levels defined for both males and females and for all ages as follows:

> Current (past month) use - At least one drink in the past 30 days (includes binge and heavy use).
>
> Binge use - Five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days (includes heavy use).
>
> Heavy use - Five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in the 2005 survey (51.8 percent). This translates to an estimated 126 million people, which is higher than the 2004 estimate of 121 million people (50.3 percent).

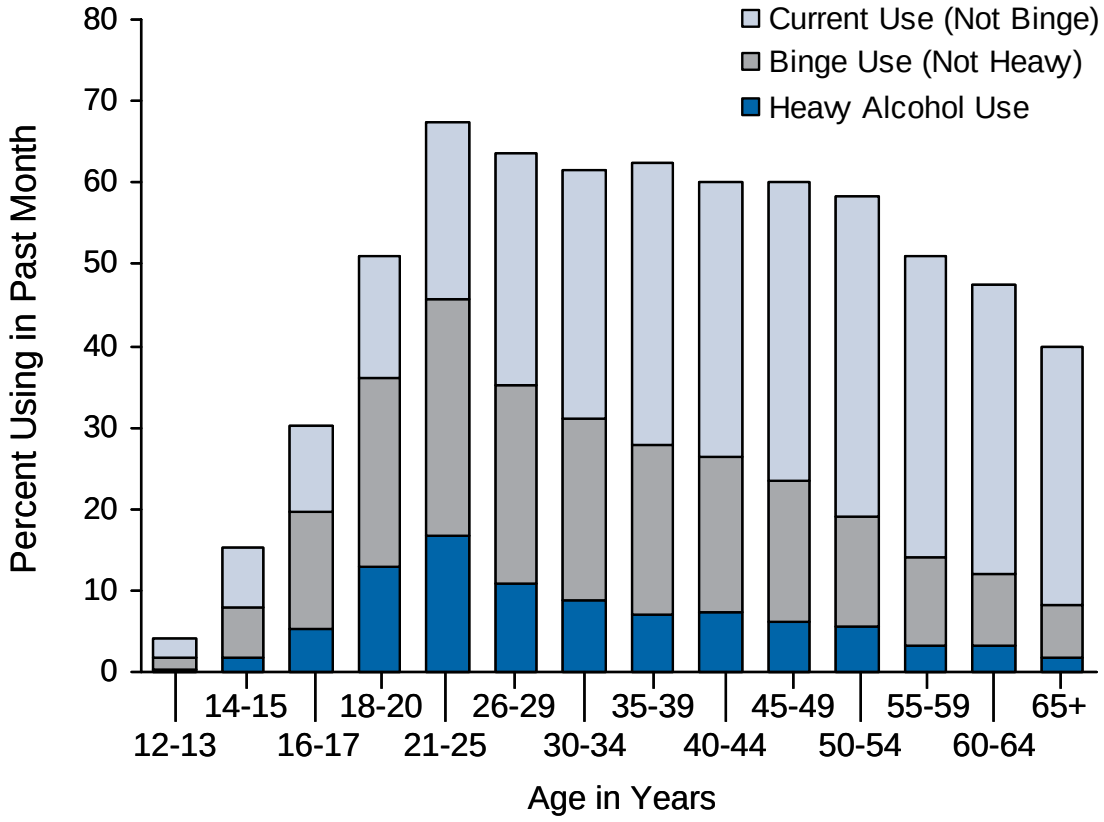
- More than one fifth (22.7 percent) of persons aged 12 or older participated in binge drinking at least once in the 30 days prior to the survey in 2005. This translates to about 55 million people, comparable with the estimates reported since 2002.

- In 2005, heavy drinking was reported by 6.6 percent of the population aged 12 or older, or 16 million people. This percentage is similar to the rates of heavy drinking in 2002 (6.7 percent), 2003 (6.8 percent), and 2004 (6.9 percent).

Age

- In 2005, rates of current alcohol use were 4.2 percent among persons aged 12 or 13, 15.1 percent of persons aged 14 or 15, 30.1 percent of 16 or 17 year olds, 51.1 percent of those aged 18 to 20, and 67.4 percent of 21 to 25 year olds (Figure 3.1). Among older age groups, the prevalence of alcohol use decreased with increasing age, from 63.7 percent among 26 to 29 year olds to 47.5 percent among 60 to 64 year olds and 40.0 percent among people aged 65 or older.

Figure 3.1 Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Age: 2005



- Rates of binge alcohol use in 2005 were 2.0 percent among 12 or 13 year olds, 8.0 percent among 14 or 15 year olds, 19.7 percent among 16 or 17 year olds, 36.1 percent among persons aged 18 to 20, and 45.7 percent among those aged 21 to 25. The rate peaked at ages 21 to 23 (49.9 percent at age 21, 46.6 percent at age 22, and 47.7 percent at age 23), then decreased beyond young adulthood from 32.9 percent of 26 to 34 year olds to 18.3 percent of persons aged 35 or older.

- The rate of binge drinking was 41.9 percent for young adults aged 18 to 25. Heavy alcohol use was reported by 15.3 percent of persons aged 18 to 25. These rates are similar to the rates in 2002, 2003, and 2004.

- Persons aged 65 or older had lower rates of binge drinking (8.3 percent) than adults in other age groups. The rate of heavy drinking among persons aged 65 or older was 1.7 percent.

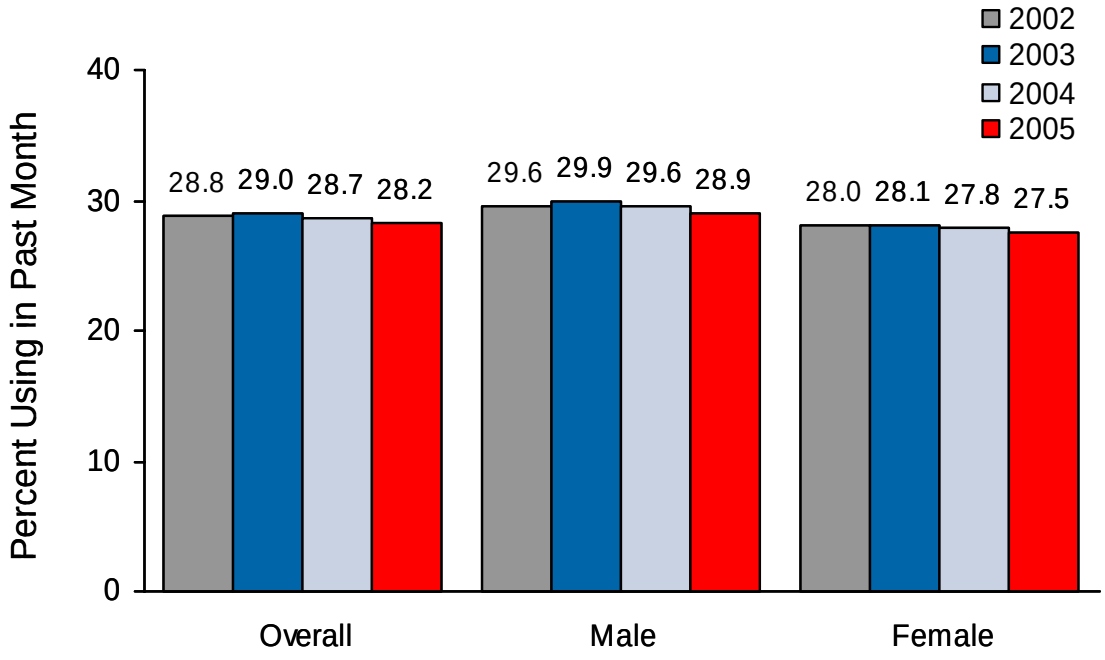
- The rate of current alcohol use among youths aged 12 to 17 declined from 17.6 percent in 2004 to 16.5 percent in 2005. Youth binge drinking also declined during that period, from 11.1 to 9.9 percent, but heavy drinking did not change significantly (2.7 percent in 2004 and 2.4 percent in 2005).

Underage Alcohol Use

- In 2005, about 10.8 million persons aged 12 to 20 (28.2 percent of this age group) reported drinking alcohol in the past month. Nearly 7.2 million (18.8 percent) were binge drinkers, and 2.3 million (6.0 percent) were heavy drinkers. These figures have remained essentially the same since the 2002 survey.

- More males than females aged 12 to 20 reported current alcohol use (28.9 vs. 27.5 percent, respectively), binge drinking (21.3 vs. 16.1 percent), and heavy drinking (7.6 vs. 4.3 percent) in 2005 (Figure 3.2).

Figure 3.2 Current Alcohol Use among Persons Aged 12 to 20, by Gender: 2002-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- Among persons aged 12 to 20, past month alcohol use rates were 12.0 percent among Native Hawaiians or Other Pacific Islanders, 15.5 percent among Asians, 19.0 percent among blacks, 21.7 percent among American Indians or Alaska Natives, 24.0 percent among those reporting two or more races, 25.9 percent among Hispanics, and 32.3 percent among whites.

- Among persons aged 12 to 20, binge drinking was reported by 22.3 percent of whites, 18.1 percent of American Indians or Alaska Natives, 17.9 percent of Hispanics, and 16.6 percent of persons reporting two or more races, but only by 7.4 percent of Asians, 8.4 percent of Native Hawaiians or Other Pacific Islanders, and 9.1 percent of blacks.

- Across geographic regions in 2005, underage current alcohol use rates were higher in the Northeast (31.4 percent) and Midwest (31.0 percent) than in the South (26.4 percent) and the West (26.0 percent). This pattern has remained essentially the same since 2002.

- In 2005, underage current alcohol use rates were similar in small metropolitan areas (29.5 percent), large metropolitan areas (27.6 percent), and nonmetropolitan areas (27.9 percent). The rate in nonmetropolitan rural areas was 23.1 percent.

Gender

- In 2005, 58.1 percent of males aged 12 or older were current drinkers, higher than the rate for females (45.9 percent). However, among youths aged 12 to 17, the percentage of females who were current drinkers (17.2 percent) was higher than that for males (15.9 percent).

- Among adults aged 18 to 25, an estimated 55.4 percent of females and 66.3 percent of males reported current drinking in 2005. These percentages are similar to 2004.

Pregnant Women

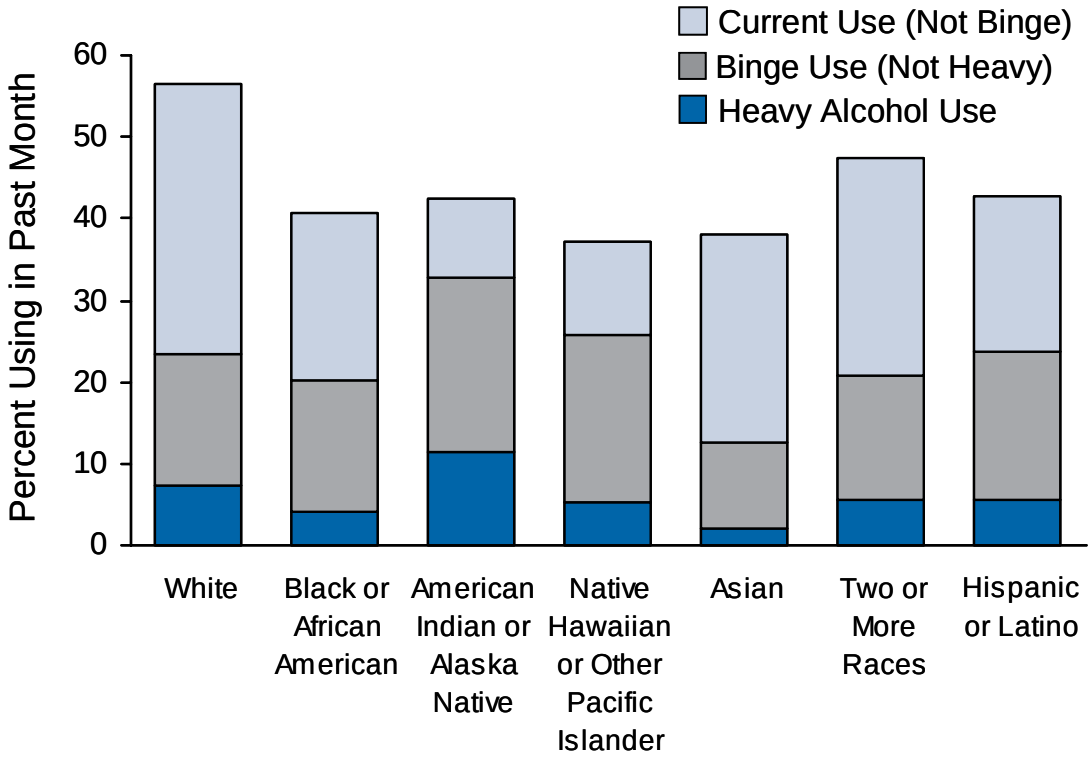
- Among pregnant women aged 15 to 44, an estimated 12.1 percent reported current alcohol use and 3.9 percent reported binge drinking. These rates were significantly lower than the rates for nonpregnant women in the same age group (53.1 and 23.3 percent, respectively). Heavy alcohol use was relatively rare (0.7 percent) among pregnant women. All of these estimates are based on data averaged over 2004 and 2005.

Race/Ethnicity

- Among persons aged 12 or older, whites in 2005 were more likely than other racial/ethnic groups to report current use of alcohol (56.5 percent) (Figure 3.3). The rates were 47.3 percent for persons reporting two or more races, 42.6 percent for Hispanics, 42.4 percent for American Indians or Alaska Natives, 40.8 percent for blacks, 38.1 percent for Asians, and 37.3 percent for Native Hawaiians or Other Pacific Islanders.

- The rate of binge alcohol use was lowest among Asians (12.7 percent). Rates for other racial/ethnic groups were 20.3 percent for blacks, 20.8 percent for persons reporting two or more races, 23.4 percent for whites, 23.7 percent for Hispanics, 25.7 percent for Native Hawaiians or Other Pacific Islanders, and 32.8 percent for American Indians or Alaska Natives.

Figure 3.3 Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Race/Ethnicity: 2005



- Among youths aged 12 to 17 in 2005, Asians had the lowest rate of past month alcohol use. Only 7.0 percent of Asian youths were current drinkers, while 11.6 percent of blacks, 12.2 percent of American Indians or Alaska Natives, 13.0 percent of those reporting two or more races, 16.7 percent of Hispanics, and 18.5 percent of white youths were current drinkers.

Education

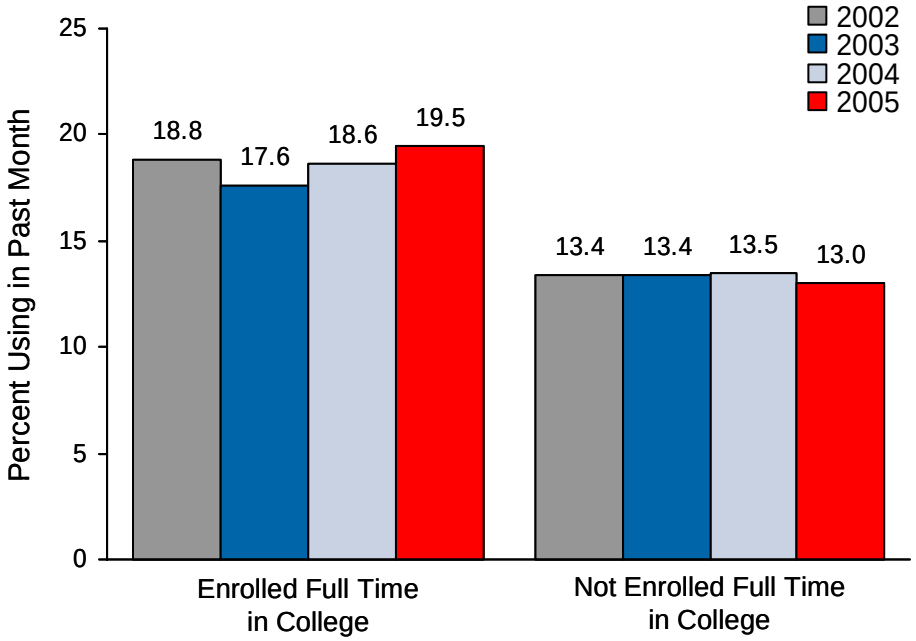
- Among adults aged 18 or older, the rate of past month alcohol use increased with increasing levels of education. Among adults with less than a high school education, 36.7 percent were current drinkers in 2005, significantly lower than the 69.4 percent of college graduates who were current drinkers. However, among adults aged 26 or older, binge and heavy alcohol use rates were lower among college graduates (18.9 and 4.9 percent, respectively) than among adults who had not completed college (21.9 vs. 6.0 percent, respectively).

College Students

- Young adults aged 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time (i.e., part-time college students and persons not currently enrolled in college) to use alcohol in the past month, binge drink, and drink heavily. Past month alcohol use was reported by 64.4 percent of full-time college students compared with 53.2 percent of persons aged 18 to 22 who were not enrolled full time. Binge and heavy use rates for college students were 44.8 and 19.5 percent, respectively, compared with 38.3 and 13.0 percent, respectively, for 18 to 22 year olds not enrolled full time in college.

- The pattern of higher rates of current alcohol use, binge alcohol use, and heavy alcohol use among full-time college students than the rates for others aged 18 to 22 has remained consistent since 2002 (Figure 3.4).

Figure 3.4 Heavy Alcohol Use among Adults Aged 18 to 22, by College Enrollment: 2002-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Employment

- Rates of current alcohol use were 63.2 percent for full-time employed adults aged 18 or older in 2005, higher than the rate for unemployed adults (56.5 percent). However, the pattern was different for heavy alcohol use; the rate of heavy alcohol use was higher for unemployed persons (10.4 percent) than for full-time employed persons (8.4 percent). There was no significant difference in the rates of binge alcohol use between unemployed adults and adults employed full time.

- Most binge and heavy alcohol users were employed in 2005. Among 52.6 million adult binge drinkers, 42.1 million (80.0 percent) were employed either full or part time. Among 15.4 million heavy drinkers, 12.5 million (80.8 percent) were employed.

Geographic Area

- The rate of past month alcohol use for people aged 12 or older in 2005 was lower in the South (47.8 percent) than in the Northeast (55.0 percent), Midwest (55.0 percent), or West (52.5 percent). This pattern has remained unchanged since 2002, but the gap between the South and the other regions may be closing because the South was the only region to show a significant increase in its current alcohol use rate between 2004 and 2005. The rate of past month alcohol use in the South in 2004 was 45.1 percent.

- Among people aged 12 or older, the rate of past month alcohol use in large metropolitan areas (54.4 percent) was higher than the 51.4 percent in small metropolitan areas and 44.2 percent in nonmetropolitan areas. Binge drinking was more prevalent in small metropolitan areas (23.7 percent) than in large metropolitan areas (22.3 percent) and nonmetropolitan areas (21.9 percent). The rate of heavy alcohol use was 6.1 percent in large metropolitan areas, 7.4 percent in small metropolitan areas, and 6.7 percent in nonmetropolitan areas.

- Among youths aged 12 to 17, the rate of binge alcohol was associated with county type. The rates of binge alcohol use were 11.5 percent in nonmetropolitan areas, 10.2 percent in small metropolitan areas, and 9.3 percent in large metropolitan areas. In completely rural counties of nonmetropolitan areas, 11.9 percent of youths reported binge drinking.

Association with Illicit Drug and Tobacco Use

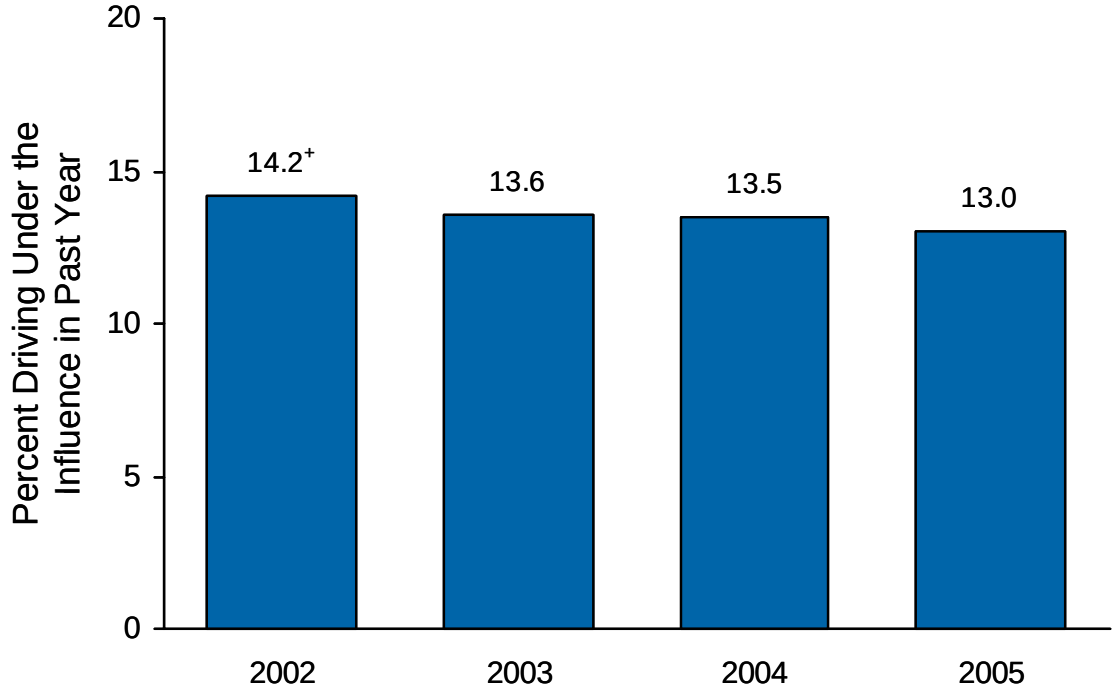
- The level of alcohol use was associated with illicit drug use in 2005. Among the 16.0 million heavy drinkers aged 12 or older, 32.0 percent were current illicit drug users. Persons who were not current alcohol users were less likely to have used illicit drugs in the past month (3.5 percent) than those who reported (a) current use of alcohol but did not meet the criteria for binge or heavy use (5.9 percent), (b) binge use but did not meet the criteria for heavy use (16.1 percent), or (c) heavy use of alcohol (32.0 percent).

- Alcohol consumption levels also were associated with tobacco use. Among heavy alcohol users aged 12 or older, 60.6 percent smoked cigarettes in the past month, while only 20.4 percent of non-binge current drinkers and 16.7 percent of persons who did not drink alcohol in the past month were current smokers. Smokeless tobacco use and cigar use also were more prevalent among heavy drinkers (11.9 and 19.2 percent, respectively) than among non-binge drinkers (1.9 and 5.0 percent) and nondrinkers (1.9 and 2.2 percent).

Driving Under the Influence of Alcohol

- In 2005, an estimated 13.0 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year (Figure 3.5). This percentage has dropped since 2002, when it was 14.2 percent. The 2005 estimate corresponds to 31.7 million persons.

Figure 3.5 Driving Under the Influence of Alcohol in the Past Year among Persons Aged 12 or Older: 2002-2005

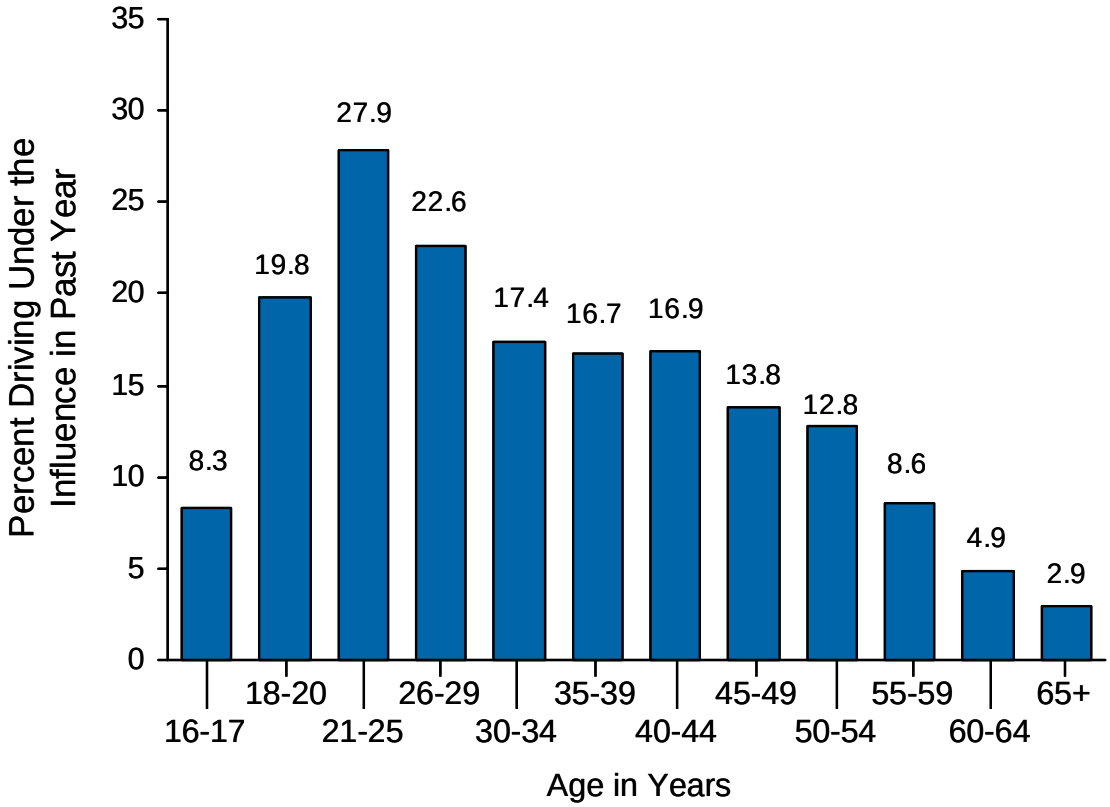


+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- Driving under the influence of alcohol was associated with age in 2005. An estimated 8.3 percent of 16 or 17 year olds, 19.8 percent of 18 to 20 year olds, and 27.9 percent of 21 to 25 year olds reported driving under the influence of alcohol in the past year (Figure 3.6). Beyond age 25, these rates showed a general decline with increasing age.

- Among persons aged 12 or older, males were nearly twice as likely as females (17.1 vs. 9.2 percent) to drive under the influence of alcohol in the past year.

Figure 3.6 Driving Under the Influence of Alcohol in the Past Year among Persons Aged 16 or Older, by Age: 2005



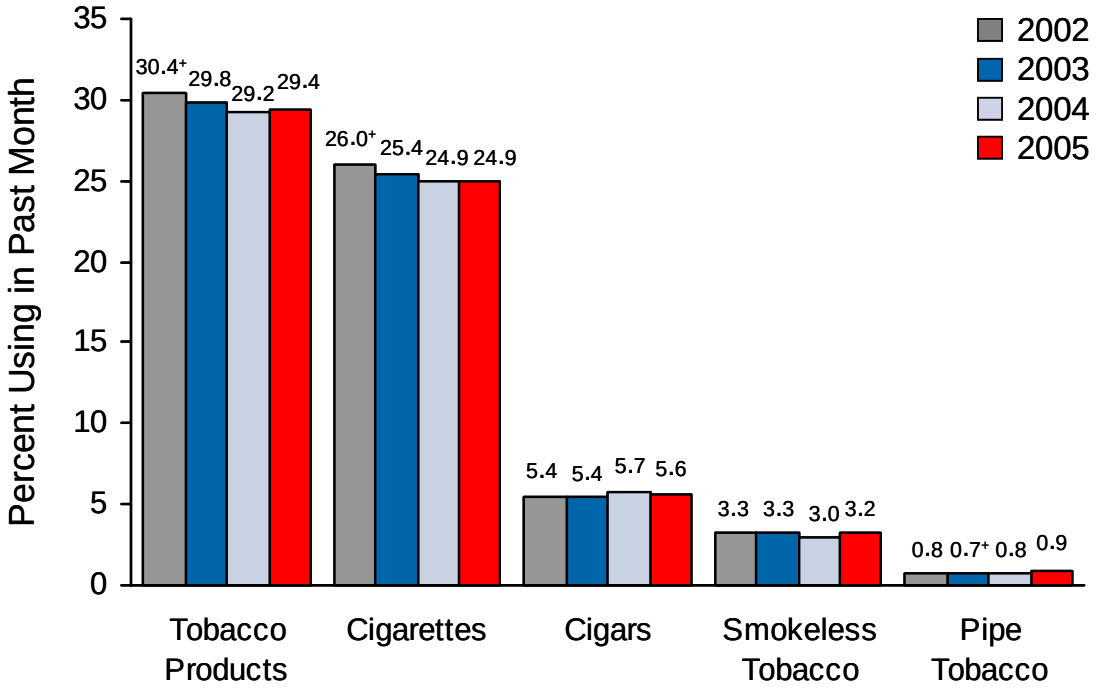
4. Tobacco Use

The National Survey on Drug Use and Health (NSDUH) includes a series of questions about the use of tobacco products, including cigarettes, chewing tobacco, snuff, cigars, and pipe tobacco. Cigarette use is defined as smoking "part or all of a cigarette." For analytic purposes, data for chewing tobacco and snuff are combined as "smokeless tobacco."

- In 2005, an estimated 71.5 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 29.4 percent of the population in that age range. In addition, 60.5 million persons (24.9 percent of the population) were current cigarette smokers; 13.6 million (5.6 percent) smoked cigars; 7.7 million (3.2 percent) used smokeless tobacco; and 2.2 million (0.9 percent) smoked tobacco in pipes (Figure 4.1).

- The rates of current use of cigarettes, smokeless tobacco, cigars, and pipe tobacco were unchanged between 2004 and 2005. However, between 2002 and 2005, past month use of a tobacco product declined from 30.4 to 29.4 percent, and past month cigarette use decreased from 26.0 to 24.9 percent.

Figure 4.1 Past Month Tobacco Use among Persons Aged 12 or Older: 2002-2005



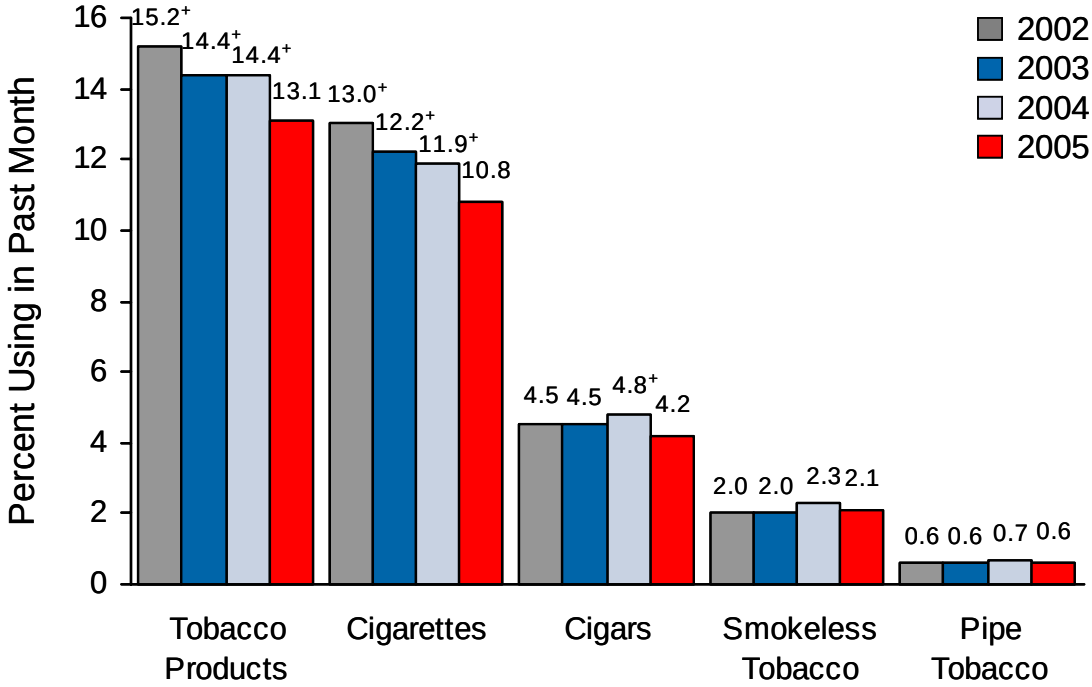
+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Age

- Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (44.3 percent) and of each specific product compared with youths aged 12 to 17 and adults aged 26 or older. In 2005, the rates of past month use among young adults were 39.0 percent for cigarettes, 12.0 percent for cigars, 5.1 percent for smokeless tobacco, and 1.5 percent for pipe tobacco. The rate of current use of smokeless tobacco by young adults did not change significantly between 2002 and 2005, but the rates of current use of cigars and pipe tobacco were higher in 2005 than they were in 2002, and the rate of current cigarette use was lower in 2005 than in 2002.

- Among youths aged 12 to 17 in 2005, 3.3 million (13.1 percent) used a tobacco product in the past month, and 2.7 million (10.8 percent) used cigarettes (Figure 4.2). The rate of past month cigarette use among 12 to 17 year olds declined from 13.0 percent in 2002 to 10.8 percent in 2005. Cigar use in the past month declined to 4.2 percent of youths in 2005 from the 2004 estimate of 4.8 percent. Past month smokeless tobacco use was reported by 2.1 percent of youths in 2005, similar to estimates since 2002.

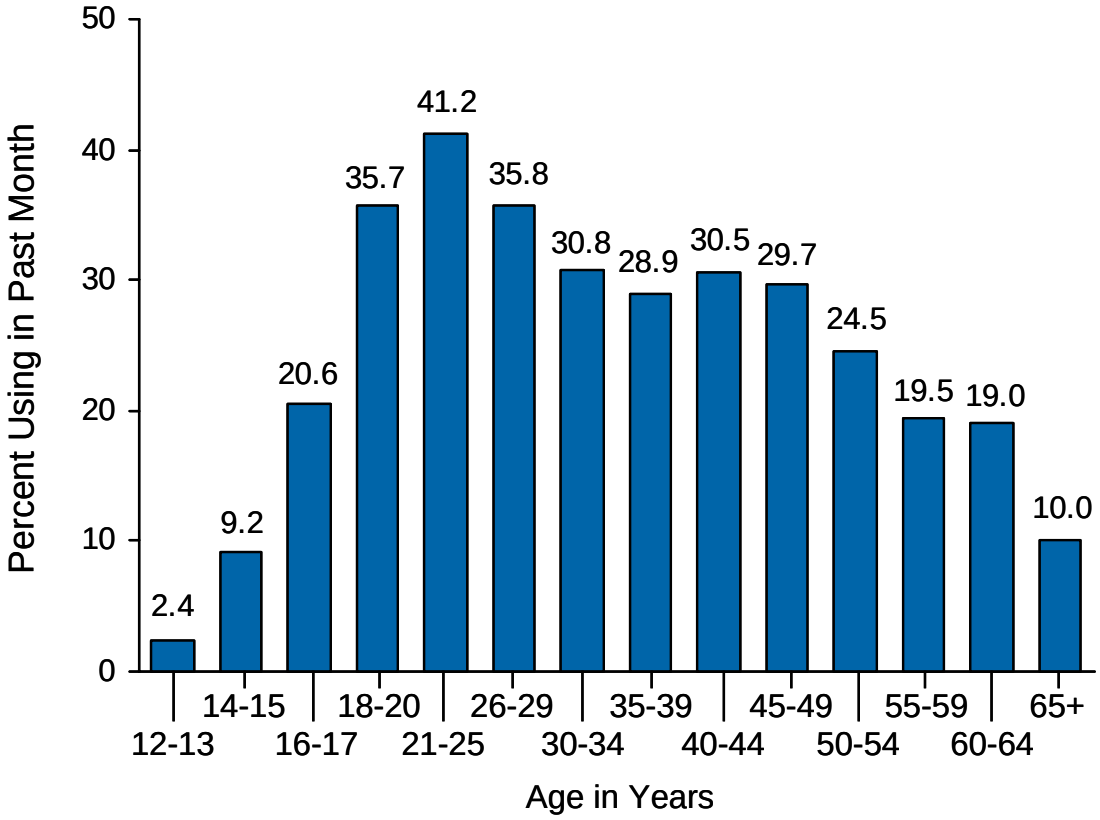
Figure 4.2 Past Month Tobacco Use among Youths Aged 12 to 17: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- In 2005, 2.4 percent of 12 or 13 year olds, 9.2 percent of 14 or 15 year olds, and 20.6 percent of 16 or 17 year olds were current cigarette smokers (Figure 4.3). Current cigarette use peaked at 41.2 percent among young adults aged 21 to 25. Less than a quarter (22.3 percent) of persons in the 35 or older age group in 2005 smoked cigarettes in the past month.

Figure 4.3 Past Month Cigarette Use, by Age: 2005



- Cigar smoking in the past month remained stable from 2002 to 2005 among adults aged 18 or older. Rates were 5.5 percent in both 2002 and 2003, and they were 5.8 percent in both 2004 and 2005. Among youths aged 12 to 17, current cigar smoking was similar in 2002 (4.5 percent), 2003 (4.5 percent), and 2004 (4.8 percent), then declined to 4.2 percent in 2005.

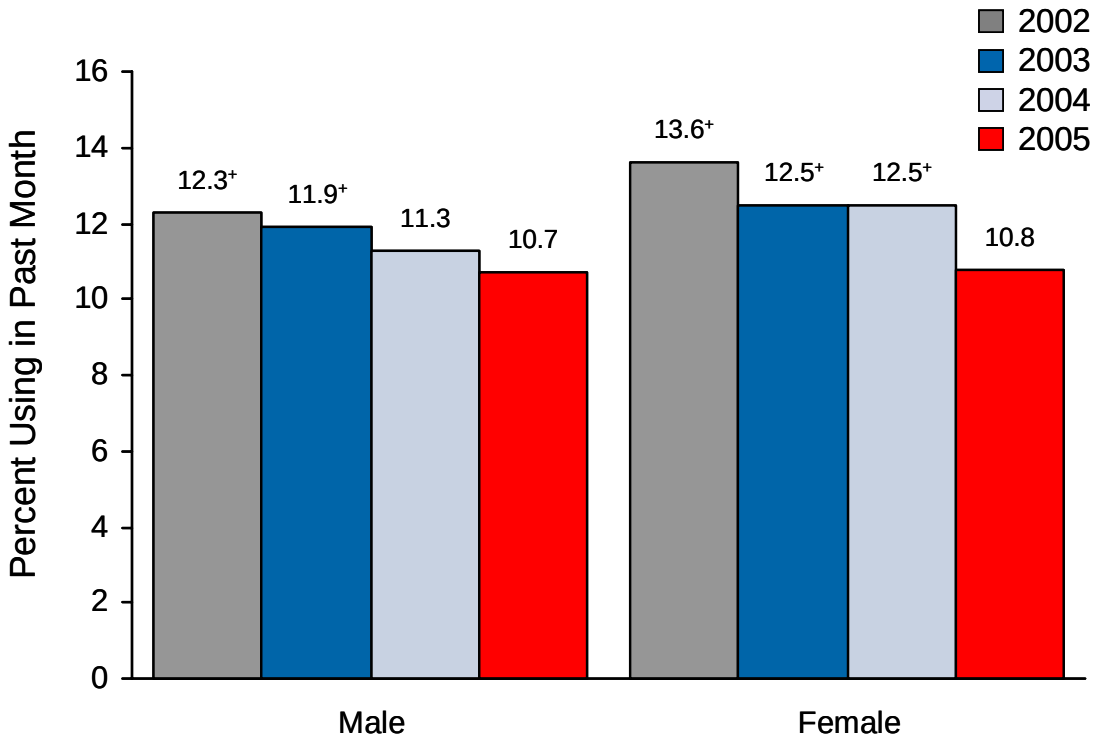
- Among adults aged 26 or older in 2005, 3.0 percent used smokeless tobacco in the past month. Among youths aged 12 to 17, the rate was 2.1 percent, and among young adults aged 18 to 25, the rate was 5.1 percent. For all three of these age groups, estimates of smokeless tobacco use in 2005 were essentially the same as those obtained in 2002.

Gender

- In 2005, the current use of a tobacco product among persons aged 12 or older was reported by a higher percentage of males (35.8 percent) than females (23.4 percent). Males also had higher rates of past month use than females of each specific tobacco product: cigarette smoking (27.4 percent of males vs. 22.5 percent of females), cigar smoking (9.6 vs. 1.8 percent), and use of smokeless tobacco (6.1 vs. 0.4 percent).

- Among youths aged 12 to 17, current cigarette smoking in 2005 was equally prevalent among females (10.8 percent) and males (10.7 percent). The rate for females in this age group declined from 13.6 percent in 2002 to 12.5 percent in 2003, remained unchanged from 2003 to 2004 (12.5 percent), then declined again between 2004 and 2005 (10.8 percent). Among 12- to 17-year-old males, the rate of current cigarette use was 12.3 percent in 2002, 11.9 percent in 2003, 11.3 percent in 2004, and 10.7 percent in 2005 (Figure 4.4).

Figure 4.4 Past Month Cigarette Use among Youths Aged 12 to 17, by Gender: 2002-2005



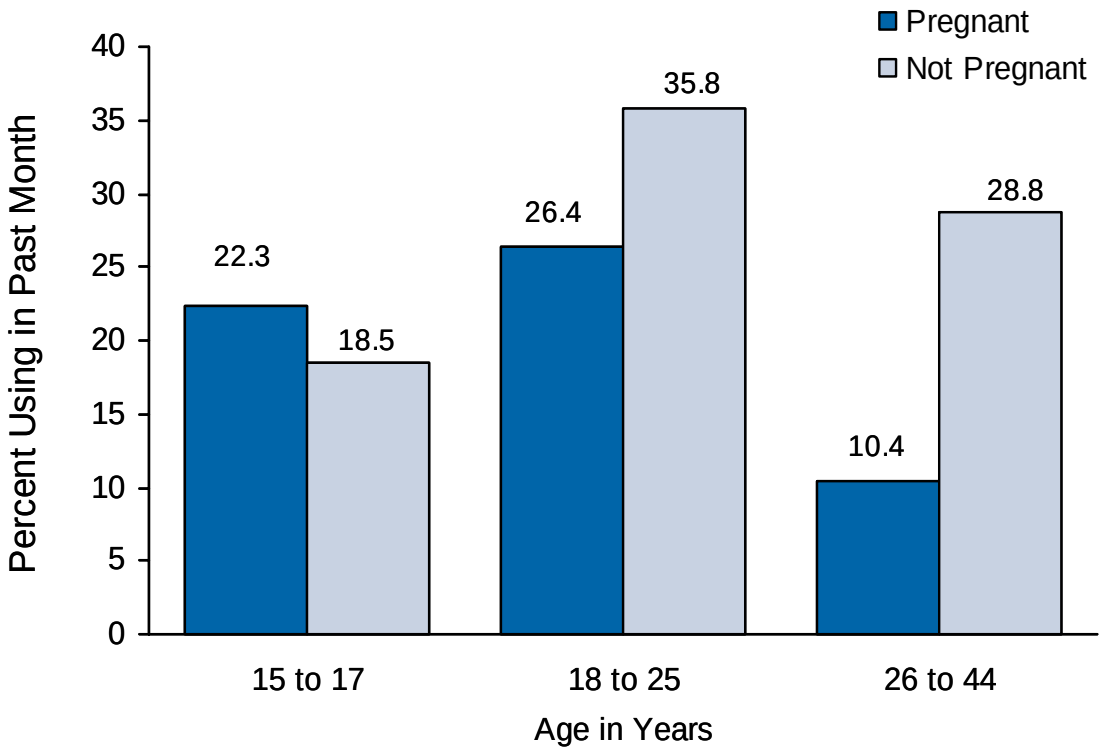
+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Pregnant Women

- Among women aged 15 to 44, combined data for 2004 and 2005 indicated that the rate of past month cigarette use was lower among those who were pregnant (16.6 percent) than it was among those who were not pregnant (29.6 percent).

- Looking at combined 2004-2005 data, rates of past month cigarette smoking were lower for pregnant women than nonpregnant women among those aged 26 to 44 (10.4 vs. 28.8 percent) and among those aged 18 to 25 (26.4 vs. 35.8 percent) (Figure 4.5). However, among those aged 15 to 17, the rate of cigarette smoking for pregnant women was higher than for nonpregnant women (22.3 vs. 18.5 percent), although the difference was not significant. Similar patterns were observed in the combined 2002-2003 data.

Figure 4.5 Past Month Cigarette Use among Women Aged 15 to 44, by Age and Pregnancy Status, 2004-2005 Combined



Race/Ethnicity

- In 2005, among persons aged 12 or older, 14.6 percent of Asians, 24.5 percent of Hispanics, 28.4 percent of blacks, 30.3 percent of Native Hawaiians or Other Pacific Islanders, 31.2 percent of whites, 33.9 percent of persons who reported two or more races, and 41.7 percent of American Indians or Alaska Natives reported that they had used a tobacco product in the past month. There were no statistically significant changes in past month tobacco use between 2004 and 2005 among any of these groups.

- In 2005, current cigarette smoking among youths aged 12 to 17 and young adults aged 18 to 25 was more prevalent among whites than blacks (12.8 vs. 6.5 percent for 12 to 17 year olds and 44.2 vs. 28.7 percent for 18 to 25 year olds). Among adults aged 26 or older, however, whites and blacks used cigarettes at about the same rate (24.8 and 27.0 percent, respectively). The rates for Hispanics were 9.1 percent among youths, 31.9 percent among young adults, and 22.2 percent among those aged 26 or older.

- Current use of smokeless tobacco increased from 3.6 percent in 2004 to 8.6 percent in 2005 among American Indians or Alaska Natives aged 18 or older. In the same age group, past month smokeless tobacco use remained stable among persons in all other racial/ethnic groups.

Education

- Cigarette smoking in the past month tended to be less prevalent among adults with more education. Among adults aged 18 or older, current cigarette use in 2005 was reported by 34.8 percent of those who had not completed high school, 31.8 percent of high school graduates who did not attend college, 28.1 percent of persons with some college, and 13.8 percent of college graduates.

- In 2005, the use of smokeless tobacco in the past month was reported by 3.5 percent of persons aged 18 or older who had not completed high school, 4.3 percent of those who completed high school but did not attend college, and 3.4 percent of those who attended some college. The prevalence among college graduates (1.9 percent) was lower than among the other groups.

College Students

- Among young adults 18 to 22 years old, full-time college students were less likely to be current cigarette smokers than their peers who were not enrolled full time in college. Cigarette use in the past month in 2005 was reported by 30.6 percent of full-time college students compared with 42.7 percent of those not enrolled full time.

- In 2005, past month cigar smoking was equally common among male full-time college students aged 18 to 22 (20.8 percent) as among males in the same age group who were not enrolled full time in college (19.8 percent).

- Past month cigar smoking among males aged 18 to 22 not enrolled full time in college declined from 22.3 percent in 2004 to 19.8 percent in 2005.

Employment

- In 2005, current cigarette smoking was more common among unemployed adults aged 18 or older than among adults who were working full time or part time (43.8 vs. 28.3 and 25.2 percent, respectively). Cigar smoking followed a similar pattern, with 10.4 percent of unemployed adults reporting past month use compared with 6.8 percent of full-time workers and 5.6 percent of part-time workers.

- Rates of current cigarette use among adults aged 18 or older decreased among unemployed persons between 2002 and 2005; rates were 49.8 percent in 2002, 42.7 percent in 2003, 44.1 percent in 2004, and 43.8 percent in 2005. Among adults who were employed full time, current use of smokeless tobacco increased from 3.7 percent in 2004 to 4.2 percent in 2005.

Geographic Area and County Type

- Current cigarette smoking among persons aged 12 or older was lowest in the West (21.0 percent) and highest in the Midwest (28.1 percent). Use of smokeless tobacco was higher in the South and Midwest (4.1 and 3.8 percent, respectively) than in the West and Northeast (2.0 and 1.9 percent, respectively). Cigar smoking, like cigarette use, was highest in the Midwest (6.7 percent).

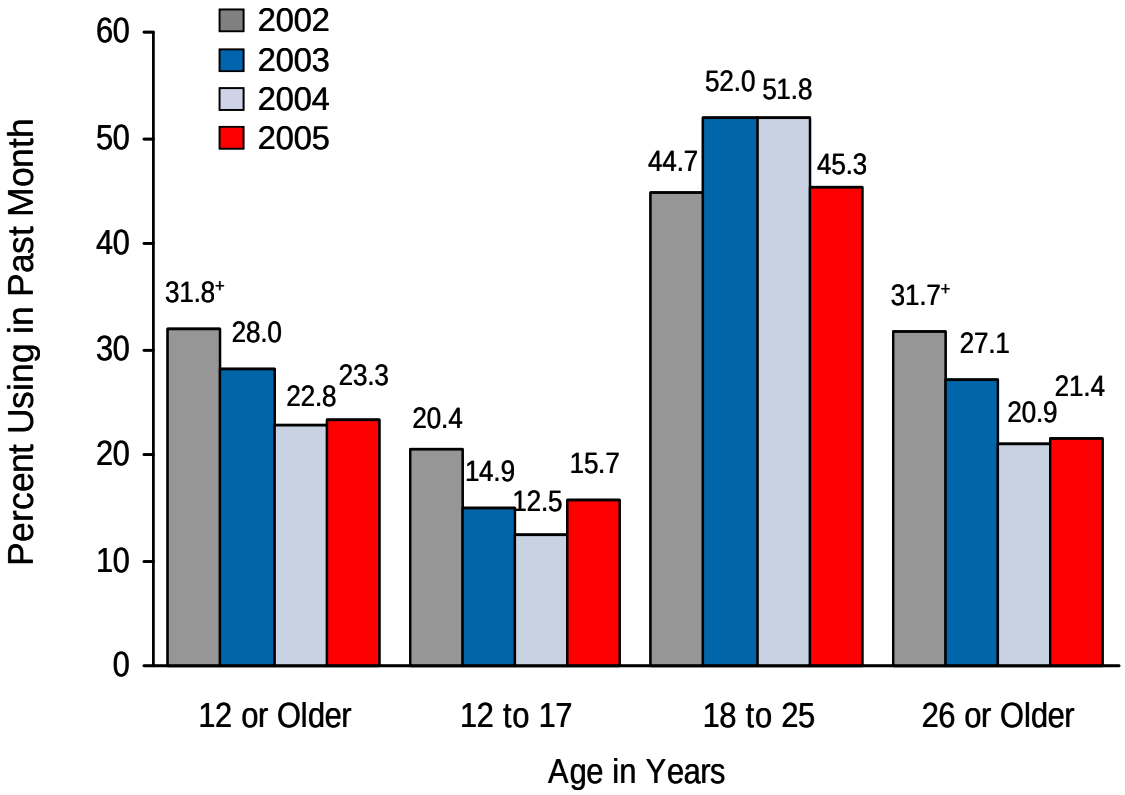
- In the Midwest, the prevalence of current cigar smoking increased from 5.6 percent in 2002 and 5.8 percent in 2003 to 6.9 percent in 2004, leveling off at 6.7 percent in 2005.

- Among persons aged 12 or older, the rate of current cigarette use was associated with county type in 2005. The rates of cigarette smoking were 29.4 percent in less urbanized nonmetropolitan areas, 29.2 percent in urbanized nonmetropolitan areas, 25.7 percent in small metropolitan areas, and 23.3 percent in large metropolitan areas. The rate for completely rural nonmetropolitan counties in 2005 was also 23.3 percent.

- In completely rural nonmetropolitan counties, current cigarette use among persons aged 12 or older declined from 31.8 percent in 2002 and 28.0 percent in 2003 to 22.8 percent in 2004, leveling off at 23.3 percent in 2005 (Figure 4.6).

- Use of smokeless tobacco in the past month among persons aged 12 or older was lowest in large metropolitan areas (1.7 percent). In small metropolitan areas, the rate was 3.7 percent; in nonmetropolitan areas, it was 6.8 percent; and in completely rural nonmetropolitan counties, the rate was 7.8 percent.

Figure 4.6 Past Month Cigarette Use among Persons in Completely Rural Counties, by Age: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Association with Illicit Drug and Alcohol Use

- Use of illicit drugs and alcohol was more common among current cigarette smokers than among nonsmokers in 2005, as in 2002 through 2004. Among persons aged 12 or older, 20.2 percent of past month cigarette smokers reported current use of an illicit drug compared with 4.1 percent of persons who were not current cigarette smokers. Past month alcohol use was reported by 67.6 percent of current cigarette smokers compared with 46.6 percent of those who did not use cigarettes in the past month. The association also was found with binge drinking (43.8 percent of current cigarette users vs. 15.7 percent of current nonusers) and heavy drinking (16.1 vs. 3.5 percent, respectively).

- Use of tobacco products other than cigarettes was higher among current cigarette smokers than among current nonsmokers. Approximately 1 in 20 current cigarette users (5.0 percent) reported using smokeless tobacco in the past month compared with 2.6 percent of nonsmokers. Moreover, 12.6 percent of current cigarette smokers also smoked cigars in the past month compared with 3.3 percent of those who did not smoke cigarettes.

5. Initiation of Substance Use

Information on substance use initiation, also known as incidence or first-time use, is important for policymakers and researchers. Measures of initiation are often leading indicators of emerging patterns of substance use. They provide valuable information that can be used in the assessment of the effectiveness of current prevention programs and in determining where prevention efforts need to focus.

With its large sample size and oversampling of youths aged 12 to 17 and young adults aged 18 to 25, the National Survey on Drug Use and Health (NSDUH) provides a variety of estimates related to substance use initiation based on questions on age and month at first use. Using this information, along with the interview date and the respondent's date of birth, a date of first use is determined for each substance used by a respondent. Estimates of the number of initiates, rates of initiation, and average age at first use can be constructed for specific time periods. For example, estimates for calendar years as far back as 1965 have been tabulated from 2002-2004 NSDUH data to show long-term trends in initiation. However, recent methodological assessments of these long-term trend estimates of initiation have suggested that they are biased, due to suspected recall errors that seem to increase with the length of recall (Gfroerer, Hughes, Chromy, Heller, & Packer, 2004). Evidence of forward and backward telescoping, where respondents shift their reported age at first use either closer to their current age or further from the interview date, also has been found (Golub, Johnson, & Labouvie, 2000; Johnson & Schultz, 2005).

Because of concerns about the validity of trend estimates of incidence based on long recall periods, an alternative approach to estimating incidence was developed and presented for the first time in the 2004 NSDUH national findings report (Office of Applied Studies [OAS], 2005b) and is continued in this 2005 NSDUH report. The new estimates describe initiation of substance use in the 12 months prior to the interview date, and individuals who initiated use within the past 12 months are defined as recent or past year initiates. Estimates for each year are produced independently based on the data from the survey conducted that year. This approach should improve the comparability of estimates across years. Although it will not eliminate reporting biases, the approach should minimize recall bias because the estimates are based on a more recent time period than the previously produced calendar year estimates. The more recent time period also provides more timely information on incidence. Finally, an advantage of this approach is that initiation estimates can be analyzed in conjunction with past year prevalence estimates because they reflect the same time period. For example, this approach allows the estimation of initiates as a proportion of past year users. For specific substances, initiation prior to age 12 is not well covered, and initiation prior to age 11 is not included at all. This problem primarily affects estimates of initiation for cigarettes, alcohol, and inhalants because they tend to be initiated at a younger age than other substances.

As a measure of central tendency, means are heavily influenced by the presence of extreme values in the data. Thus, for the purposes of this report, mean age at initiation will refer specifically to the mean age at initiation among persons aged 12 to 49. This constraint was implemented so that the mean age estimates reported would not be influenced by those few respondents who were past year initiates at age 50 or older. This should increase the utility of

these results to health researchers and analysts by providing a better picture of the substance use initiation behaviors among the civilian, noninstitutionalized population in the United States. Note that this constraint only affects estimates of mean age at initiation; other estimates in this chapter, including the number and prevalence of past year initiates, are among all persons aged 12 or older.

See Section B.4.1 in Appendix B for further discussion of the methods and bias in initiation estimates. The Substance Abuse and Mental Health Services Administration (SAMHSA) continues to study the advantages and disadvantages of alternative methods of estimating incidence.

Illicit Drugs

- In 2005, an estimated 2.9 million persons aged 12 or older used an illicit drug for the first time within the past 12 months; this averages to nearly 8,000 initiates per day. This estimate was not significantly different from the number in 2004 (2.8 million). Most initiates (56.1 percent) were younger than age 18 when they first used, and the majority of new users (56.2 percent) were female. The average age at initiation among persons aged 12 to 49 was 18.7 years.

- The specific drug categories with the largest number of recent initiates among persons aged 12 or older were nonmedical use of pain relievers (2.2 million) and marijuana use (2.1 million), followed by nonmedical use of tranquilizers (1.3 million), then by use of inhalants (0.9 million) and cocaine (0.9 million) (Figure 5.1).

- Among persons aged 12 to 49, the average age at first use of inhalants in 2005 was 16.1 years; it was 17.4 years for marijuana, 19.7 years for cocaine, 21.2 years for pain relievers, and 25.7 years for tranquilizers (Figure 5.2).

Marijuana

- In 2005, there were 2.1 million persons who had used marijuana for the first time within the past 12 months; this averages to approximately 6,000 initiates per day. This estimate was not significantly different from the numbers in 2004 (2.1 million), 2003 (2.0 million), and 2002 (2.2 million) (Figure 5.3).

- Most (59.1 percent) of the 2.1 million recent marijuana initiates were younger than age 18 when they first used. Among youths aged 12 to 17, an estimated 4.5 percent had used marijuana for the first time within the past year, which was lower than the rate in 2004 (5.0 percent), but this difference was not statistically significant.

- As a percentage of those who had not used marijuana prior to the past year, youth marijuana initiation declined significantly from 5.8 percent in 2004 to 5.2 percent in 2005.

Figure 5.1 Past Year Initiates for Specific Illicit Drugs among Persons Aged 12 or Older: 2005

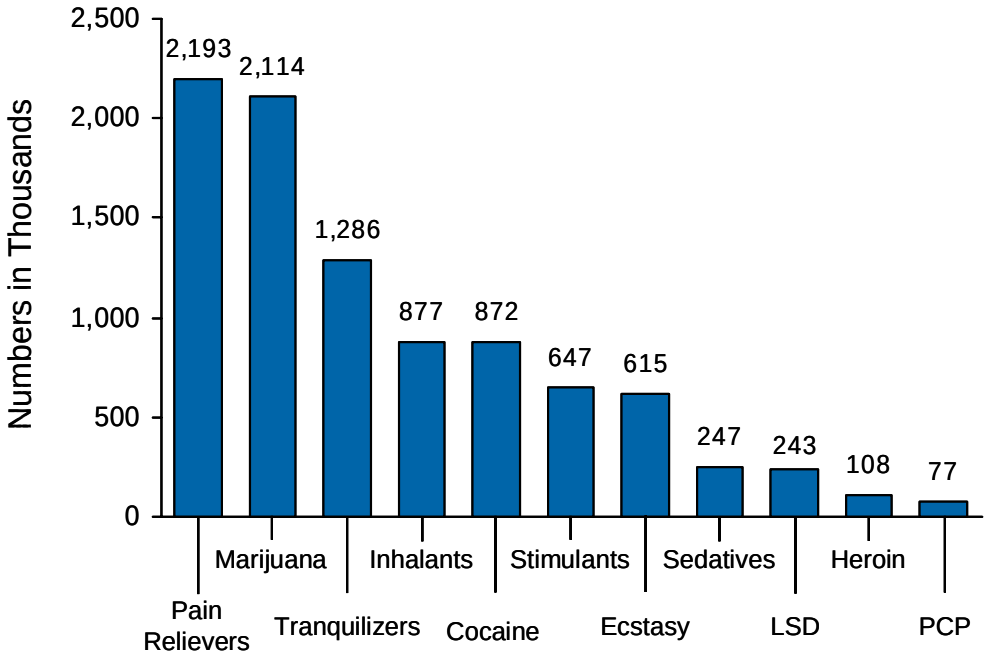


Figure 5.2 Mean Age at First Use for Specific Illicit Drugs among Past Year Initiates Aged 12 to 49: 2005

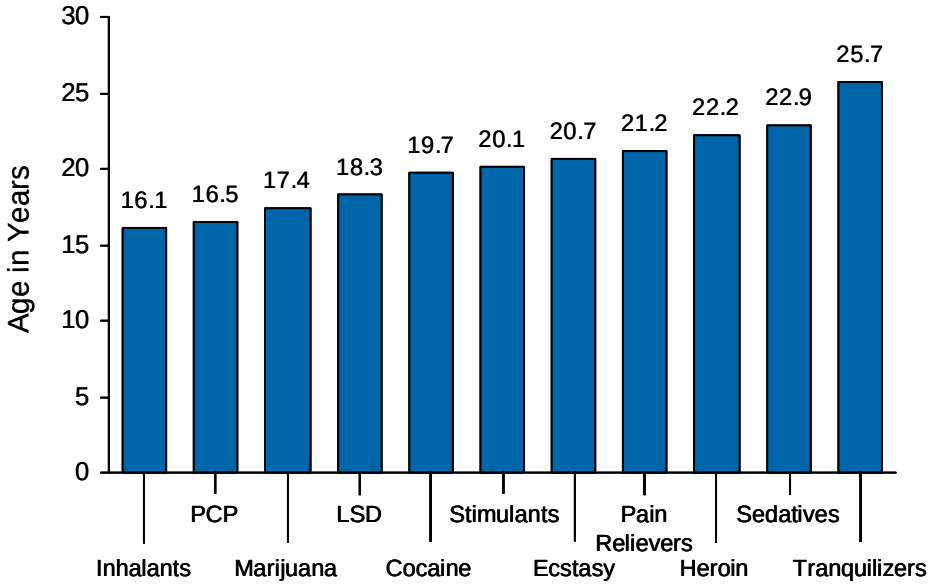
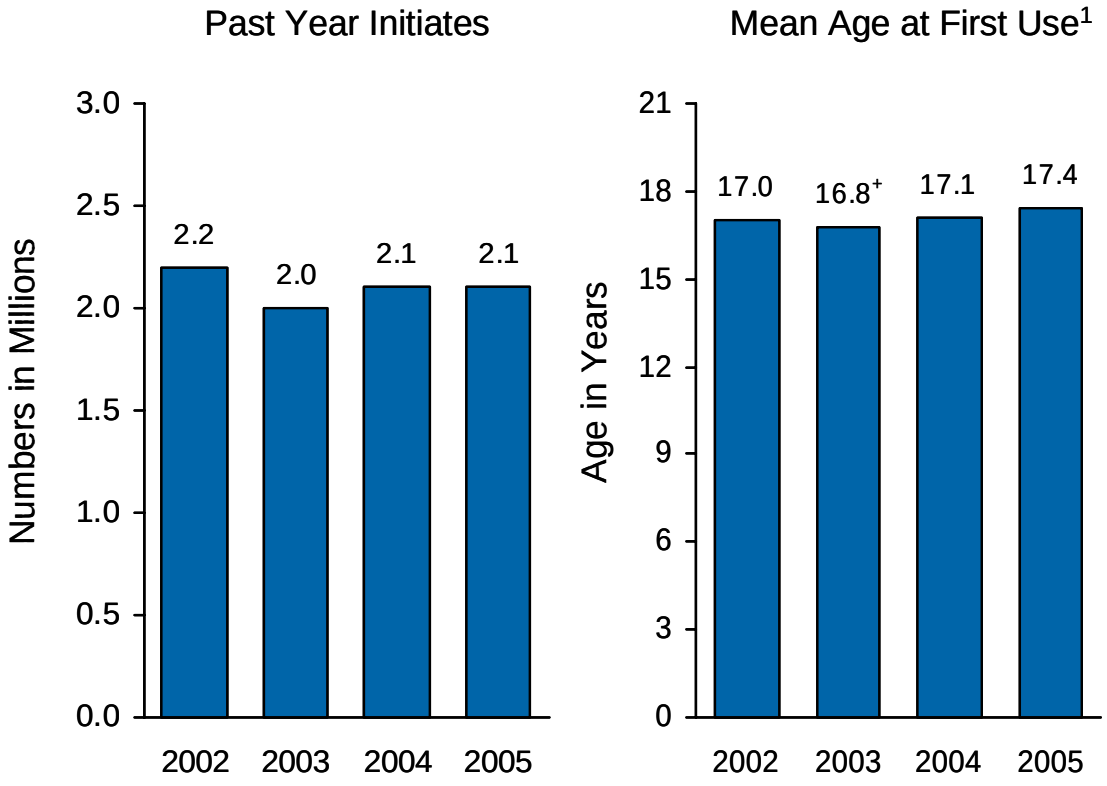


Figure 5.3 Past Year Marijuana Initiates among Persons Aged 12 or Older and Mean Age at First Use of Marijuana among Past Year Marijuana Initiates Aged 12 to 49: 2002-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.
[1] Mean age at first use estimates are among recent initiates aged 12 to 49.

- In 2005, the average age at first marijuana use among recent initiates aged 12 to 49 was 17.4 years. This average increased from 17.0 years in 2002, 16.8 years in 2003, and 17.1 years in 2004, although only the difference between the 2005 and 2003 mean ages was significant (Figure 5.3). Excluding initiation at age 21 or older, the mean ages of initiation were 15.9 years in 2002, 15.9 years in 2003, 16.0 years in 2004, and 16.0 years in 2005.

Cocaine

- In 2005, there were 872,000 persons aged 12 or older who had used cocaine for the first time within the past 12 months; this averages to approximately 2,400 initiates per day. This estimate was lower than the number in 2002 (1.0 million).

- Most (62.3 percent) of the 0.9 million recent cocaine initiates were 18 or older when they first used. The average age at first use among recent initiates aged 12 to 49 was 19.7 years, which was similar to the average age in 2002 (19.8 years).

Heroin

- In 2005, there were 108,000 persons aged 12 or older who had used heroin for the first time within the past 12 months. The average age at first use among recent initiates aged 12 to 49 was 22.2 years in 2005. There were no significant changes in the number of initiates or in the average age at first use from 2002 to 2005.

Hallucinogens

- In 2005, there were 953,000 persons aged 12 or older who had used hallucinogens for the first time within the past 12 months. This estimate was not significantly different from the estimates in 2004 (934,000) or 2003 (886,000), but it was lower than the estimate in 2002 (1.2 million).

- Although there was no significant change between 2004 and 2005 in the number of past year initiates of LSD or Ecstasy, there were declines between 2002 and 2003. The number of past year LSD initiates among persons aged 12 or older was 338,000 in 2002, 200,000 in 2003, 235,000 in 2004, and 243,000 in 2005. The number of Ecstasy initiates in the past year was 1.2 million in 2002, 642,000 in 2003, 607,000 in 2004, and 615,000 in 2005. Most (65.9 percent) of the recent Ecstasy initiates in 2005 were aged 18 or older at the time they first used Ecstasy. Among past year initiates aged 12 to 49, the average age at initiation of Ecstasy in 2005 was 20.7 years.

Inhalants

- In 2005, there were 877,000 persons aged 12 or older who had used inhalants for the first time within the past 12 months; 72.3 percent were under age 18 when they first used. The average age at first use among recent initiates aged 12 to 49 was 16.1 years in 2005. There were no significant changes in the number of inhalant initiates or the average age at first use from 2002 to 2005.

Psychotherapeutics

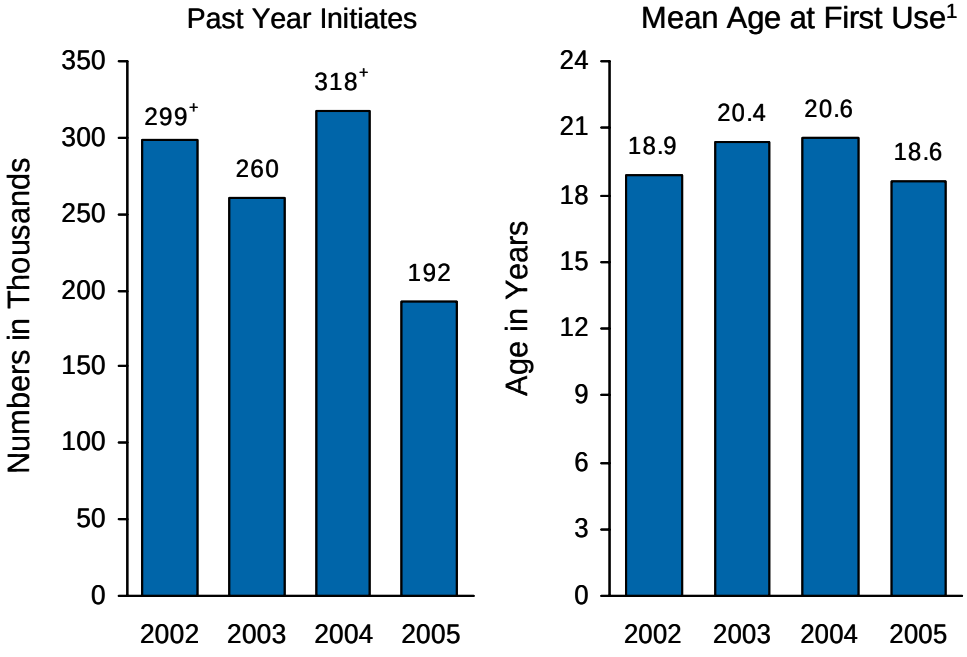
- Psychotherapeutics include the nonmedical use of any prescription-type pain relievers, tranquilizers, stimulants, or sedatives. Over-the-counter substances are not included. In 2005, there were 2.5 million persons aged 12 or older who used psychotherapeutics nonmedically for the first time within the past year. The numbers of new users of specific psychotherapeutics in 2005 were 2.2 million for pain relievers, 1.3 million for tranquilizers, 647,000 for stimulants, and 247,000 for sedatives. These estimates are similar to the corresponding estimates for 2004.

- The average age at first nonmedical use of psychotherapeutics among recent initiates aged 12 to 49 was 22.2 years. For specific drug classes, the average ages were 20.1 years for stimulants, 21.2 years for pain relievers, 22.9 years for sedatives, and 25.7 years for tranquilizers.

- In 2005, the number of new nonmedical users of OxyContin® aged 12 or older was 526,000, with an average age at first use of 23.2 years among those aged 12 to 49. These estimates are similar to estimates for 2004 (615,000 and 22.9 years, respectively).

- The number of recent new users of methamphetamine taken nonmedically among persons aged 12 or older was 192,000 in 2005 (Figure 5.4). Between 2002 and 2004, the number of methamphetamine initiates remained steady at around 300,000 per year, but there was a decline from 2004 (318,000 initiates) to 2005. The average age of new methamphetamine users aged 12 to 49 was 18.9 years in 2002, 20.4 years in 2003, 20.6 years in 2004, and 18.6 years in 2005.

Figure 5.4 Past Year Methamphetamine Initiates among Persons Aged 12 or Older and Mean Age at First Use of Methamphetamine among Past Year Methamphetamine Initiates Aged 12 to 49: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.
1 Mean age at first use estimates are among recent initiates aged 12 to 49.

Alcohol

- In 2005, there were 4.3 million persons aged 12 or older who had used alcohol for the first time within the past 12 months; this averages to approximately 12,000 initiates per day. The number of alcohol initiates was significantly greater than in 2002 (3.9 million), but similar to the numbers in 2003 (4.1 million) and 2004 (4.4 million).

- Most (88.9 percent) of the 4.3 million recent alcohol initiates were younger than 21 at the time of initiation.

- In 2005, the average age at first alcohol use among recent initiates aged 12 to 49 was 16.4 years. This average age was 16.6 years in 2002 and 16.4 years in both 2003 and 2004, but these are not statistically different from the average age at first use in 2005. Excluding initiation at age 21 or older, the mean ages were 15.5 years in 2002 and 15.6 years in 2003, 2004, and 2005.

Tobacco

- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.3 million in 2005, which was significantly greater than the estimate for 2002 (1.9 million) (Figure 5.5). Most new smokers in 2005 were under age 18 when they first smoked cigarettes (63.4 percent).

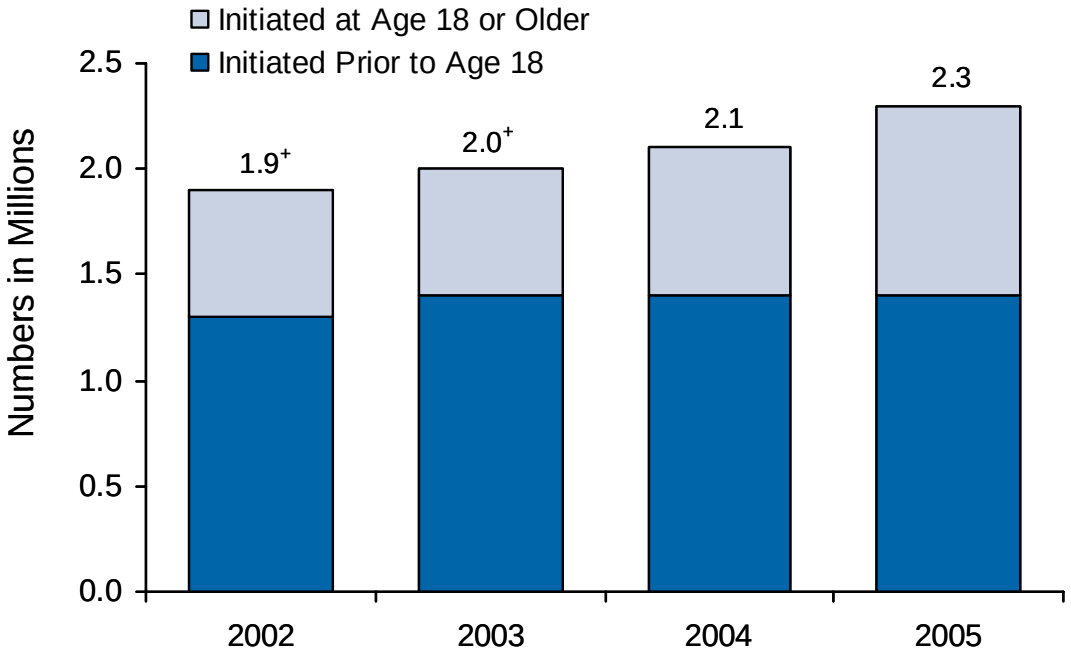
- In 2005, the average age of first cigarette use among recent initiates aged 12 to 49 was 17.3 years. This average was similar to the averages in 2002 (16.9 years), 2003 (16.9 years), and 2004 (16.7 years).

- The initiation rate (i.e., the percentage of nonsmokers who initiated cigarette use within the past 12 months) was 2.6 percent in 2002, 2003, and 2004, and it was 2.7 percent in 2005. Among youths aged 12 to 17 years, the incidence showed no significant changes during this period in that it was 6.7 percent in 2002, 6.6 percent in 2003, 6.8 percent in 2004, and 6.6 percent in 2005. This pattern was observed for both male and female youths (Figure 5.6).

- In 2005, the number of persons who had started smoking cigarettes daily within the past 12 months was 1.0 million. This estimate is similar to the estimates for 2002 (1.0 million), 2003 (1.1 million), and 2004 (1.1 million). Of these new daily smokers, 43.1 percent, or 0.4 million (an average of about 1,140 initiates per day), were younger than age 18 when they started smoking daily.

- The average age of first daily smoking among new daily smokers aged 12 to 49 in 2005 was 19.7 years. This was not significantly different from the average in 2002 (19.9 years), 2003 (19.8 years), or 2004 (18.8 years).

Figure 5.5 Past Year Cigarette Initiates among Persons Aged 12 or Older, by Age at First Use: 2002-2005



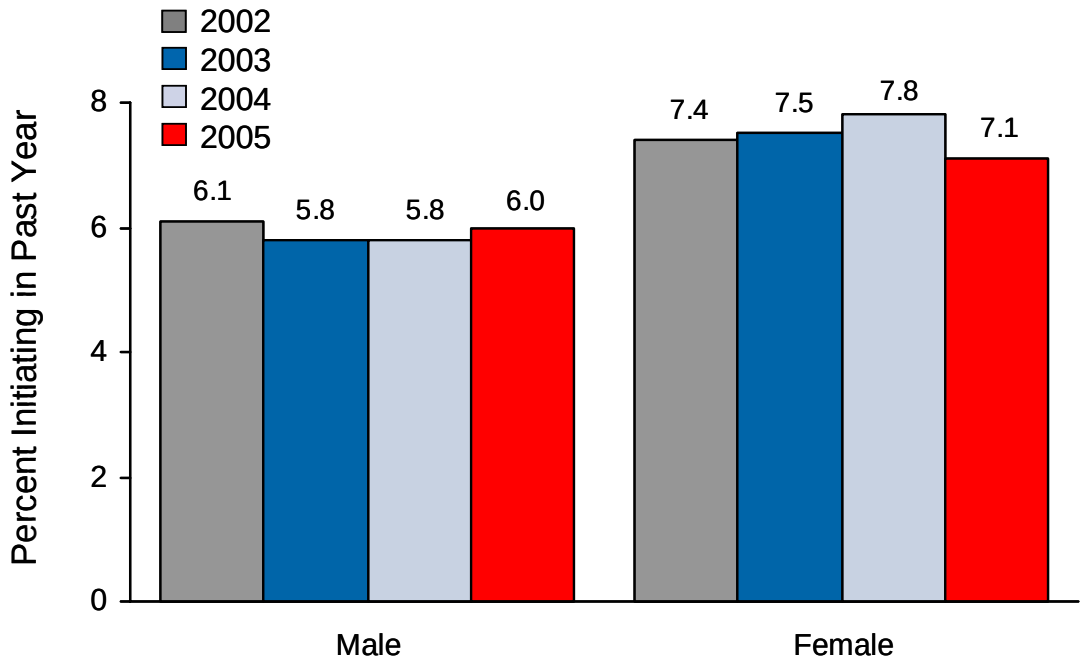
+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- In 2005, there were 3.3 million persons aged 12 or older who had used cigars for the first time in the past 12 months, a significant increase in the number of initiates from 2002 (2.9 million) and 2003 (2.7 million). The average age at first cigar use was 21.2 years among past year cigar initiates aged 12 or 49 in 2005.

- The number of persons aged 12 or older initiating use of smokeless tobacco in the past year was higher in 2005 (1.1 million) than in 2002 (951,000) and 2003 (928,000), but it was similar to the number in 2004 (999,000). Three quarters (74.6 percent) of new initiates in 2005 were male, and more than half (53.9 percent) were under age 18 when they first used.

- The average age at first smokeless tobacco use among recent initiates aged 12 to 49 in 2005 was 18.3 years. Averages were 18.2 years for males and 18.9 years for females.

Figure 5.6 Past Year Cigarette Initiation among Youths Aged 12 to 17 Who Had Never Smoked, by Gender: 2002-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

6. Youth Prevention-Related Measures

The National Survey on Drug Use and Health (NSDUH) includes questions for youths aged 12 to 17 about a number of risk and protective factors that may affect the likelihood that they will engage in substance use. Risk factors are individual characteristics and environmental influences associated with an increased vulnerability to the initiation, continuation, or escalation of substance use. Protective factors include individual resilience and other circumstances that appear to reduce the likelihood of substance use. Risk and protective factors include variables that operate at different stages of development and reflect different domains of influence, including the individual, family, peer, school, community, and societal levels (Hawkins, Catalano, & Miller, 1992). Interventions to prevent substance use generally are designed to ameliorate the influence of risk factors and enhance the effectiveness of protective factors.

This chapter presents findings for youth prevention-related measures collected in the 2005 NSDUH and compares these with findings from previous years. Included are measures of perceived risk from substance use (cigarettes, alcohol, and illicit drugs), perceived availability of substances, perceived parental disapproval of substance use, feelings about peer substance use, involvement in fighting and delinquent behavior, participation in religious and other activities, exposure to substance use prevention messages and programs, and parental involvement.

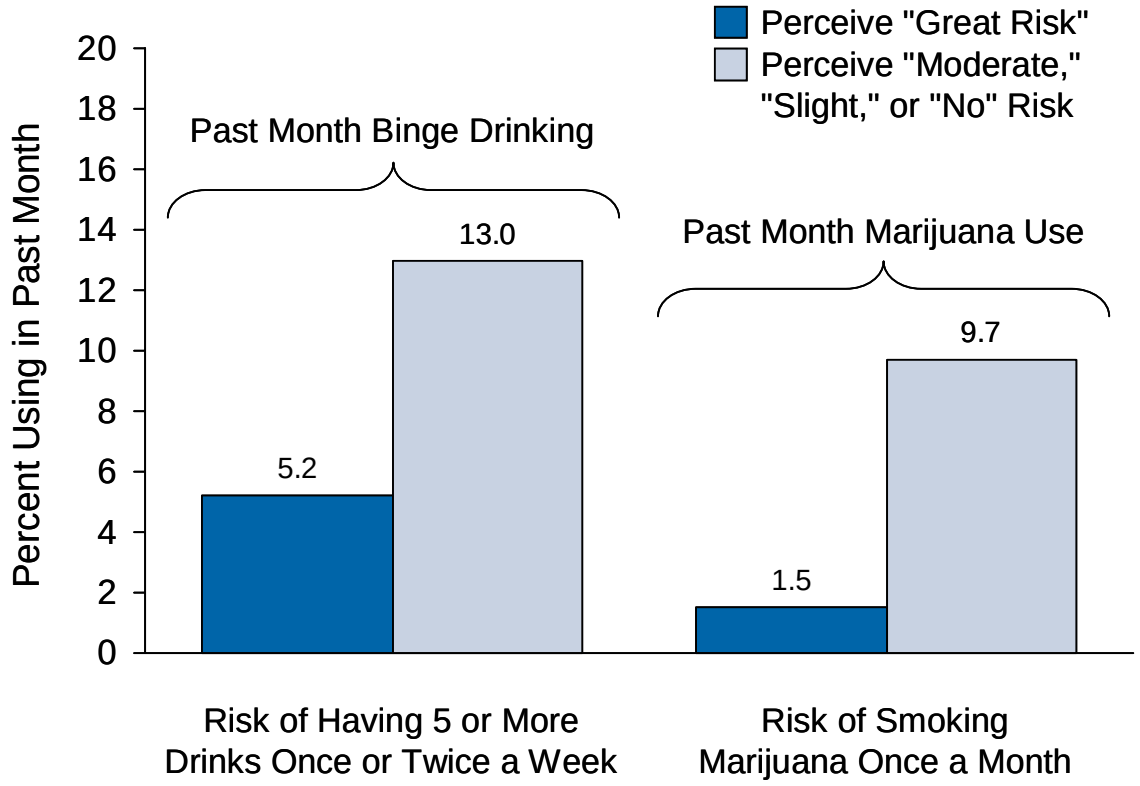
In this chapter, rates of substance use are compared for persons responding differently to questions reflecting risk or protective factors, such as the perceived risk of harm from using a substance. Because the NSDUH data for an individual are collected at only one point in time, it is not possible to determine causal connections from these data. However, a number of research studies of youths have shown that reducing risk factors and increasing protective factors can reduce rates of substance use (Botvin, Botvin, & Ruchlin, 1998). Earlier chapters of this report show that marijuana use, cigarette use, and binge use of alcohol among youths decreased between 2004 and 2005, yet corresponding changes in individual risk and protective factors for the same period may or may not have occurred. There can be many reasons for this, such as the lack of or weak causal connection, a lagged relationship between the occurrence of a risk factor and the change in drug behavior, or that individual use is typically the result of multiple simultaneous risk factors rather than a single factor (Newcomb, Maddahian, & Bentler, 1986).

Perceptions of Risk

One factor that can influence whether youths will use tobacco, alcohol, or illicit drugs is the extent to which youths believe these substances might cause them harm. NSDUH respondents were asked how much they thought people risk harming themselves physically and in other ways when they use various substances. Response choices for these items were "great risk," "moderate risk," "slight risk," or "no risk."

- The percentages of youths reporting binge alcohol use and use of cigarettes and marijuana in the past month were lower among those who perceived great risk in using these substances than among those who did not perceive great risk. For example, 5.2 percent of youths aged 12 to 17 in 2005 who perceived great risk from "having 5 or more drinks of an alcoholic beverage once or twice a week" reported binge drinking in the past month (consumption of five or more drinks of an alcoholic beverage on a single occasion on at least 1 day in the past 30 days); by contrast, past month binge drinking was reported by 13.0 percent of youths who saw moderate, slight, or no risk from having five or more drinks of an alcoholic beverage once or twice a week (Figure 6.1). Past month marijuana use was reported by 1.5 percent of youths who saw great risk in smoking marijuana once a month compared with 9.7 percent of youths who saw moderate, slight, or no risk.

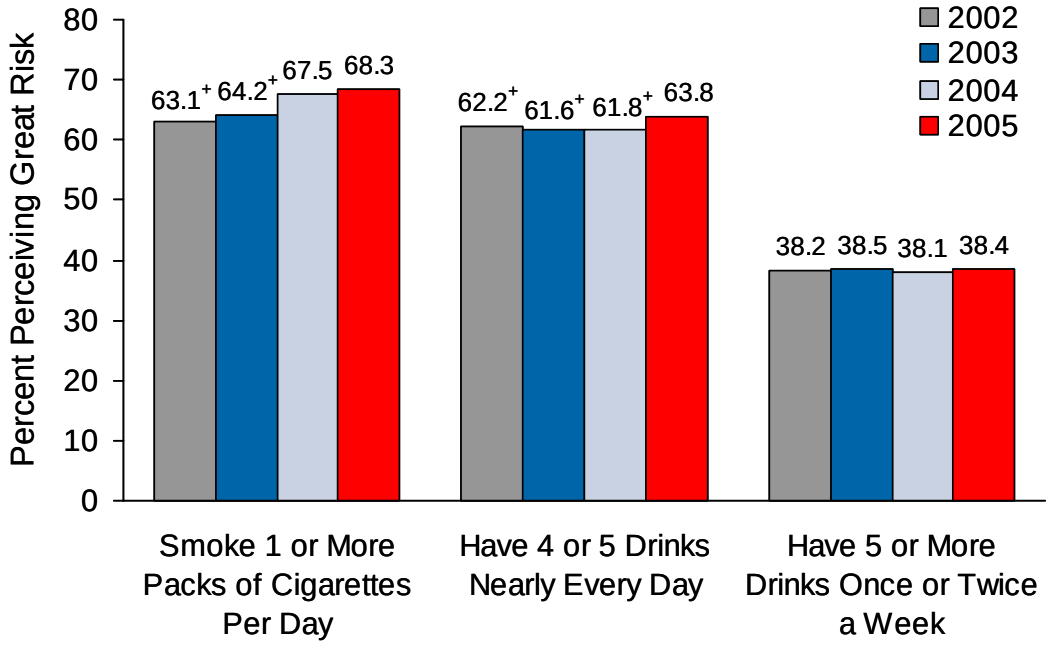
Figure 6.1 Past Month Binge Drinking and Marijuana Use among Youths Aged 12 to 17, by Perceptions of Risk: 2005



- Increases in the perceived risk of using a substance often are associated with decreases in the rate of use of that substance. Looking over 4 years, the proportion of youths aged 12 to 17 who reported perceiving great risk from smoking one or more packs of cigarettes per day increased from 63.1 percent in 2002 to 68.3 percent in 2005 (Figure 6.2). Over the same period, the rate of past month cigarette smoking among youths decreased from 13.0 to 10.8 percent, and the rate of lifetime cigarette smoking declined from 33.3 to 26.7 percent (Figure 6.3). There was no change between 2004 and 2005 in the percentage of youths who perceived a great risk of smoking one or more packs of cigarettes per day (67.5 percent in 2004 and 68.3 percent in 2005).

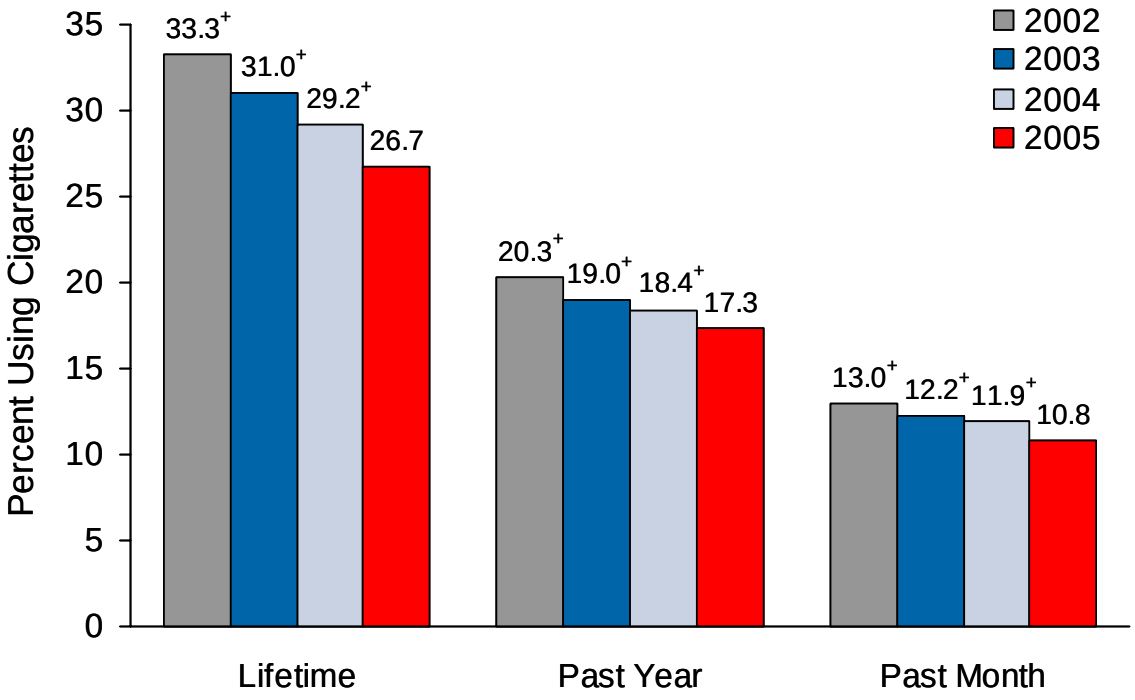
- The perceived risk of having five or more drinks of an alcoholic beverage once or twice a week was stable between 2002 and 2005, while the perceived risk of having four or five drinks nearly every day changed during the period (Figure 6.2). The percentages of youths aged 12 to 17 who reported that they perceived great risk in having five or more drinks of an alcoholic beverage once or twice a week were 38.2 percent in 2002, 38.5 percent in 2003, 38.1 percent in 2004, and 38.4 percent in 2005. The percentage of youths indicating a great risk in having four or five drinks nearly every day had been stable between 2002 and 2004, but rose from 61.8 percent in 2004 to 63.8 percent in 2005. Past month binge use of alcohol decreased among youths from 11.1 percent in 2004 to 9.9 percent in 2005, and heavy use remained unchanged, 2.7 percent in 2004 and 2.4 percent in 2005.

Figure 6.2 Perceived Great Risk of Cigarette and Alcohol Use among Youths Aged 12 to 17: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

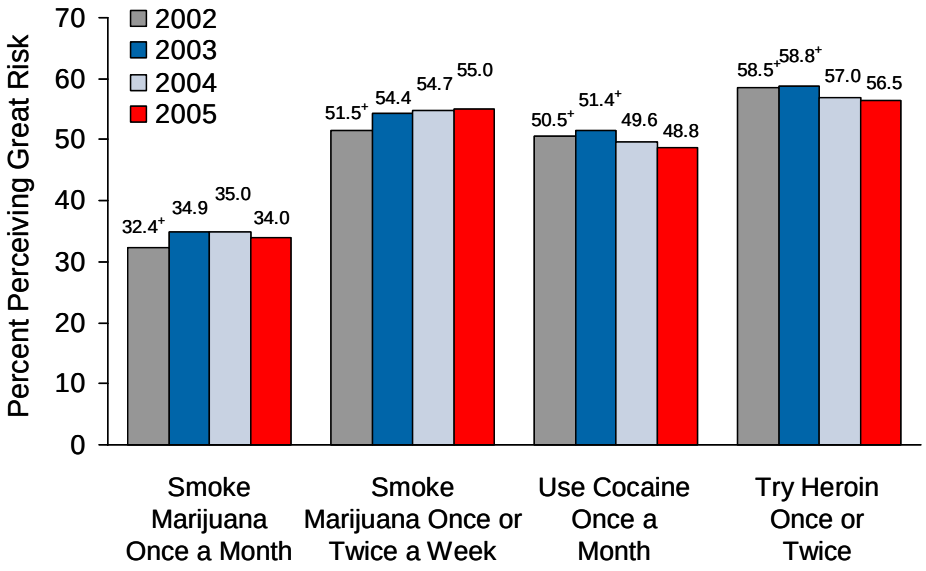
Figure 6.3 Lifetime, Past Year, and Past Month Cigarette Use among Youths Aged 12 to 17: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

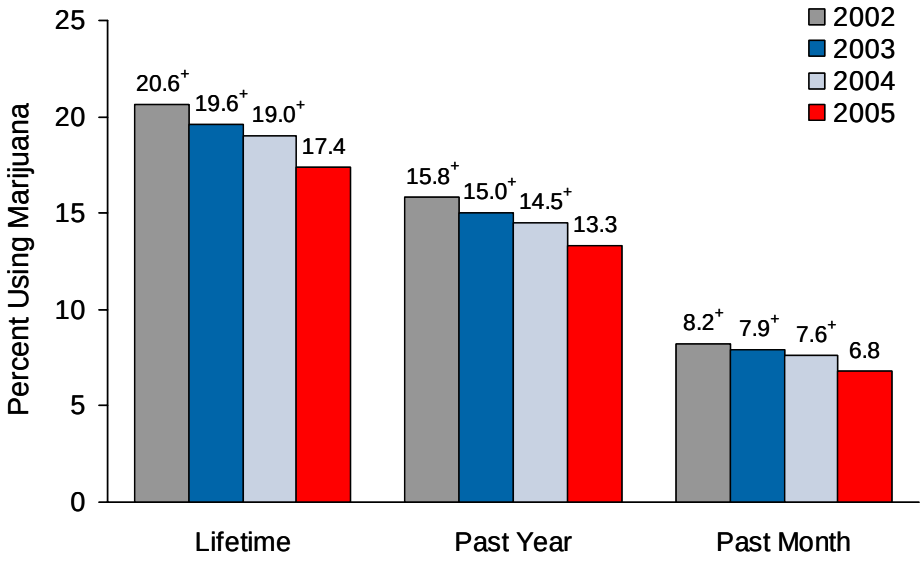
- In 2005, 55.0 percent of youths indicated a great risk in smoking marijuana once or twice a week, and 34.0 percent perceived a great risk in smoking marijuana once a month (Figure 6.4). There was no change in the perceived risk of using marijuana in either of these frequencies among youths between 2004 and 2005. Looking over a 4-year period, the perceived risk of marijuana use increased for these two measures between 2002 and 2003 and remained stable from 2003 through 2005. Between 2002 and 2005, marijuana use among youths decreased overall, although not all decreases between years were statistically significant. The prevalence of lifetime marijuana use decreased between 2002 and 2003, while the prevalence of lifetime, past year, and past month marijuana use decreased between 2004 and 2005 (Figure 6.5). From 2002 to 2005, lifetime use of marijuana dropped from 20.6 to 17.4 percent, past year use declined from 15.8 to 13.3 percent, and past month use fell from 8.2 to 6.8 percent.

Figure 6.4 Perceived Great Risk of Use of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Figure 6.5 Lifetime, Past Year, and Past Month Marijuana Use among Youths Aged 12 to 17: 2002-2005

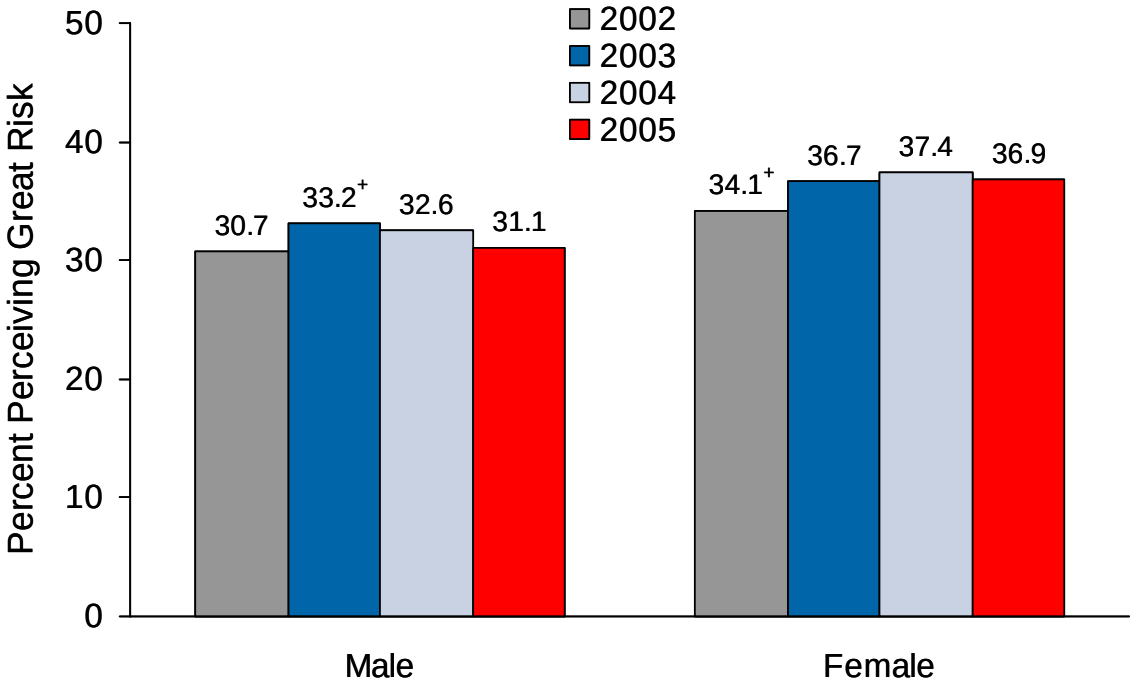


+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- Between 2004 and 2005, the perception of great risk of smoking marijuana once a month among both male and female youths aged 12 to 17 remained unchanged (Figure 6.6). For males, 32.6 percent indicated a great risk in 2004, and 31.1 percent indicated that in 2005. Among females, 37.4 percent reported a great risk in 2004, and 36.9 percent indicated great risk in 2005.

- Between 2004 and 2005, there were no changes in the perceived risk of marijuana, cocaine, heroin, or LSD use. However, since 2002, there have been increases in the perceived risk of smoking marijuana once a month (from 32.4 to 34.0 percent) and smoking marijuana once or twice a week (from 51.5 to 55.0 percent). On the other hand, the percentage of youths aged 12 to 17 who perceived that trying heroin once or twice is a great risk declined from 58.5 percent in 2002 to 56.5 percent in 2005, and those who perceived that using cocaine once a month is a great risk declined from 50.5 to 48.8 percent.

Figure 6.6 Perceived Great Risk of Smoking Marijuana Once a Month among Youths Aged 12 to 17, by Gender: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

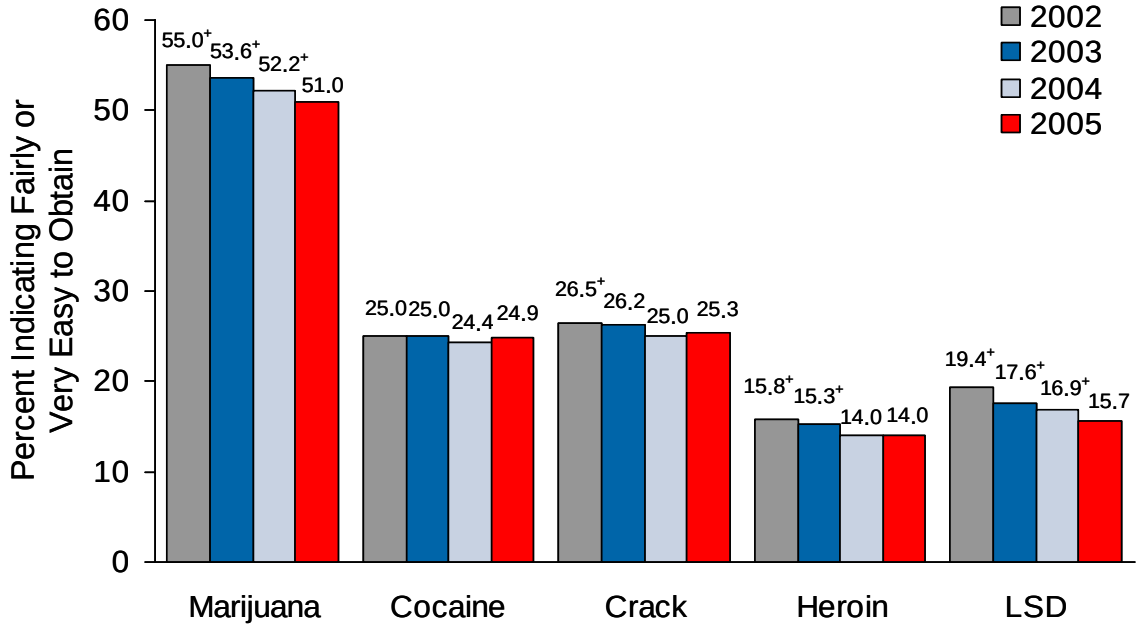
Perceived Availability

- Over half (51.0 percent) of youths aged 12 to 17 reported in 2005 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some (Figure 6.7). Around one quarter reported it would be easy to get cocaine (24.9 percent) or crack (25.3 percent). One in seven (14.0 percent) indicated that heroin would be "fairly" or "very" easily available, and about one in six (15.7 percent) said it would be easy for them to get LSD if they wanted some.

- The perceived availability of marijuana declined from 52.2 percent in 2004 to 51.0 percent in 2005, and the perceived availability of LSD declined during the same period from 16.9 to 15.7 percent. The perceived availability of cocaine, crack, and heroin remained unchanged between 2004 and 2005.

- The perceived availability decreased between 2002 and 2005 for marijuana (from 55.0 to 51.0 percent), crack (from 26.5 to 25.3 percent), heroin (from 15.8 to 14.0 percent), and LSD (from 19.4 to 15.7 percent). However, the percentage reporting that it would be easy to obtain cocaine showed no decline over this period (25.0 percent in 2002 and 24.9 percent in 2005).

Figure 6.7 Perceived Availability of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- The percentage of youths who reported that drugs would be easy to obtain if they wanted some was associated with age, with perceived availability increasing with age. For example, in 2005, 22.0 percent of those aged 12 or 13 said it would be fairly or very easy to obtain marijuana compared with 53.8 percent of those aged 14 or 15 and 75.5 percent of those aged 16 or 17.

- In 2005, 15.5 percent of youths aged 12 to 17 indicated that they had been approached by someone selling drugs in the past month, similar to the 16.3 percent reported in 2004. Youths who reported being approached by someone selling drugs, compared with those who reported no such approaches, were much more likely to have used an illicit drug in their lifetime (61.3 vs. 21.5 percent), in the past year (51.2 vs. 14.1 percent), and in the past month (32.6 vs. 5.8 percent).

Perceived Parental Disapproval of Substance Use

- Most youths aged 12 to 17 believed their parents would "strongly disapprove" of their using substances. In 2005, 91.1 percent of youths aged 12 to 17 reported that their parents would strongly disapprove of their smoking one or more packs of cigarettes per day, while the remaining 8.9 percent believed their parents would "somewhat disapprove" or "neither approve nor disapprove." A majority of youths (90.2 percent) reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice, and 88.9 percent reported their parents would strongly disapprove of their having one or two drinks of an alcoholic beverage nearly every day. These rates of perceived parental disapproval in 2005 were similar to those seen in 2004.

- Youths aged 12 to 17 who believed their parents would strongly disapprove of their using a particular substance were less likely to use that substance than were youths who believed their parents would somewhat disapprove or neither approve nor disapprove. For example, past month cigarette use was reported by 7.9 percent of youths who perceived strong parental disapproval of their smoking one or more packs of cigarettes per day compared with 40.5 percent of youths who believed their parents would not strongly disapprove. Current marijuana use also was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.6 vs. 27.0 percent).

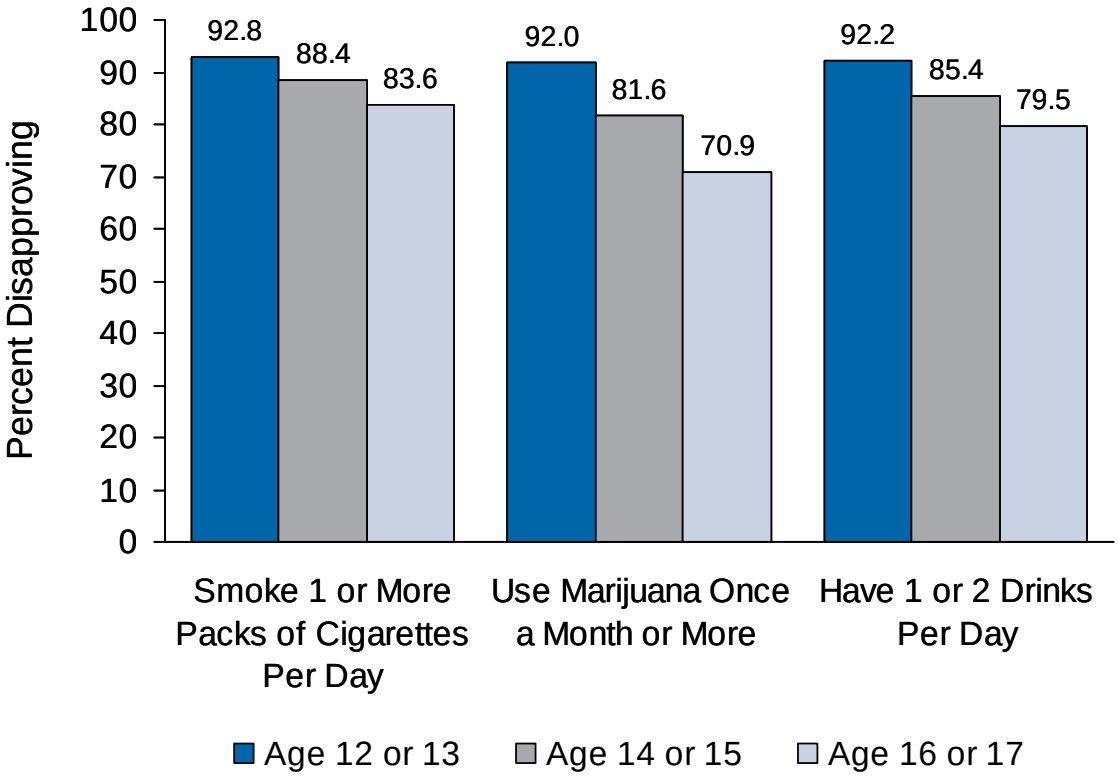
Feelings about Peer Substance Use

- A majority of youths aged 12 to 17 reported that they disapprove of their peers using substances. In 2005, 88.2 percent of youths "strongly" or "somewhat" disapproved of their peers smoking one or more packs of cigarettes per day; 80.8 percent reported similar feelings about their peers trying marijuana or hashish once or twice; and 85.6 percent strongly or somewhat disapproved of peers having one or two drinks of an alcoholic beverage nearly every day. These rates are similar to those observed in 2004.

- The percentage disapproving of peers' substance use generally decreased with age. In 2005, disapproval of peers using marijuana once a month or more, for example, was reported by 92.0 percent of youths aged 12 or 13, 81.6 percent of those aged 14 or 15, and 70.9 percent of those aged 16 or 17 (Figure 6.8).

- Past month marijuana use was reported by 2.4 percent of youths aged 12 to 17 who disapproved of their peers using marijuana once a month or more compared with 26.0 percent of youths who reported that they neither approve nor disapprove of such behavior from their peers.

Figure 6.8 Disapproval of Peer Substance Use among Youths Aged 12 to 17, by Age: 2005

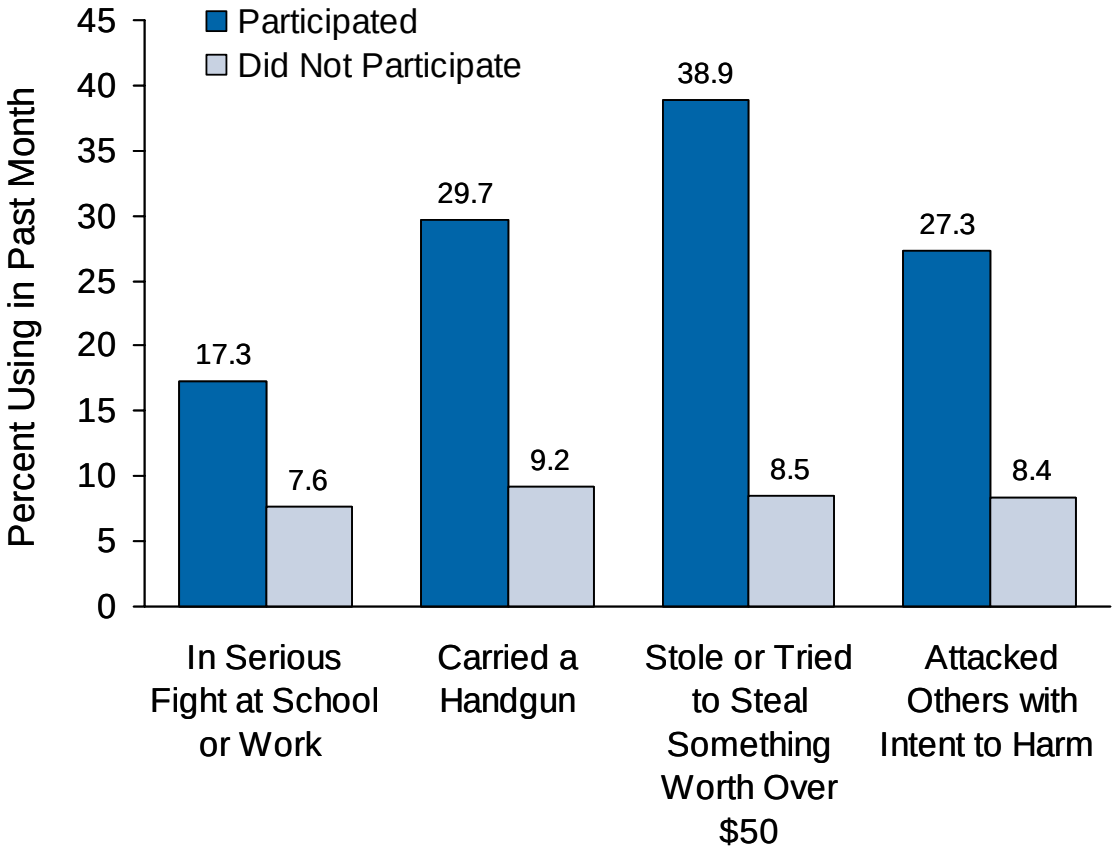


Fighting and Delinquent Behavior

- In 2005, 23.4 percent of youths aged 12 to 17 reported that, in the past year, they had gotten into a serious fight at school or at work; 16.8 percent had taken part in a group-against-group fight; 3.2 percent had carried a handgun at least once; 3.3 percent had sold illegal drugs (down from 3.8 percent in 2004); 4.2 percent had, at least once, stolen or tried to steal something worth more than $50; and 7.4 percent had, in at least one instance, attacked others with intent to seriously hurt them (down from 8.2 percent in 2004).

- Youths who had engaged in fighting or other delinquent behaviors were more likely than other youths to have used illicit drugs. For example, past month illicit drug use was reported by 17.3 percent of youths who had gotten into serious fights at school or work in the past year compared with 7.6 percent of those who had not, and by 38.9 percent of those who had stolen or tried to steal something worth over $50 in the past year compared with 8.5 percent of those who had not (Figure 6.9).

Figure 6.9 Past Month Illicit Drug Use among Youths Aged 12 to 17, by Participation in Fighting and Delinquent Behavior in the Past Year: 2005



Religious Beliefs and Participation in Activities

- In 2005, 32.8 percent of youths aged 12 to 17 reported that they had attended religious services 25 or more times in the past year; 76.9 percent expressed agreement with the statement that religious beliefs are a very important part of their lives; 67.9 percent agreed with the statement that religious beliefs influence how they make decisions in life; and 34.9 percent agreed with the statement that it is important for their friends to share their religious beliefs. Findings for these measures remained stable from 2004 to 2005. Illicit drug, alcohol, and cigarette use were lower among youths who agreed with these statements than among those who disagreed. For example, past month illicit drug use was reported by 7.7 percent of those who agreed that religious beliefs are a very important part of life compared with 17.2 percent of those who disagreed with that statement.

Exposure to Substance Use Prevention Messages and Programs

- Approximately one in eight youths aged 12 to 17 (11.7 percent) reported in 2005 that they had participated in drug, tobacco, or alcohol prevention programs outside of school in the past year. The prevalence of past month alcohol use was lower among youths who reported participating in these programs, 14.0 percent, than among youths who did not, 16.9 percent. However, for past month use of marijuana, there was no statistically significant difference between those who participated (5.8 percent used marijuana) and those who did not (6.9 percent used marijuana). Similarly, there was no difference between the two groups in current cigarette use (10.4 percent among participants and 10.8 percent among nonparticipants).

- In 2005, 59.8 percent of youths aged 12 to 17 reported that they had talked at least once in the past year with at least one of their parents about the dangers of drug, tobacco, or alcohol use—similar to the 60.3 percent in 2004. Among youths who reported having had such conversations with their parents, rates of current alcohol, cigarette, and illicit drug use were lower than among youths who did not talk about substance abuse. For example, past month binge drinking was reported by 9.2 percent of youths who had talked with their parents about drug, tobacco, or alcohol use compared with 11.0 percent of those who had not. Past month use of marijuana was lower among youths who had talked with their parents (6.4 percent) than among those who had not (7.4 percent).

- Almost four fifths (77.9 percent) of youths aged 12 to 17 enrolled in school reported in 2005 they had seen or heard drug or alcohol prevention messages at school in the past year, a percentage similar to the 2004 estimate of 78.2 percent. Past month use of an illicit drug was lower for youths exposed to such messages in school (9.2 percent) than for youths not reporting such exposure (13.2 percent).

- Out-of-school exposure to drug or alcohol prevention messages in the past year was reported by 81.1 percent of youths aged 12 to 17 in 2005, a decline from 83.0 percent in 2004. Past month rates of use of any illicit drug, marijuana, any illicit drug other than marijuana, alcohol, and binge alcohol among those reporting no exposure to drug or alcohol prevention messages outside of school were all similar to rates among those who reported that they had seen prevention messages outside of school. Past month cigarette use showed a significant difference (12.6 percent among those who had not been exposed vs. 10.3 percent among those who had).

Parental Involvement

- Youths aged 12 to 17 were asked a number of questions related to the extent of support, oversight, and control that they perceived their parents exercised over them in the year prior to the survey. In 2005, among youths aged 12 to 17 enrolled in school in the past year, 79.2 percent reported that in the past year their parents always or sometimes checked on whether or not they had completed their homework, 79.5 percent reported that their parents always or sometimes provided help with their homework, and 68.7 percent reported that their parents limited the amount of time that they spent out with friends on school nights. Also in 2005, among all youths aged 12 to 17, 87.5 percent reported that in the past year their parents made them always or sometimes do chores around the house, 38.6 percent reported that their parents limited the amount of time that they watched television, and 85.9 percent reported that their parents always or sometimes let them know that they had done a good job. All of these percentages were similar to those for 2004 with the exception of the percentage reporting that their parents provided help with homework, which had declined from the 80.8 percent that had been reported in 2004.

- In 2005, past month use of any illicit drug, cigarettes, and alcohol was lower among youths aged 12 to 17 who reported that their parents always or sometimes engaged in monitoring behaviors than among youths whose parents "seldom" or "never" engaged in such behaviors. For example, the rate of past month use of any illicit drug was 8.1 percent for youths whose parents always or sometimes helped with homework compared with 17.4 percent among youths who indicated that their parents seldom or never helped. Rates for current cigarette smoking were 9.3 and 17.7 percent for the two groups of youths, respectively, and rates of past month alcohol use were 14.5 versus 27.2 percent.

7. Substance Dependence, Abuse, and Treatment

The National Survey on Drug Use and Health (NSDUH) includes a series of questions to assess the prevalence of substance use disorders (i.e., dependence on or abuse of a substance) in the past 12 months. Substances include alcohol and illicit drugs, such as marijuana, cocaine, heroin, hallucinogens, and inhalants, and the nonmedical use of prescription-type psychotherapeutic drugs. These questions are used to classify persons as dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994).

The questions on dependence ask about health and emotional problems associated with substance use, unsuccessful attempts to cut down on use, tolerance, withdrawal, reducing other activities to use substances, spending a lot of time engaging in activities related to substance use, or using the substance in greater quantities or for a longer time than intended. The questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to substance use. Dependence is considered to be a more severe substance use problem than abuse because it involves the psychological and physiological effects of tolerance and withdrawal. Although individuals may meet the criteria specified for both dependence and abuse, persons meeting the criteria for both are classified as having dependence, but not abuse. Persons defined with abuse do not meet the criteria for dependence.

This chapter provides estimates of the prevalence and patterns of substance use disorders occurring in the past year from the 2005 NSDUH and compares these estimates against the results from the 2002, 2003, and 2004 surveys. It also provides estimates of the prevalence and patterns of the receipt of treatment in the past year for problems related to substance use and discusses the need for and receipt of treatment at specialty facilities for problems associated with substance use.

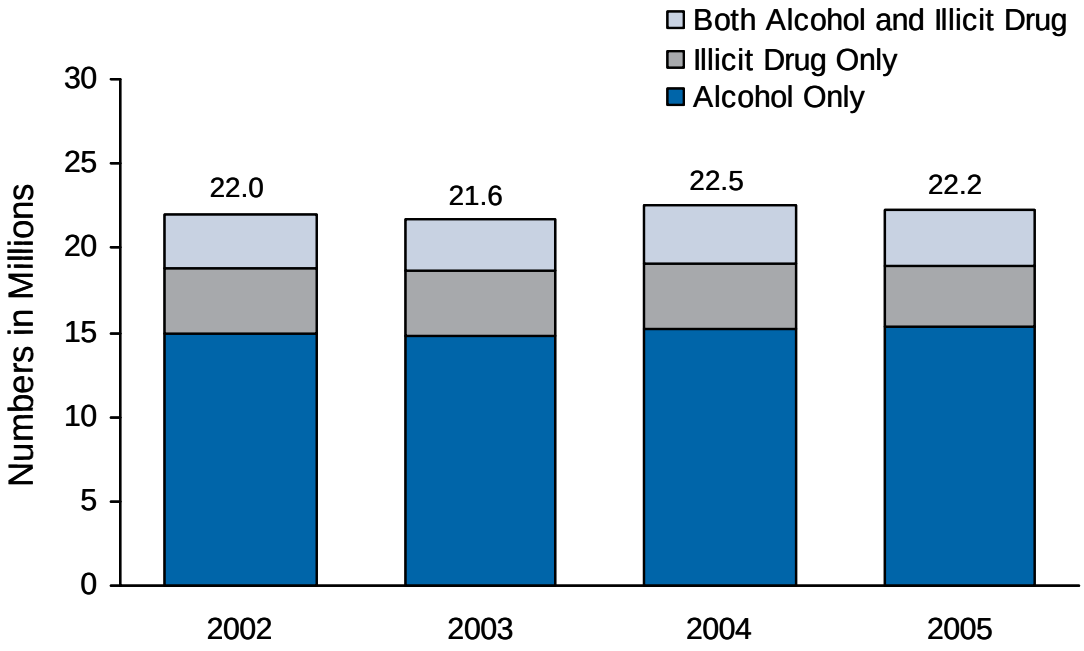
7.1 Substance Dependence or Abuse

- In 2005, an estimated 22.2 million persons aged 12 or older were classified with substance dependence or abuse in the past year (9.1 percent of the population aged 12 or older) (Figure 7.1). Of these, 3.3 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.6 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs.

- Between 2002 and 2005, there was no change in the number of persons with substance dependence or abuse (22.0 million in 2002, 21.6 million in 2003, 22.5 million in 2004, and 22.2 million in 2005).

- There were 18.7 million persons aged 12 or older classified with dependence on or abuse of alcohol in 2005 (7.7 percent). This estimate has remained stable since 2002.

Figure 7.1 Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2005

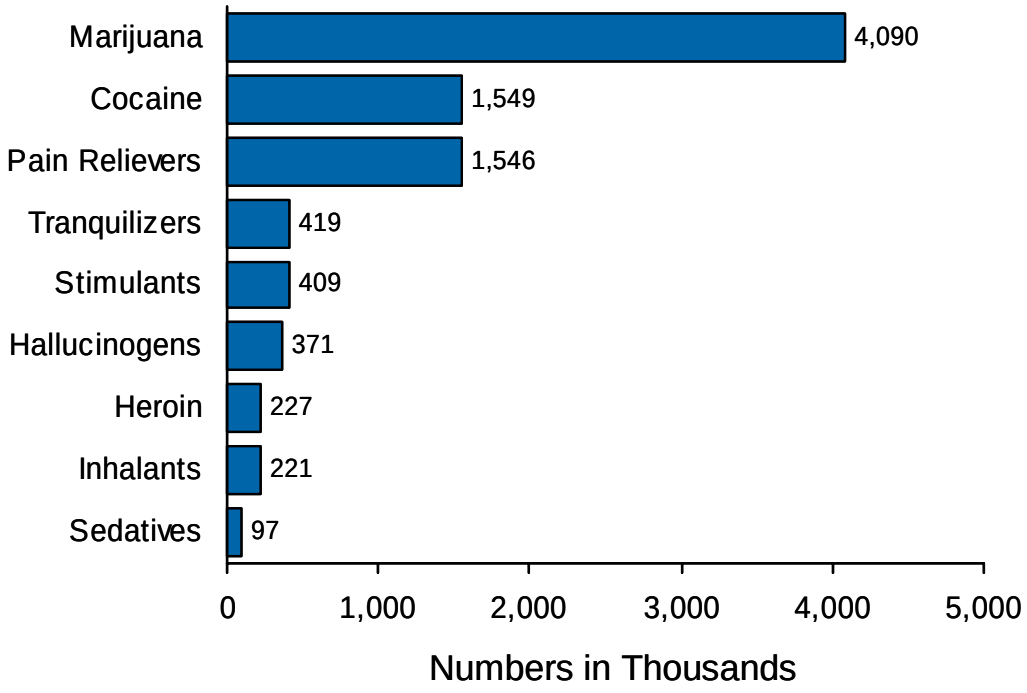


[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- The specific illicit drugs that had the highest levels of past year dependence or abuse in 2005 were marijuana, followed by cocaine and pain relievers. Of the 6.8 million persons aged 12 or older classified with dependence on or abuse of illicit drugs, 4.1 million were dependent on or abused marijuana in 2005 (Figure 7.2). This number represents 1.7 percent of the total population aged 12 or older and 59.9 percent of all those classified with illicit drug dependence or abuse. There were 1.5 million persons who were classified with dependence on or abuse of cocaine, about the same as the number classified with dependence on or abuse of pain relievers.

- There were no changes between 2002 and 2005 in the percentages of persons with dependence on or abuse of illicit drugs (3.0 percent in 2002, 2.9 percent in 2003, 3.0 percent in 2004, and 2.8 percent in 2005) and dependence on or abuse of alcohol (7.7 percent in 2002, 7.5 percent in 2003, 7.8 percent in 2004, and 7.7 percent in 2005). However, there was a decrease in the rate of dependence on or abuse of marijuana from 2004 to 2005 (1.9 to 1.7 percent).

Figure 7.2 Dependence on or Abuse of Specific Illicit Drugs in the Past Year among Persons Aged 12 or Older: 2005

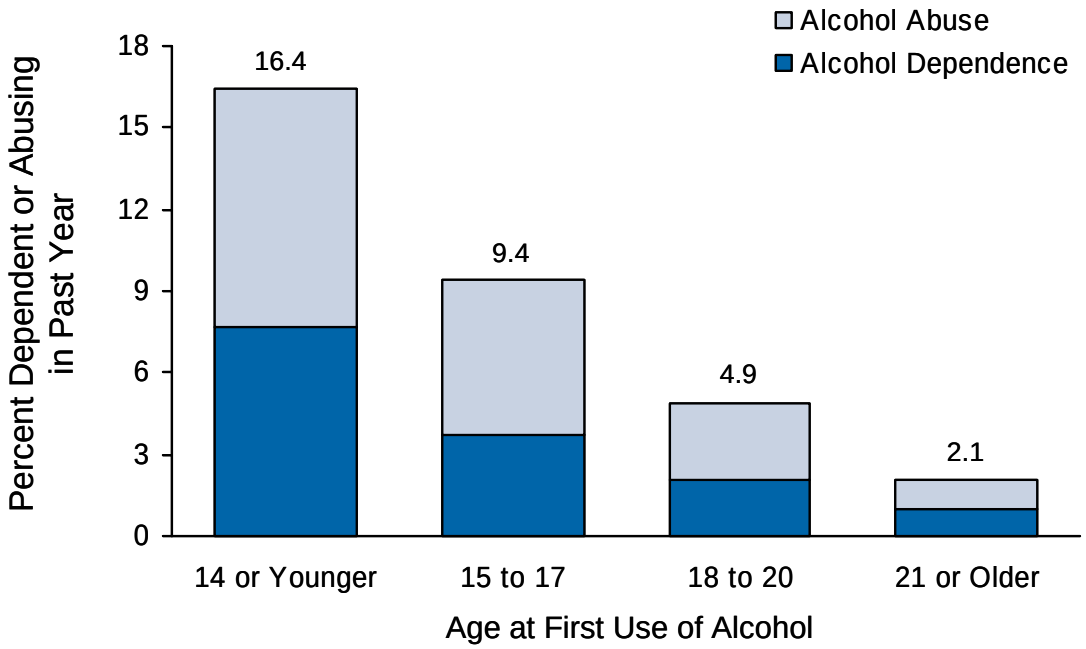


Age at First Use

- In 2005, among adults aged 18 or older who first tried marijuana at age 14 or younger, 13.3 percent were classified with illicit drug dependence or abuse, higher than the 2.4 percent of adults who had first used marijuana at age 18 or older.

- Among adults, there was an association between age at first use of alcohol and dependence on or abuse of alcohol in 2005. Among adults aged 18 or older who first tried alcohol at age 14 or younger, 17.8 percent were classified with alcohol dependence or abuse compared with only 3.9 percent of adults who had first used alcohol at age 18 or older. Adults aged 21 or older who had first used alcohol before age 21 also were more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (9.6 vs. 2.1 percent) (Figure 7.3).

Figure 7.3 Alcohol Dependence or Abuse in the Past Year among Adults Aged 21 or Older, by Age at First Use of Alcohol: 2005



Age

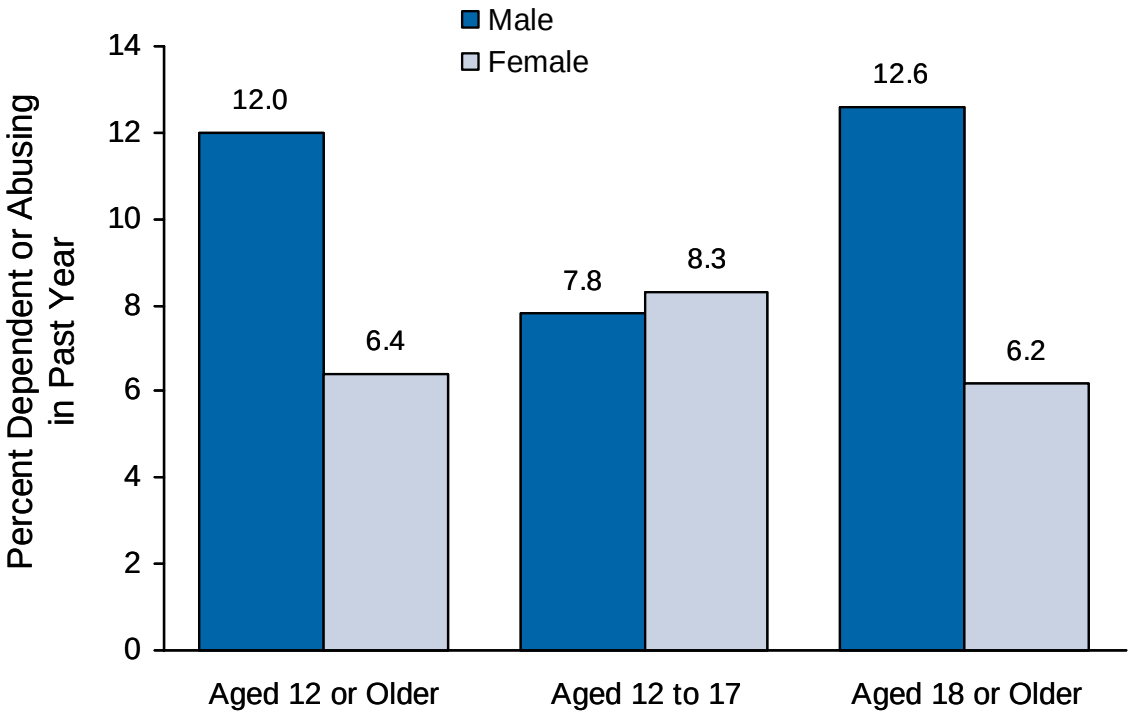
- Rates of substance dependence or abuse were associated with age. In 2005, young adults aged 18 to 25 had higher rates of substance dependence or abuse (21.8 percent) than youths aged 12 to 17 (8.0 percent) and adults aged 26 or older (7.1 percent). Among persons with substance dependence or abuse, the proportion dependent on or abusing illicit drugs was associated with age in 2005: 58.2 percent of youths aged 12 to 17, 38.6 percent of young adults aged 18 to 25, and 22.3 percent of adults aged 26 or older with substance dependence or abuse were dependent on or abused illicit drugs.

- Among youths aged 12 to 17, the rate of substance dependence or abuse decreased between 2004 and 2005 from 8.8 to 8.0 percent. This decline was driven by a decrease in the rate of illicit drug dependence or abuse among youths aged 12 to 17 (5.3 to 4.7 percent). The rates of alcohol dependence or abuse were 6.0 percent in 2004 and 5.5 percent in 2005, but this was not a statistically significant change.

Gender

- As was the case from 2002 through 2004, males aged 12 or older in 2005 were about twice as likely to be classified with substance dependence or abuse as females (12.0 vs. 6.4 percent) (Figure 7.4). Among youths aged 12 to 17, however, the rate of substance dependence or abuse among males was similar to the rate among females (7.8 vs. 8.3 percent).

Figure 7.4 Substance Dependence or Abuse in the Past Year, by Age and Gender: 2005



- There was a decrease in the rate of illicit drug dependence or abuse among males aged 12 or older from 3.9 percent in 2004 to 3.5 percent in 2005. The rate for females did not change between 2004 and 2005 (2.2 vs. 2.1 percent).

Race/Ethnicity

- In 2005, among persons aged 12 or older, the rate of substance dependence or abuse was highest among American Indians or Alaska Natives (21.0 percent) and lowest among Asians (4.5 percent). Other racial/ethnic groups reported generally similar rates: Native Hawaiians or Other Pacific Islanders (11.0 percent), persons reporting two or more races (10.9 percent), whites (9.4 percent), Hispanics (9.3 percent), and blacks (8.5 percent). These rates were all similar to the rates seen in 2004.

Education/Employment

- Rates of substance dependence or abuse were associated with level of education in 2005. Among adults aged 18 or older, those who graduated from high school but did not attend any college and those who graduated from college had lower rates of dependence or abuse (9.0 and 8.0 percent, respectively) than those who were not high school graduates and those with some college (10.2 and 10.3 percent, respectively).

- Rates of substance dependence or abuse were associated with current employment status in 2005. A higher percentage of unemployed adults aged 18 or older were classified with dependence or abuse (17.6 percent) than were full-time employed adults (10.2 percent) and part-time employed adults (11.2 percent).

- Most adults aged 18 or older with substance dependence or abuse in 2005 were employed either full or part time. Of the 20.2 million adults classified with dependence or abuse, 15.5 million (76.7 percent) were employed.

Criminal Justice Populations

- In 2005, adults aged 18 or older who were on parole or a supervised release from jail during the past year were more likely to be classified with dependence on or abuse of a substance (33.7 percent) than those who were not on parole or supervised release during the past year (9.1 percent).

- In 2005, probation status was associated with substance dependence or abuse. The rate of substance dependence or abuse was 37.2 percent among adults who were on probation during the past year, which is significantly higher than the rate among adults who were not on probation during the past year (8.7 percent).

Geographic Area

- Rates of substance dependence or abuse in 2005 for persons aged 12 or older showed evidence of differences by region. The rates were 9.7 percent in the West, 9.6 percent in the Midwest, 8.8 percent in the South, and 8.5 percent in the Northeast.

- In 2005, among persons aged 12 or older, the rate for substance dependence or abuse was 9.0 percent in large metropolitan counties, 9.9 percent in small metropolitan counties, and 8.2 percent in nonmetropolitan counties.

7.2 Past Year Treatment for a Substance Use Problem

Estimates described in this section refer to treatment received to reduce or stop illicit drug or alcohol use, or for medical problems associated with the use of illicit drugs or alcohol. This includes treatment received in the past year at any location, such as a hospital (inpatient), rehabilitation facility (outpatient or inpatient), mental health center, emergency room, private doctor's office, prison or jail, or a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous. Persons could report receiving treatment at more than one location. Note that the definition of treatment in this section is different from the definition of specialty treatment described in Section 7.3. Specialty treatment only includes treatment at a hospital (inpatient), a rehabilitation facility (inpatient or outpatient), or a mental health center.

Individuals who reported receiving substance use treatment but were missing information on whether the treatment was specifically for alcohol use or illicit drug use were not counted in estimates of illicit drug use treatment or in estimates of alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

- There were 3.9 million persons aged 12 or older (1.6 percent of the population) who received some kind of treatment for a problem related to the use of alcohol or illicit drugs in 2005. Of these, 1.5 million received treatment for the use of both alcohol and illicit drugs, 0.7 million received treatment for the use of illicit drugs but not alcohol, and 1.3 million received treatment for the use of alcohol but not illicit drugs. (Note that estimates by substance do not add to the total number of persons receiving treatment because the total includes persons who reported receiving treatment but did not report for which substance the treatment was received.)

- Between 2004 and 2005, there was no statistically significant change in the number or percentage of the population receiving substance use treatment within the past year (3.8 million, 1.6 percent in 2004; 3.9 million, 1.6 percent in 2005).

Location of Treatment and Substance Treated

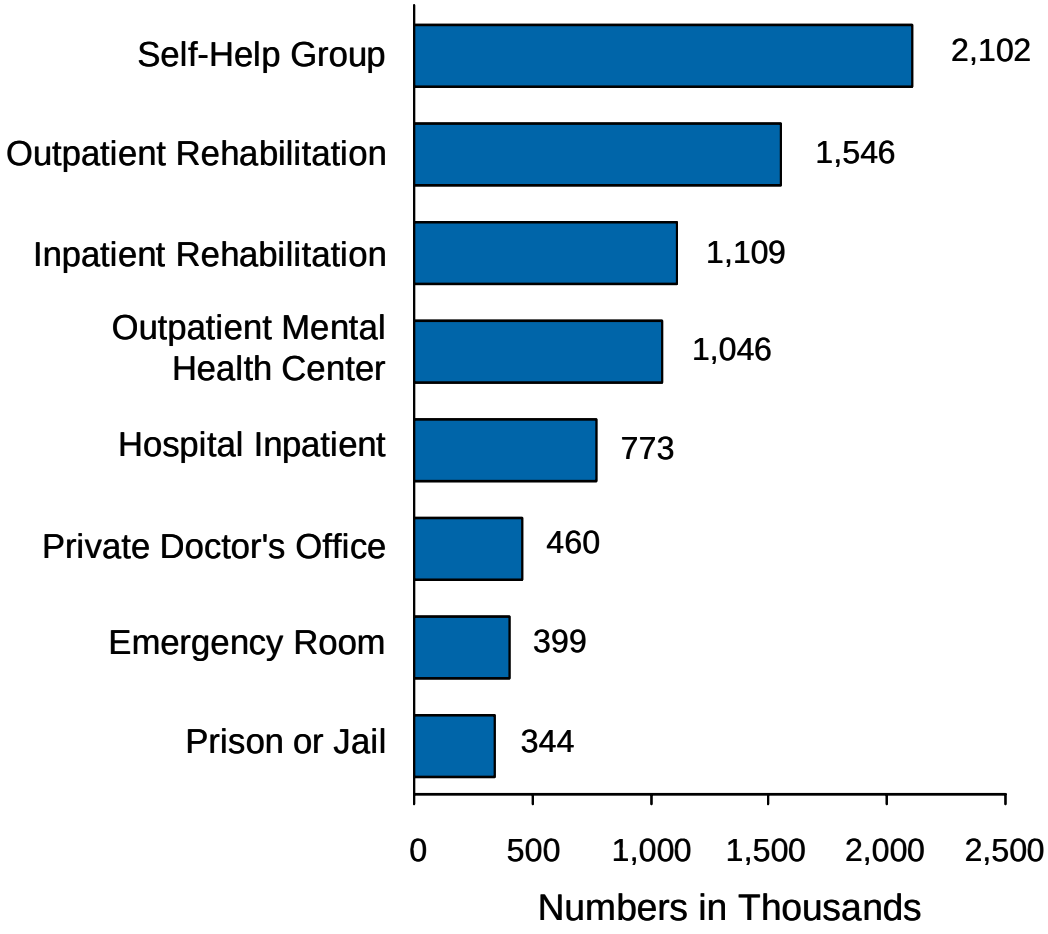
- In 2005, among the 3.9 million persons aged 12 or older who received treatment for alcohol or illicit drug use in the past year, more than half (2.1 million) received treatment at a self-help group (Figure 7.5). There were 1.5 million persons who received treatment at a rehabilitation facility as an outpatient, 1.1 million at a rehabilitation facility as an inpatient, 1.0 million at a mental health center as an outpatient, 773,000 at a hospital as an inpatient, 460,000 at a private doctor's office, 399,000 at an emergency room, and 344,000 at a prison or jail. None of these estimates changed significantly between 2004 and 2005.

- More than half (2.5 million) of the 3.9 million persons who received treatment for a substance use problem in the past year received treatment for alcohol use during their most recent treatment. There were 1.1 million persons who received treatment for marijuana use during their most recent treatment. Estimates for other drugs were 797,000 persons for cocaine, 466,000 for pain relievers, 358,000 for hallucinogens, 351,000 for stimulants, and 326,000 for heroin. (Note that respondents could indicate that they received treatment for more than one substance during their most recent treatment.)

7.3 Need and Receipt of Specialty Treatment

This section discusses the need for and receipt of treatment for a substance use problem at a "specialty" treatment facility. Specialty treatment is defined as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. An individual is defined as needing treatment for an alcohol or drug use problem if he or she met the DSM-IV (APA, 1994) diagnostic criteria for dependence on or abuse of alcohol or illicit drugs in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months.

Figure 7.5 Locations Where Past Year Substance Use Treatment Was Received among Persons Aged 12 or Older: 2005



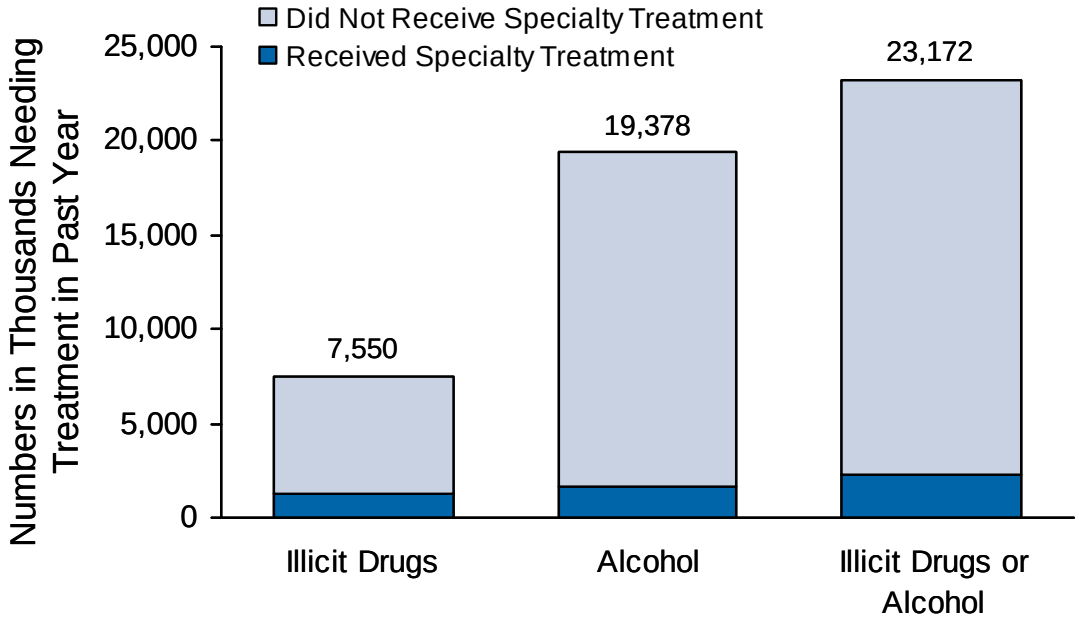
In this section (7.3), an individual needing treatment for an illicit drug use problem is defined as receiving treatment for his or her drug use problem only if he or she reported receiving specialty treatment for drug use in the past year. Thus, an individual who needed treatment for illicit drug use but only received specialty treatment for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility was not counted as receiving treatment for drug use. Similarly, an individual who needed treatment for an alcohol use problem was only counted as receiving alcohol use treatment if the treatment was received for alcohol use at a specialty treatment facility. Individuals who reported receiving specialty substance use treatment but were missing information on whether the treatment was specifically for alcohol use or drug use were not counted in estimates of specialty drug use treatment or in estimates of specialty alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

In addition to questions about symptoms of substance use problems that are used to classify respondents' need for treatment based on DSM-IV criteria, NSDUH includes questions asking respondents about their perceived need for treatment (i.e., whether they felt they needed treatment or counseling for illicit drug use or alcohol use). In this report, estimates for felt need for treatment are only discussed for persons who were classified as needing treatment (based on DSM-IV criteria) but did not receive treatment at a specialty facility. Similarly, estimates for whether a person made an effort to get treatment are only discussed for persons who felt the need for treatment.

Illicit Drug or Alcohol Use Treatment and Treatment Need

- In 2005, the number of persons aged 12 or older needing treatment for an illicit drug or alcohol use problem was 23.2 million (9.5 percent of the population aged 12 or older) (Figure 7.6). Of these, 2.3 million (0.9 percent of persons aged 12 or older and 10.0 percent of those who needed treatment) received treatment at a specialty facility. Thus, there were 20.9 million persons (8.6 percent of the population aged 12 or older) who needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year.

Figure 7.6 Need for and Receipt of Specialty Treatment in the Past Year for Illicit Drug or Alcohol Use among Persons Aged 12 or Older: 2005



- The number of persons needing treatment for a substance use problem in 2005 (23.2 million) was not statistically different from the numbers reported since 2002. Similarly, the number of persons needing but not receiving treatment in 2005 (20.9 million) was similar to the numbers since 2002. The number of persons receiving specialty treatment in 2005 was essentially the same as the estimates in 2004 and 2002 (2.3 million in these 3 years), but it was higher than the number in 2003 (1.9 million).

- Of the 2.3 million people aged 12 or older who received specialty substance use treatment, 748,000 persons received treatment for both alcohol and illicit drug use, 878,000 received treatment for alcohol use only, and 532,000 received treatment for illicit drug use only.

- In 2005, among persons who received their last or current substance use treatment at a specialty facility in the past year, 45.3 percent reported using their "own savings or earnings" as a source of payment for their most recent specialty treatment. In addition, 31.9 percent reported using private health insurance, 27.9 percent reported using public assistance other than Medicaid, 24.3 percent reported using Medicaid, 23.4 percent reported relying on family members, and 20.8 percent reported using Medicare. (Note that persons could report more than one source of payment.)

- In 2005, more than half of the 2.3 million persons aged 12 or older who received specialty substance use treatment in the past year also received treatment at a self-help group (1.4 million persons). In addition, among those who received specialty substance use treatment, 361,000 persons received treatment at an emergency room, 254,000 received treatment at a private doctor's office, and 229,000 received treatment at a prison or jail.

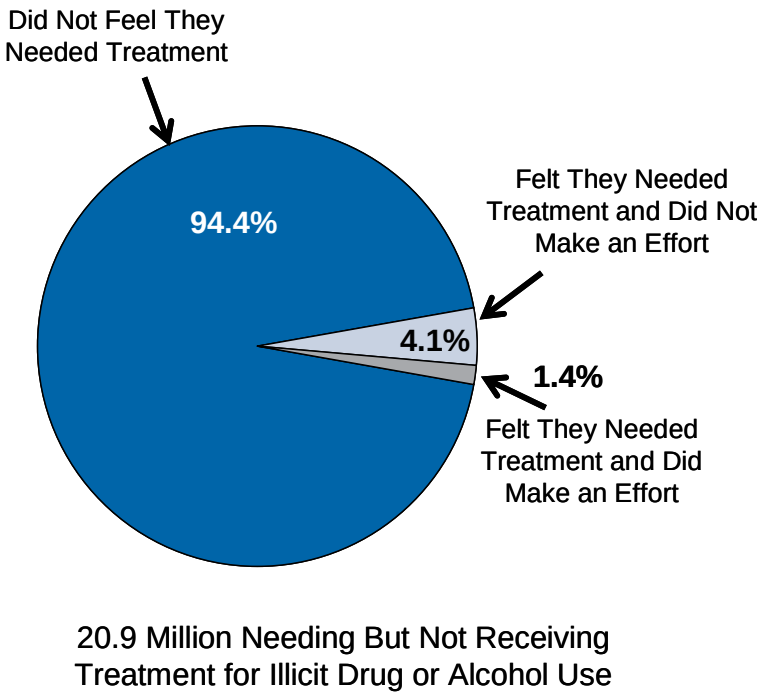
- Of the 20.9 million people in 2005 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1.2 million persons (5.6 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem (Figure 7.7). Of these 1.2 million persons who felt they needed treatment, 296,000 (25.5 percent) reported that they made an effort to get treatment, and 865,000 (74.5 percent) reported making no effort to get treatment.

- The number of people who felt they needed treatment and made an effort to get it among those who needed but did not receive treatment was not statistically different in 2005 (296,000) from the number reported in 2004 (441,000).

- In 2005, there were 2.1 million youths aged 12 to 17 (8.3 percent of this population) who needed treatment for an illicit drug or alcohol use problem. Of this group, only 181,000 youths received treatment at a specialty facility (8.6 percent of youths who needed treatment), leaving 1.9 million youths who needed treatment for a substance use problem but did not receive it at a specialty facility.

- Between 2004 and 2005, there was a decrease in the number and percentage of youths aged 12 to 17 who needed treatment for an alcohol or illicit drug use problem: 2.3 million in 2004 (9.1 percent) compared with 2.1 million in 2005 (8.3 percent).

Figure 7.7 Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2005

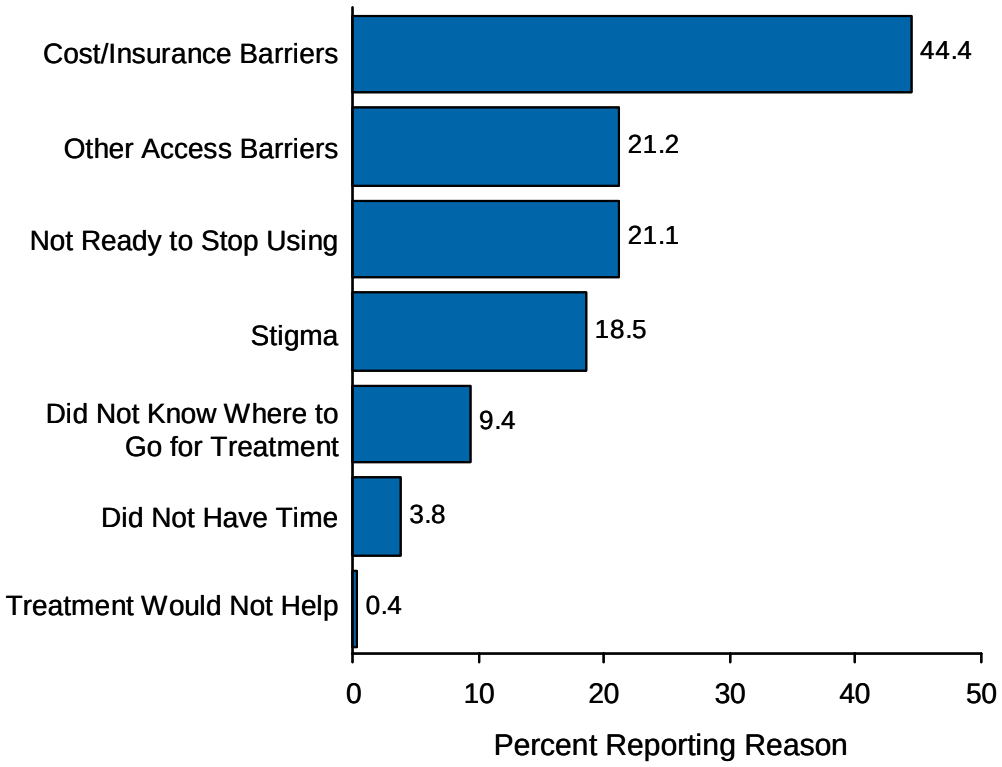


Note: Due to rounding, these percentages do not add to 100 percent.

- Based on 2004-2005 combined data, the five most often reported reasons for not receiving illicit drug or alcohol use treatment among persons who needed but did not receive treatment at a specialty facility and felt they needed treatment were (a) not ready to stop using (37.9 percent), (b) cost or insurance barriers (35.1 percent), (c) stigma (e.g., negative opinions from neighbors and community, negative effect on job) (23.9 percent), (d) did not know where to go for treatment (14.3 percent), and (e) other access barriers (e.g., no transportation, no openings in programs) (13.4 percent).

- Based on 2004-2005 combined data, among persons who needed but did not receive illicit drug or alcohol use treatment, felt they needed treatment, and made an effort to receive treatment, the four most often reported reasons for not receiving treatment were (a) cost or insurance barriers (44.4 percent), (b) other access barriers (21.2 percent), (c) not ready to stop using (21.1 percent), and (d) stigma (18.5 percent) (Figure 7.8).

Figure 7.8 Reasons for Not Receiving Substance Use Treatment among Persons Aged 12 or Older Who Needed and Made an Effort to Get Treatment But Did Not Receive Treatment and Felt They Needed Treatment: 2004-2005 Combined



- Persons who made no effort to receive treatment were more likely to report that they were not ready to stop using (45.3 percent) as a reason for not receiving treatment than persons who made an effort to receive treatment (21.1 percent) (2004-2005 combined data). Among those who made no effort to receive treatment, 26.3 percent reported stigma and 31.0 percent reported cost and insurance barriers as reasons for not receiving treatment.

Illicit Drug Use Treatment and Treatment Need

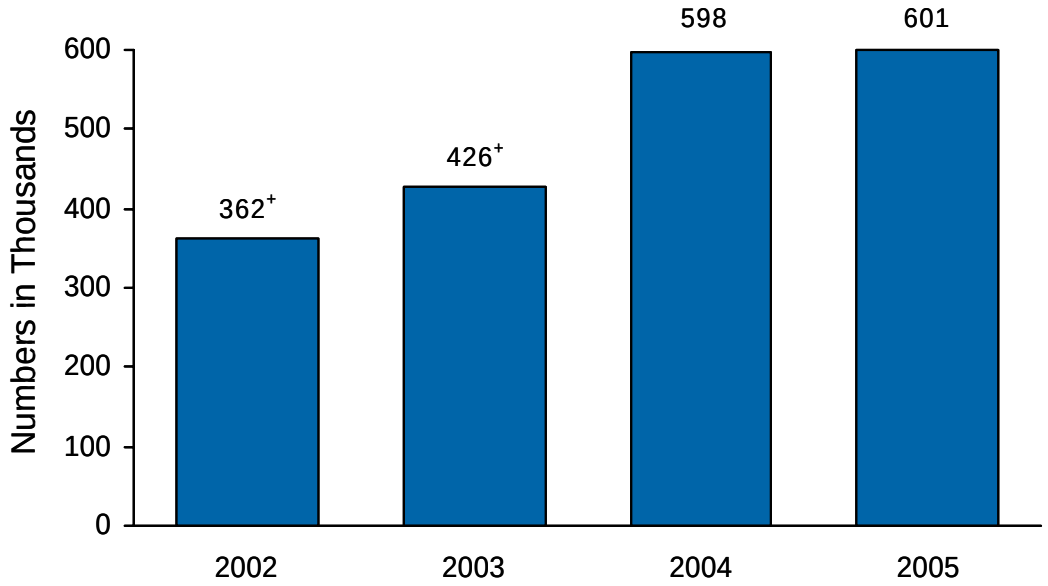
- In 2005, the number of persons aged 12 or older needing treatment for an illicit drug use problem was 7.6 million (3.1 percent of the total population). Of these, 1.3 million (0.5 percent of the total population and 17.0 percent of the people who needed treatment) received treatment at a specialty facility for an illicit drug use problem in the past year. Thus, there were 6.3 million persons (2.6 percent of the total population) who needed treatment but did not receive treatment at a specialty facility for an illicit drug use problem in 2005 (Figure 7.6).

- The number of persons needing but not receiving specialty treatment in the past year for an illicit drug use problem in 2005 (6.3 million) was essentially the same as the estimates in 2002 (6.3 million) and 2003 (6.2 million) and also was not statistically different from the estimate in 2004 (6.6 million). The number of persons needing treatment for illicit drug use in 2005 (7.6 million) was similar to the number needing treatment in 2004 (8.1 million), 2003 (7.3 million), and 2002 (7.7 million).

- Of the 6.3 million people who needed but did not receive specialty treatment for illicit drug use in 2005, there were 601,000 (9.6 percent) who reported that they felt they needed treatment for their illicit drug use problem. Of the 601,000 persons who felt they needed treatment, 175,000 (29.1 percent) reported that they made an effort, and 426,000 (70.9 percent) reported making no effort to get treatment.

- Among persons needing but not receiving treatment for an illicit drug use problem, the number who felt they needed treatment in 2005 (601,000) was similar to the number reported in 2004 (598,000), but it was higher than the numbers in 2003 (426,000) and 2002 (362,000) (Figure 7.9).

Figure 7.9 Number of Persons Aged 12 or Older Who Felt the Need for Illicit Drug Use Treatment among Those Needing But Not Receiving Specialty Treatment for an Illicit Drug Use Problem in the Past Year: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- Among youths aged 12 to 17, there were 1.3 million (4.9 percent) who needed treatment for an illicit drug use problem in 2005. Of this group, only 142,000 received treatment at a specialty facility (11.3 percent of youths aged 12 to 17 who needed treatment), leaving 1.1 million youths who needed treatment but did not receive it at a specialty facility.

- Among people who needed but did not receive illicit drug use treatment and felt they needed treatment (based on 2004-2005 combined data), the six most often reported reasons for not receiving treatment were (a) cost or insurance barriers (36.7 percent), (b) not ready to stop using (34.7 percent), (c) stigma (24.4 percent), (d) did not feel the need for treatment at the time or could handle the problem without treatment (16.3 percent), (e) did not know where to go for treatment (16.3 percent), and (f) other access barriers (16.1 percent).

Alcohol Use Treatment and Treatment Need

- In 2005, the number of persons aged 12 or older needing treatment for an alcohol use problem was 19.4 million (8.0 percent of the population aged 12 or older). Of these, 1.6 million (0.7 percent of the total population and 8.4 percent of the people who needed treatment for an alcohol use problem) received alcohol use treatment at a specialty facility. Thus, there were 17.8 million people who needed treatment but did not receive treatment at a specialty facility for an alcohol use problem (Figure 7.6).

- Between 2004 and 2005, there were no statistically significant changes in the number of persons needing or receiving treatment for an alcohol use problem.

- Among the 17.8 million people who needed but did not receive treatment for an alcohol use problem in 2005, there were 641,000 (3.6 percent) who felt they needed treatment for their alcohol use problem. Of these, 154,000 (24.0 percent) made an effort but were unable to get treatment, and 487,000 (76.0 percent) did not make an effort to get treatment.

- In 2005, there were 1.5 million youths (5.8 percent) aged 12 to 17 who needed treatment for an alcohol use problem. Of this group, only 119,000 received treatment at a specialty facility (0.5 percent of all youths and 8.1 percent of youths who needed treatment), leaving 1.3 million youths who needed but did not receive treatment.

8. Prevalence and Treatment of Mental Health Problems

This chapter presents findings on mental health problems in the United States, including the prevalence and treatment of serious psychological distress (SPD) and major depressive episode (MDE) and the association of these problems with substance use and substance dependence or abuse (substance use disorder).

SPD is an overall indicator of past year nonspecific psychological distress that is constructed from the K6 scale administered to adults aged 18 or older in the National Survey on Drug Use and Health (NSDUH). The K6 scale consists of six questions that gather information on how frequently a respondent experienced symptoms of psychological distress during the 1 month in the past year when he or she was at his or her worst emotionally. Responses to these six questions are combined to produce a score ranging from 0 to 24, where a score of 13 or greater is considered SPD. This cutoff is based on research suggesting that scores above this threshold indicate a high probability of having serious mental illness. The questions used to measure SPD and the scoring algorithm are included in Section B.4.4 of Appendix B.

The data related to SPD in this report are not comparable with data in previous reports due to changes in the survey administration of this instrument. In the 2001-2003 NSDUHs, the K6 was embedded in a module that had survey questions addressing a variety of mental health–related symptoms. The 2004 NSDUH employed a split-sample design in which approximately half of the adult respondents (sample A) were administered the K6 questions as it was administered in prior years of the survey. The other half of the adult respondents (sample B) were administered only the K6 questions without other mental health symptom questions in the module. Analyses comparing sample A and sample B data found significant differences in the reporting of the K6 items. In 2005, the full sample of adults were surveyed using the K6 as a stand-alone instrument (i.e., as in sample B in 2004). The 2004 NSDUH report showed trends in SPD from 2002 to 2004 using the A sample for 2004 estimates. In this report, 2005 SPD data are compared only with the 2004 sample B data, for which the questions were administered similarly.

In 2005, adults also were administered a module of questions to measure lifetime and past year prevalence of MDE, the severity of MDE as measured by role impairment, and treatment received specifically for depression. A similar set of questions on MDE also was administered to the full sample of youths aged 12 to 17. Some questions in the adolescent depression module were slightly modified to make them more appropriate for youths. For example, "lost interest" in the adult module was changed to "lost interest and became bored." Adult and youth depression estimates are presented separately in this chapter because of differences in the modules.

MDE is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had symptoms that met the criteria for major depressive disorder as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994). It should be

noted that no exclusions were made for MDE caused by medical illness, bereavement, or substance use disorders.

Although there is substantial overlap in the populations classified with SPD and MDE, there are important distinctions between the definitions of the two. Meeting the criteria for SPD indicates that the respondent exhibited a high level of distress due to any type of mental problem, which may include general symptoms related to phobia, anxiety, or depression. However, meeting the criteria for MDE indicates that the respondent had the specific physical and emotional symptom profile indicative of major depression. The questions used to measure MDE and role impairment and the scoring algorithm for these responses are included in Section B.4.5 of Appendix B.

This chapter also presents data on the receipt of treatment for any type of mental health problem among adults and adolescents. This may be different from the treatment received specifically for MDE, and it is possible for a respondent to have indicated receipt of treatment for depression without having indicated that he or she received treatment for any mental health problems. Different questions and definitions of treatment and counseling are used for adults and youths. Treatment for adults is defined as the receipt of treatment or counseling for any problem with emotions, "nerves," or mental health in the past year in any inpatient or outpatient setting or the use of prescription medication for a mental or emotional condition. Treatment for youths is defined as receiving treatment or counseling for problems with behaviors or emotions from specific mental health or other health professionals in school, home, or from other outpatient or inpatient settings within the past year. Both the youth and the adult questions specifically exclude treatment for problems with substance use, which is asked about elsewhere in the interview. Estimates of unmet need for treatment are reported separately for all adults and for adults with SPD. Unmet need is defined using a question in the 2005 NSDUH that asks whether the respondent perceived a need for mental health treatment or counseling at any time in the 12 months prior to the interview but did not receive it.

It is important to note that because the survey covers only the U.S. civilian, noninstitutionalized population, persons who were residing in long-term psychiatric or other institutions at the time of interview were excluded from the NSDUH sample.

8.1 Adults Aged 18 or Older

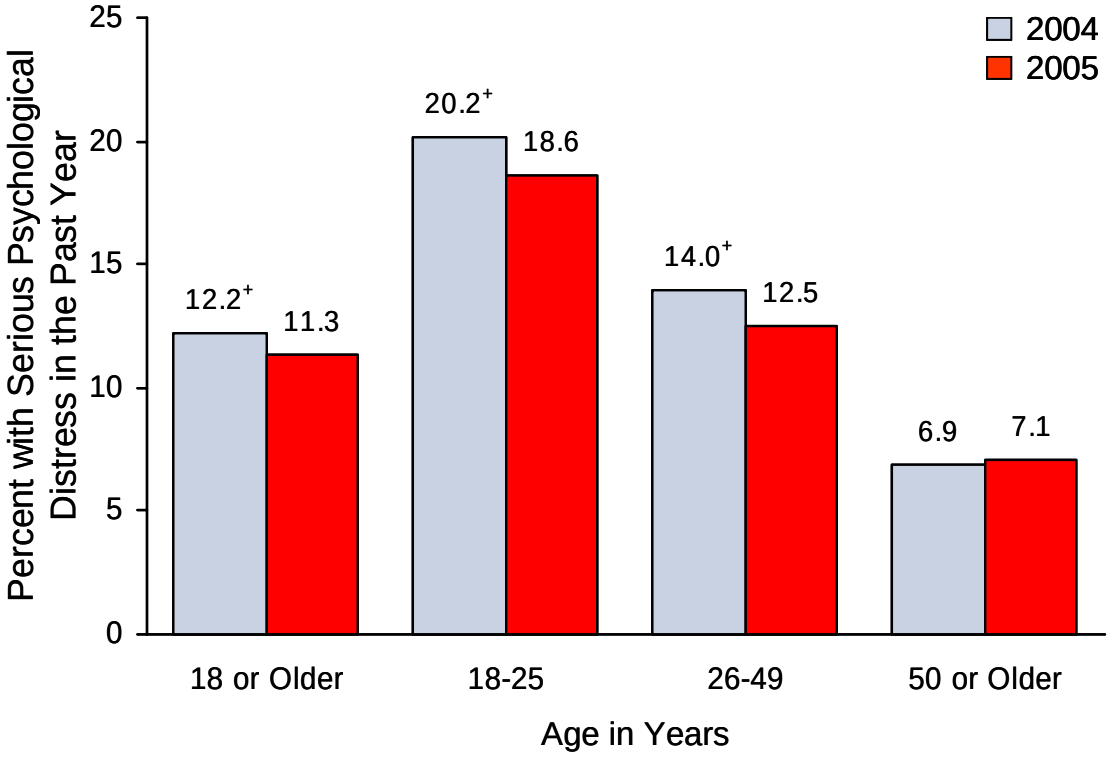
Prevalence of Serious Psychological Distress

- In 2005, there were an estimated 24.6 million adults aged 18 or older in the United States with SPD in the past year. This represents 11.3 percent of all adults in this country, a significantly lower rate compared with the rate of 12.2 percent in 2004 (Figure 8.1).

- Rates of SPD in 2005 were highest for adults aged 18 to 25 (18.6 percent) and lowest for adults aged 50 or older (7.1 percent).

- The prevalence of SPD among women aged 18 or older (14.0 percent) was higher than that among men in that age group (8.4 percent).

Figure 8.1 Rates of Serious Psychological Distress in the Past Year among Adults Aged 18 or Older, by Age: 2004-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- In 2005, rates of past year SPD were lowest among Asians at 7.2 percent. Rates for other racial/ethnic groups were 10.7 percent among blacks, 11.4 percent among whites, 11.7 percent among Hispanics, 16.8 percent among persons reporting two or more races, and 21.1 percent among American Indians or Alaska Natives.

Serious Psychological Distress and Substance Use and Dependence or Abuse

- In 2005, adults who used illicit drugs in the past year were significantly more likely to have SPD compared with adults who did not use an illicit drug (22.0 vs. 9.6 percent).

- Past year illicit drug use was higher among adults with SPD (26.9 percent) than among adults without SPD (12.1 percent). Similarly, the rate of past month cigarette use was higher among adults with SPD (42.8 percent) than among adults without SPD (24.5 percent).

- The rate of heavy alcohol use (drinking five or more drinks on the same occasion [i.e., at the same time or within a couple of hours of each other] on each of 5 or more days in the past 30 days) among adults with SPD in the past year was higher (9.4 percent) than the rate reported among adults without SPD in the past year (6.8 percent). Similarly, among adults with SPD, the rate of binge alcohol use (drinking five or more drinks on the same occasion on at least 1 day in the past 30 days) was 28.9 percent, higher than the 23.5 percent among adults who did not meet the criteria for SPD.

- SPD in the past year was associated with past year substance dependence or abuse in 2005. Among adults with SPD in 2005, 21.3 percent (5.2 million) were dependent on or abused illicit drugs or alcohol. The rate among adults without SPD was 7.7 percent (14.9 million).

- In 2005, fewer men who were dependent on or abused illicit drugs met the criteria for SPD than women who were dependent on or abused illicit drugs (28.1 vs. 54.0 percent).

Treatment and Unmet Need for Treatment among Adults with Serious Psychological Distress

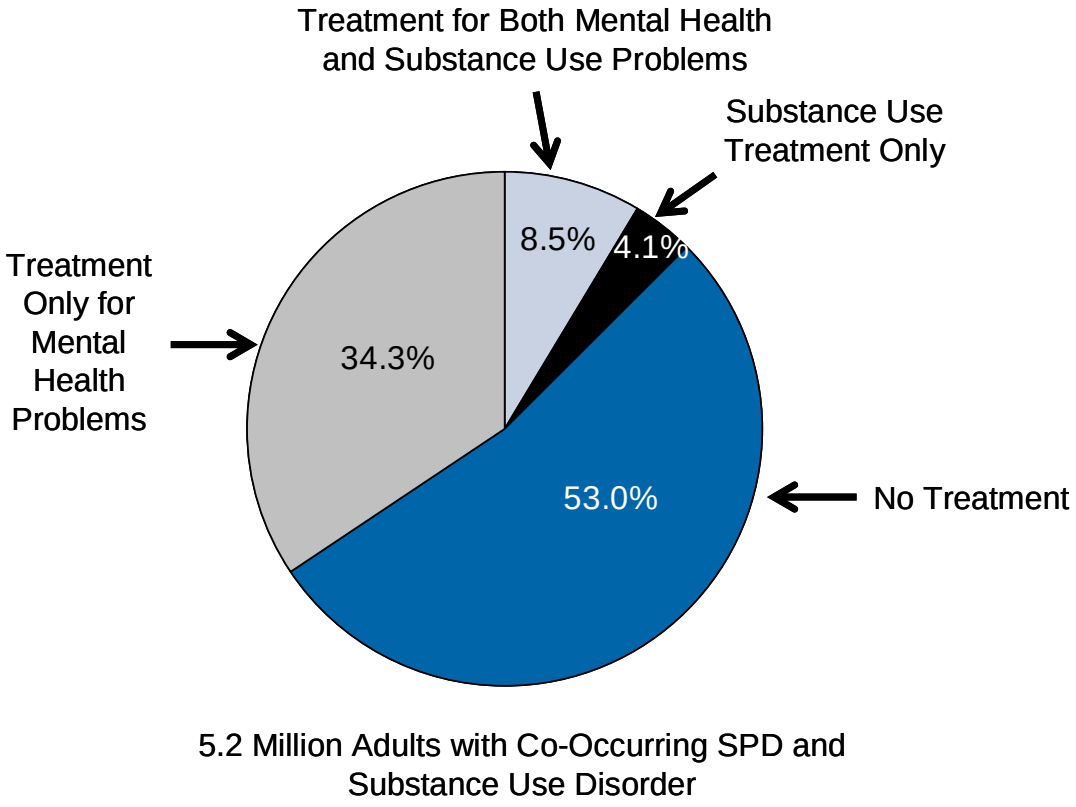
- Among the 24.6 million adults with SPD in 2005, 11.1 million (45.3 percent) received treatment for a mental health problem in the past year. This was a higher proportion than in 2004 (41.6 percent). Among adults with SPD, 39.4 percent received a prescription medication, 28.5 percent received outpatient treatment, and 4.6 percent received inpatient treatment for a mental health problem in the past year.

- In 2005, among adults with SPD in the past year who did not receive treatment and reported an unmet need for treatment, cost or insurance issues were the most frequently reported reason for not obtaining treatment (53.5 percent). Other reasons for not receiving treatment included not feeling a need for treatment at the time or believing that the problem could be handled without treatment (32.3 percent), stigma associated with treatment (26.2 percent), not knowing where to go for services (21.8 percent), and not having time (16.6 percent).

Treatment among Adults with Co-Occurring Serious Psychological Distress and Substance Use Disorders

- Among the 5.2 million adults with both SPD and substance dependence or abuse (i.e., a substance use disorder) in 2005, about half (47.0 percent) received mental health treatment or substance use treatment at a specialty facility: 8.5 percent received both treatment for mental health problems and specialty substance use treatment, 34.3 percent received only treatment for mental health problems, and 4.1 percent received only specialty substance use treatment (Figure 8.2).

Figure 8.2 Past Year Treatment among Adults Aged 18 or Older with Both Serious Psychological Distress and a Substance Use Disorder: 2005



Note: Due to rounding, these percentages do not add to 100 percent.

Prevalence of Major Depressive Episode

- In 2005, there were 30.8 million adults (14.2 percent of persons aged 18 or older) who had at least one MDE in their lifetime, and 15.8 million adults (7.3 percent of persons aged 18 or older) had at least one MDE in the past year. In 2004, there were 17.1 million adults (8.0 percent) who had at least one MDE during the past year. This represents a statistically significant decline in the rate of past year MDE between 2004 and 2005.

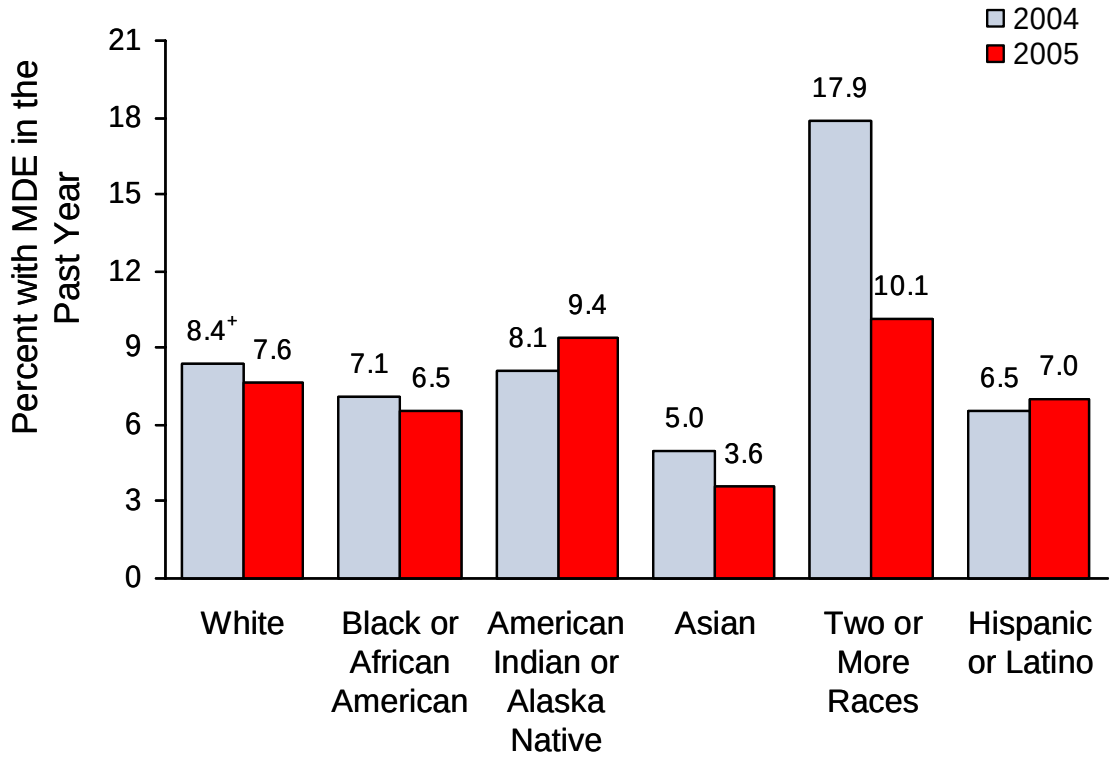
- The lifetime prevalence of MDE was 15.7 percent among persons aged 18 to 25, 16.0 percent among persons aged 26 to 49 and, 11.6 percent among persons aged 50 or older.

- The past year prevalence of MDE was highest for adults aged 18 to 25 (9.7 percent) and lowest for those aged 50 or older (5.1 percent).

- The past year prevalence of MDE was higher among adult females than among adult males (9.3 vs. 5.2 percent).

- Among adults, past year prevalence of MDE was associated with race/ethnicity in 2005. The rate of MDE among persons aged 18 or older was lowest among Asians (3.6 percent). Rates for other groups were 10.1 percent among persons reporting two or more races, 9.4 percent among American Indians or Alaska Natives, 7.6 percent among whites, 7.0 percent among Hispanics, and 6.5 percent among blacks (Figure 8.3).

Figure 8.3 Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Race/Ethnicity: 2004-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

Note: Due to low precision, estimates for Native Hawaiians or Other Pacific Islanders are not shown.

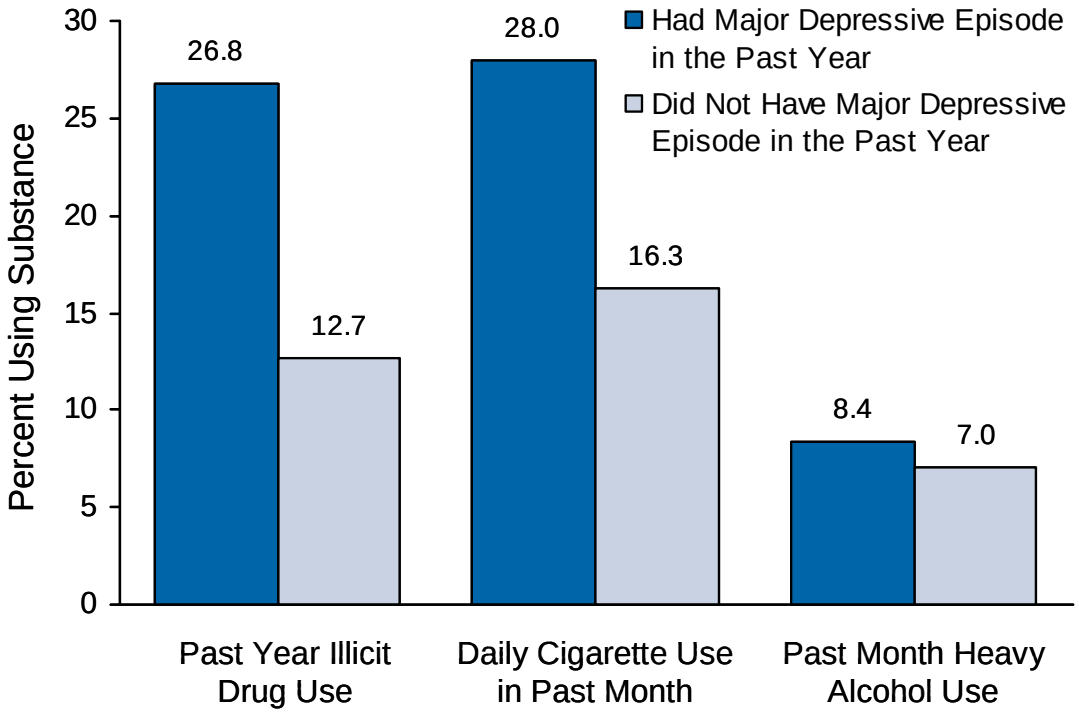
- Among adults aged 18 or older, past year prevalence of MDE was higher among unemployed persons (14.4 percent) than among persons employed full time (6.3 percent), persons not in the labor force (8.0 percent), and persons employed part time (8.2 percent).

Major Depressive Episode and Substance Use and Dependence or Abuse

- In 2005, adults with MDE in the past year were more likely than those without MDE to have used an illicit drug in the past year (26.8 vs. 12.7 percent) (Figure 8.4). A similar pattern was observed for specific types of past year illicit drug use, such as marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type psychotherapeutics.

- Past month heavy alcohol use also was associated with MDE in the past year in 2005. Among persons with MDE in the past year, 8.4 percent were heavy alcohol users, higher than the 7.0 percent of persons without MDE in the past year. Similarly, among persons with MDE, the rate of daily cigarette use was 28.0 percent, while the rate was 16.3 percent among persons without MDE.

Figure 8.4 Substance Use among Adults Aged 18 or Older, by Major Depressive Episode in the Past Year: 2005



- Having MDE in the past year was associated with past year substance dependence or abuse in 2005. Among adults who had MDE in 2005, 19.9 percent were dependent on or abused alcohol or illicit drugs, while among persons without MDE only 8.4 percent were dependent on or abused alcohol or illicit drugs. Adults with MDE were more likely than those without MDE to be dependent on or abuse illicit drugs (8.3 vs. 2.1 percent) and alcohol (14.8 vs. 7.4 percent).

- Among adults aged 18 or older with substance dependence or abuse in the past year, 15.6 percent had at least one MDE in the past year, higher than the 6.4 percent who had at least one MDE in the past year among those who did not have substance dependence or abuse.

Treatment for Major Depressive Episode

- Among adults aged 18 or older who had MDE in the past year, 65.6 percent received treatment (i.e., saw or talked to a medical doctor or other professional or used prescription medication) for depression in the same time period.

- In 2005, women who had MDE in the past year were more likely than men to receive treatment for depression in the past year (70.9 vs. 55.6 percent).

- Among adults aged 18 or older with MDE in the past year, approximately half of those with no insurance (47.9 percent) received treatment for depression in the past year compared with higher rates for those with insurance: 67.4 percent of adults with MDE in the past year who had private insurance, 76.5 percent of adults with Medicaid or CHIP, and 79.6 percent of adults with other health insurance (including Medicare, CHAMPUS, TRICARE, CHAMPVA, VA, and other sources of health care or insurance) received treatment for depression in the past year.

- Among adults with MDE in the past year who saw or talked to a health care professional in the past year for depression, 39.8 percent believed this treatment helped "a lot" or "extremely," and 32.0 percent believed this care helped "not at all" or "a little."

- Among adults aged 18 or older with MDE in the past year, 53.1 percent who received prescription medication for depression in the past year believed that the medication had helped "a lot" or "extremely." This is significantly higher than the percentage of those who saw or talked to a medical doctor or other professional who believed that this treatment helped "a lot" or "extremely" (39.8 percent).

Treatment for Mental Health Problems and Unmet Treatment Need among All Adults

- In 2005, there were 28.2 million adults who received treatment for mental health problems during the past 12 months. This represents 13.0 percent of the population 18 years or older and is similar to the rate in 2004 (12.8 percent).

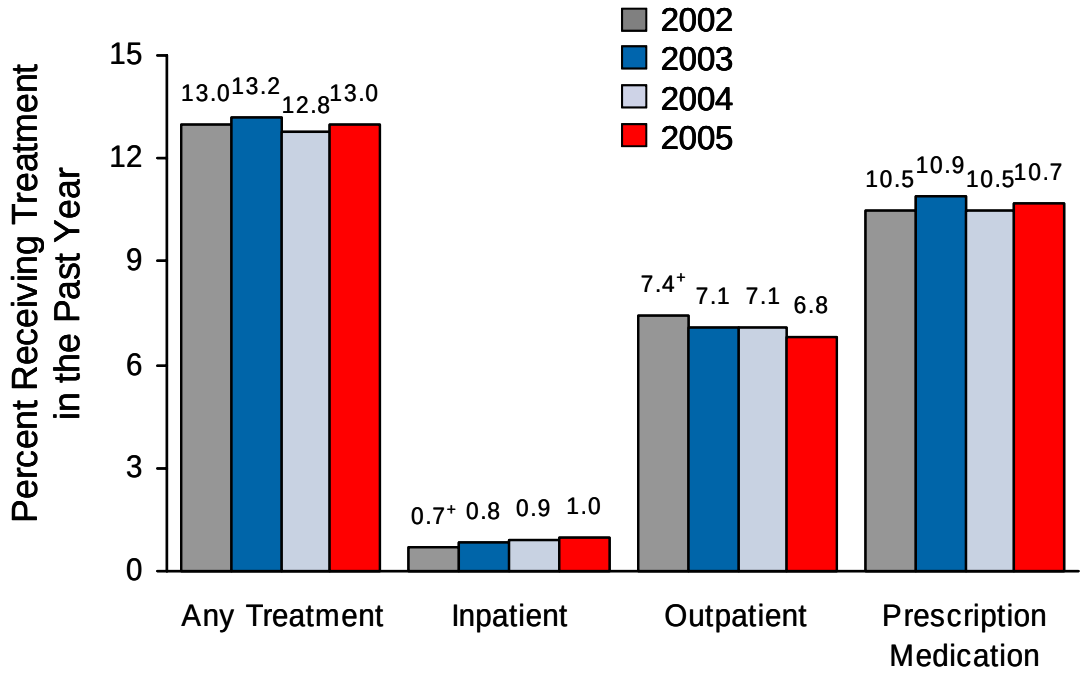
- The treatment type most often reported by the adult population in 2005 was prescription medication (10.7 percent), followed by outpatient treatment (6.8 percent) (Figure 8.5). About 2.1 million adults (1.0 percent) received inpatient care for mental health problems during the past year. These patterns of utilization were not significantly different from those seen in 2004.

- Rates of treatment for mental health problems were associated with age for adults aged 18 or older: 11.2 percent for adults aged 18 to 25, 13.9 percent for adults aged 26 to 49, and 12.5 percent for adults aged 50 or older.

- Men were less likely than women to receive outpatient treatment (4.6 vs. 8.9 percent) and prescription medication (7.0 vs. 14.1 percent) for mental health problems in the past year. There was no gender difference in the rates of inpatient treatment (0.9 vs. 1.1 percent) in 2005.

- Among racial/ethnic groups, the rates of treatment for adults in 2005 were 15.4 percent for American Indians or Alaska Natives, 15.1 percent for whites, 14.4 percent for persons reporting two or more races, 8.9 percent for blacks, 7.8 percent for Hispanics, and 4.0 percent for Asians.

Figure 8.5 Past Year Treatment for Mental Health Problems among Adults Aged 18 or Older, by Type of Treatment: 2002-2005

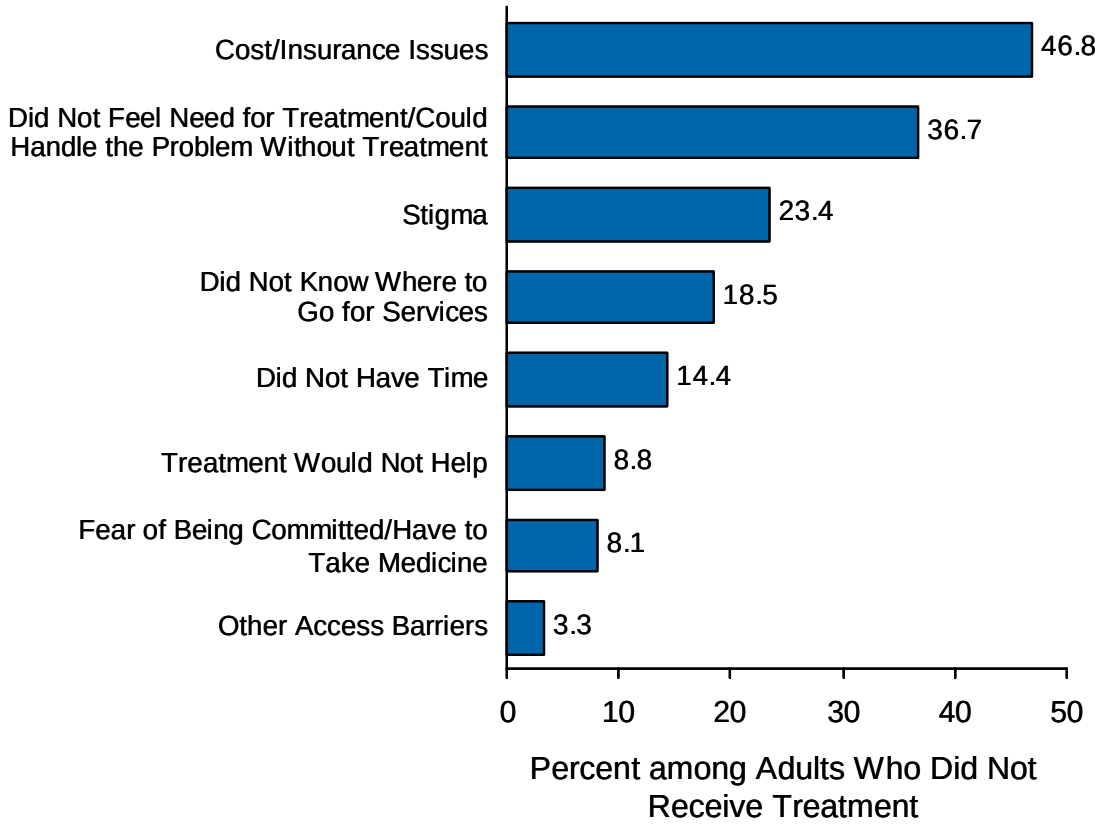


+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- In 2005, there were 11.2 million adults aged 18 or older (5.1 percent) who reported an unmet need for treatment or counseling for mental health problems in the past year. This included 5.7 million adults who did not receive mental health treatment. Among the 5.5 million adults who did receive treatment or counseling for a mental health problem in the past year, 19.4 percent reported an unmet need. (Unmet need among adults who received treatment may reflect a delay in treatment or a perception of insufficient treatment.)

- Among the 5.7 million adults who reported an unmet need for treatment or counseling for mental health problems and did not receive treatment in the past year, several barriers to treatment were reported. These included cost or insurance issues (46.8 percent), not feeling a need for treatment at the time or believing that the problem could be handled without treatment (36.7 percent), stigma associated with treatment (23.4 percent), and not knowing where to go for services (18.5 percent) (Figure 8.6).

Figure 8.6 Reasons for Not Receiving Treatment in the Past Year among Adults Aged 18 or Older with an Unmet Need for Treatment Who Did Not Receive Treatment: 2005

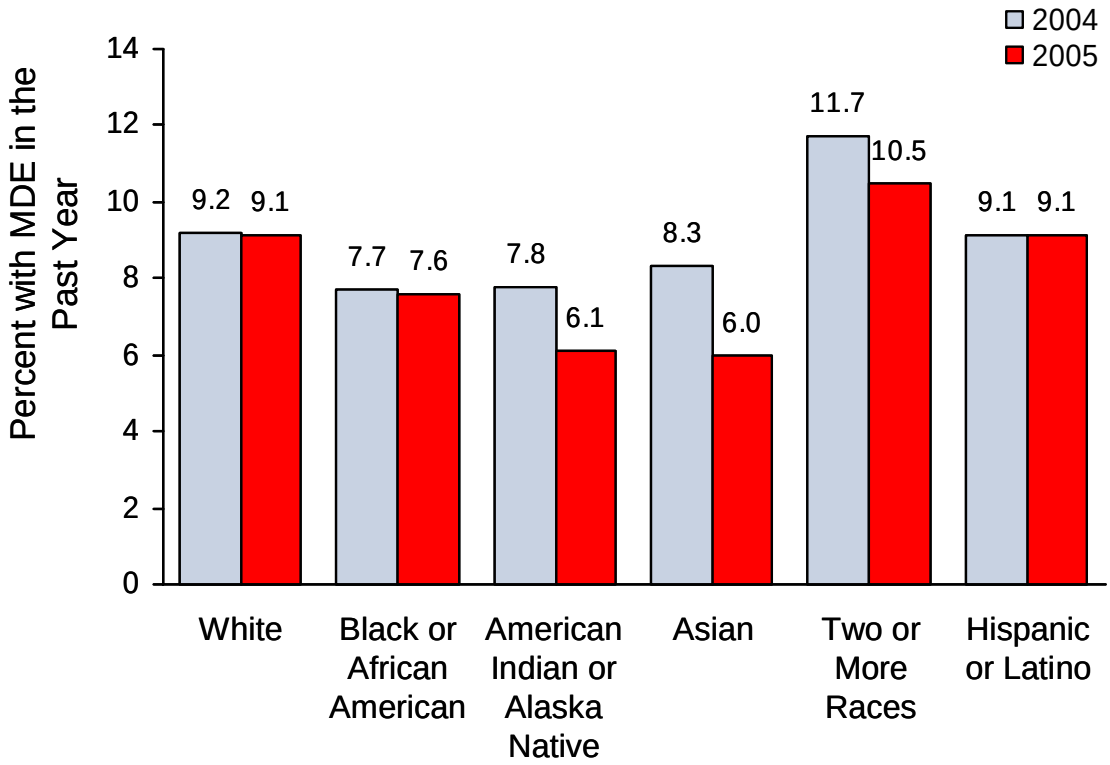


8.2 Youths Aged 12 to 17

Prevalence of Major Depressive Episode

- In 2005, there were 3.4 million youths aged 12 to 17 years (13.7 percent of the population aged 12 to 17 years old) who had at least one MDE in their lifetime and 2.2 million youths (8.8 percent) who had MDE during the past year.
- Among youths, the past year prevalence of MDE ranged from 4.3 percent among 12 year olds to 11.2 percent among those aged 16 and 11.9 percent among those aged 17.
- The rate of MDE in the past year was higher for adolescent females (13.3 percent) than for adolescent males (4.5 percent).
- Among youths, 9.1 percent of Hispanics had MDE in the past year, similar to the rate for non-Hispanic youths (8.7 percent) (Figure 8.7). Among 12 to 17 year olds, youths who reported two or more races had the highest prevalence of lifetime MDE (19.0 percent) in 2005.

Figure 8.7 Major Depressive Episode in the Past Year among Youths Aged 12 to 17, by Race/Ethnicity: 2004-2005



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

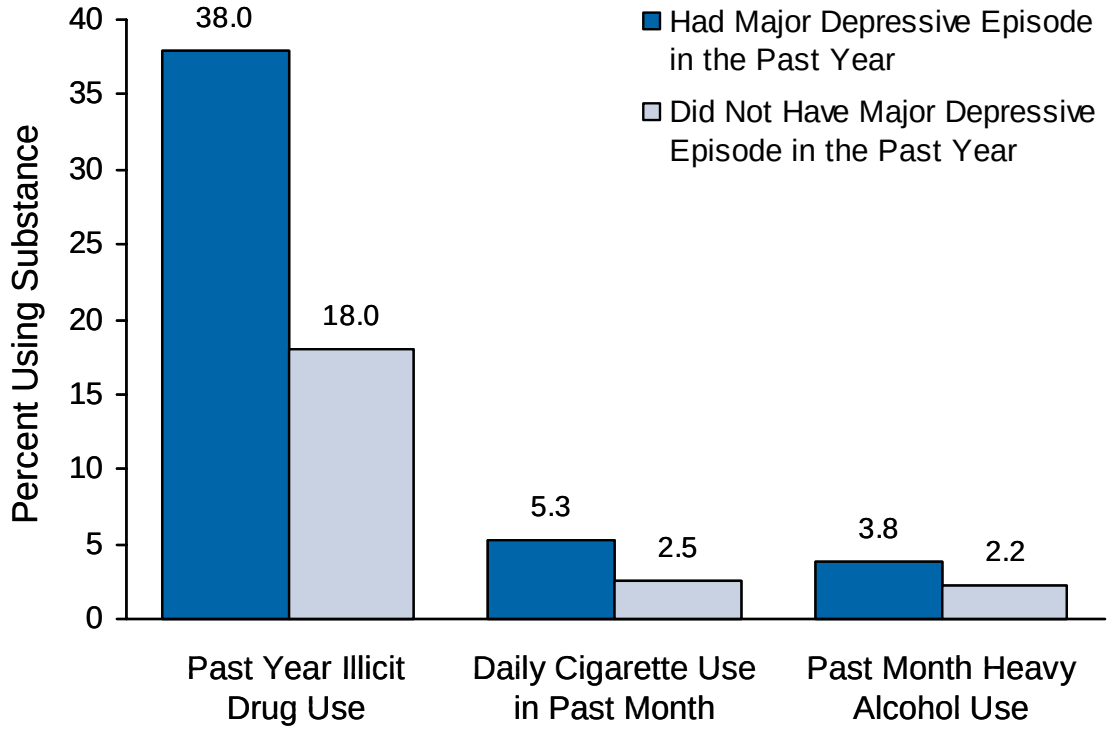
Note: Due to low precision, estimates for Native Hawaiians or Other Pacific Islanders are not shown.

Major Depressive Episode and Substance Use

- Among 12 to 17 year olds who had past year MDE, 38.0 percent had used illicit drugs during the same period (Figure 8.8). This was significantly more than the 18.0 percent of youths who did not have past year MDE who used illicit drugs during the past year. This pattern was similar for specific types of illicit drug use, including marijuana, cocaine, hallucinogens, inhalants, and the nonmedical use of prescription-type psychotherapeutics.

- In 2005, youths who had MDE during the past year were more likely to report daily cigarette use in comparison with those who did not have MDE during the past year (5.3 vs. 2.5 percent).

Figure 8.8 Substance Use among Youths Aged 12 to 17, by Major Depressive Episode in the Past Year: 2005



- The occurrence of MDE in the past year among youths aged 12 to 17 was associated with a higher prevalence of illicit drug or alcohol dependence or abuse (19.8 percent). Among youths who did not report past year MDE, 6.9 percent had illicit drug or alcohol dependence or abuse during the same period.

- Among youths with past year dependence on or abuse of illicit drugs or alcohol, 21.7 percent had at least one MDE in the past year, higher than the 7.7 percent with MDE in the past year among adolescents with no past year dependence or abuse.

Treatment for Major Depressive Episode

- In 2005, 37.8 percent of youths aged 12 to 17 with past year MDE received treatment for depression (saw or talked to a medical doctor or other professional or used prescription medication). Among youths with past year MDE, 20.5 percent saw or talked to a medical doctor or other professional only, 2.6 percent used prescription medication only, and 14.4 percent received treatment from both sources for depression in the past year.

- Among persons aged 12 to 17 who received specialty treatment for illicit drug or alcohol use in the past year, 19.1 percent had MDE during the year. This is significantly higher than the percentage of youths with MDE in the past year who did not receive specialty treatment (8.7 percent).

- Among youths aged 12 to 17 in 2005 with MDE during the past year who saw or talked to a medical doctor or other professional for depression, 41.6 percent believed that this treatment helped "not at all" or "a little." In addition, 34.0 percent believed that this treatment was "a lot of help" or "extremely helpful."

- In 2005, among youths aged 12 to 17 with MDE in the past year who received prescription medication for depression, 28.7 percent believed that the prescription medication helped "not at all" or "a little." Nearly half of youths with MDE in the past year (47.2 percent) who received prescription medication for depression in the past year reported the medication was "a lot of help" or "extremely helpful."

Mental Health Treatment among Youths

- In 2005, there were 5.5 million youths aged 12 to 17 (21.8 percent) who received treatment or counseling for emotional or behavior problems in the year prior to the interview. Adolescent females were more likely than adolescent males to report past year treatment for mental health problems (23.6 vs. 20.0 percent) (Figure 8.9).

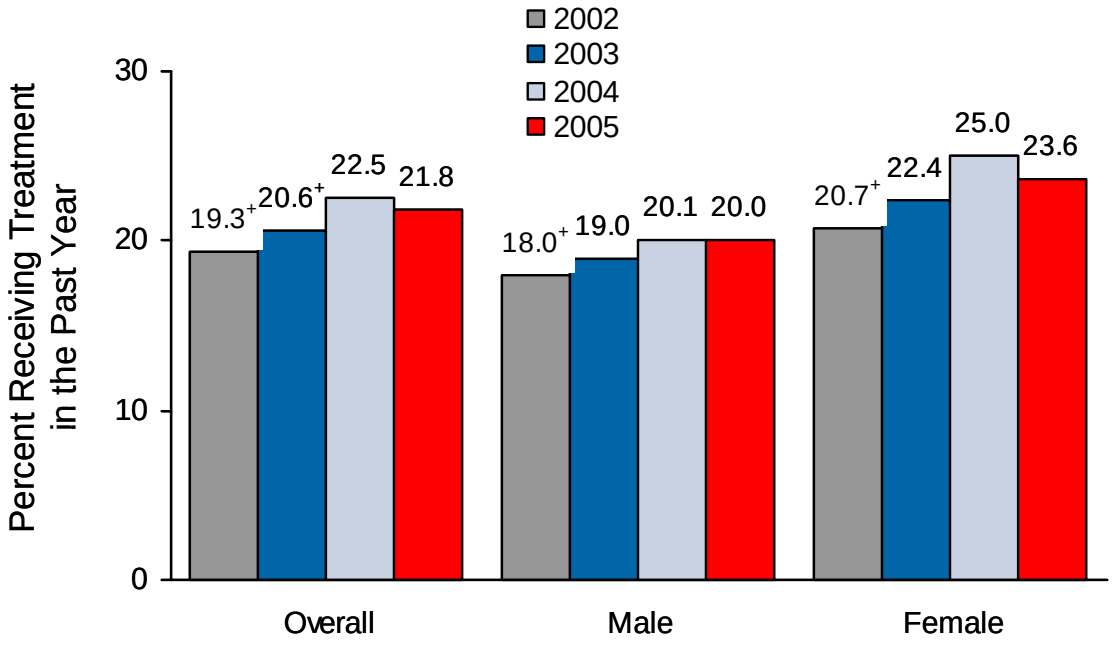
- The rate of treatment for mental health problems among youths aged 12 to 17 who used illicit drugs in the past year (32.0 percent) was higher than the rate among youths who did not use illicit drugs (19.3 percent).

- The rate of illicit drug use in the past year was higher among youths who received mental health treatment or counseling in the past year than among those who did not (29.1 vs. 17.2 percent). This pattern also was observed for marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type psychotherapeutics.

- Youths aged 12 to 17 who received mental health treatment or counseling in the past year were more likely to use alcohol in the past year than those who did not receive treatment or counseling (39.7 vs. 31.5 percent). Youths receiving mental health treatment or counseling in the past year also were more likely to have smoked cigarettes in the past year (25.8 vs. 14.9 percent).

- In 2005, among youths who received mental health treatment or counseling in the past year, 14.2 percent were dependent on or abused illicit drugs or alcohol in the past year, higher than the 6.3 percent who did not receive treatment or counseling.

Figure 8.9 Past Year Treatment for Mental Health Problems among Youths Aged 12 to 17, by Gender: 2002-2005



+ Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

9. Discussion of Trends in Substance Use among Youths and Young Adults

This report presents findings from the 2005 National Survey on Drug Use and Health (NSDUH). Conducted since 1971 and previously named the National Household Survey on Drug Abuse (NHSDA), the survey underwent several methodological improvements in 2002 that have affected prevalence estimates. As a result, the 2002 through 2005 estimates are not comparable with estimates from 2001 and earlier surveys. Therefore, the primary focus of the report is on comparisons of measures of substance use and mental health problems across subgroups of the U.S. population in 2005 and changes between 2004 and 2005, as well as between 2002 and 2005. This chapter provides an additional discussion of the findings concerning a topic of great interest—trends in substance use among youths and young adults.

NSDUH shows declines from 2002 to 2005 among youths aged 12 to 17 for past month rates of use (i.e., current use) of alcohol, cigarettes, marijuana, hallucinogens (such as Ecstasy and LSD), and the nonmedical use of prescription-type psychotherapeutic drugs. The past month use of cocaine and inhalants, however, showed no change among youths during that time period. Among young adults aged 18 to 25, the rates of current use of alcohol and marijuana were similar in 2002 and 2005. Cigarette use and Ecstasy use declined among young adults, but cocaine use and nonmedical use of prescription drugs increased.

An important step in the analysis and interpretation of NSDUH or any other survey data is to compare the results with those from other data sources. This can be difficult sometimes because the other surveys typically have different purposes, definitions, and designs. Research has established that surveys of substance use and other sensitive topics often produce inconsistent results because of different methods used. Thus, it is important to understand that conflicting results often reflect differing methodologies, not incorrect results. Despite this limitation, comparisons can be very useful. Consistency across surveys can provide confirmation or support for conclusions about trends and patterns of use, and inconsistent results can point to areas for further study. Further discussion of this issue is included in Appendix D, along with descriptions of methods and results from other sources of substance use and mental health data.

Unfortunately, few additional data sources are available at this time to compare with NSDUH results. One established source is Monitoring the Future (MTF), a study sponsored by the National Institute on Drug Abuse (NIDA). MTF surveys students in the 8th, 10th, and 12th grades in classrooms during the spring of each year, and it also collects data by mail from a subsample of adults who had participated earlier in the study as 12th graders (Johnston, O'Malley, Bachman, & Schulenberg, 2006a). Historically, NSDUH rates of substance use among youths have been lower than those of MTF, but the two sources usually have shown similar trends. NSDUH and MTF rates of substance use generally have been similar among young adults, and the two sources also have shown similar trends.

A comparison of NSDUH and MTF estimates for 2002 to 2005 is shown in Tables 9.1 and 9.2 for several substances that are defined similarly in the two surveys. MTF data on 8th and 10th graders combined give the closest match on age to NSDUH youth estimates, while MTF

follow-up data on persons aged 19 to 24 provide the closest match on age to NSDUH young adult estimates. The NSDUH results are consistent with MTF trends. Both surveys show decreases between 2002 and 2005 in the percentages of youths using marijuana, Ecstasy, LSD, alcohol, and cigarettes in the lifetime, past year, and past month, with the exception of LSD in the past month for MTF and cigarettes in the past year for MTF for which an estimate is not available. Both surveys show no difference in the rates of past month cocaine and inhalant use among youths between 2002 and 2005. Data on young adults also show generally consistent trends in the two surveys for use of specific illicit drugs, as well as alcohol and cigarettes.

Table 9.1 Comparison of NSDUH and MTF Prevalence Estimates among Youths: 2002-2005

Substance/ Time Period	NSDUH Ages 12-17				MTF 8th and 10th Grades			
	2002	2003	2004	2005	2002	2003	2004	2005
Marijuana								
Lifetime	20.6[a]	19.6[a]	19.0[a]	17.4	29.0[a]	27.0	25.7	25.3
Past Year	15.8[a]	15.0[a]	14.5[a]	13.3	22.5[a]	20.5	19.7	19.4
Past Month	8.2[a]	7.9[a]	7.6[a]	6.8	13.1[a]	12.3[a]	11.2	10.9
Cocaine								
Lifetime	2.7[a]	2.6	2.4	2.3	4.9	4.4	4.4	4.5
Past Year	2.1[a]	1.8	1.6	1.7	3.2	2.8	2.9	2.9
Past Month	0.6	0.6	0.5	0.6	1.4	1.1	1.3	1.3
Ecstasy								
Lifetime	3.3[a]	2.4[a]	2.1[a]	1.6	5.5[a]	4.3[a]	3.6	3.4
Past Year	2.2[a]	1.3[a]	1.2	1.0	3.9[a]	2.6	2.1	2.2
Past Month	0.5[a]	0.4	0.3	0.3	1.6[a]	0.9	0.8	0.8
LSD								
Lifetime	2.7[a]	1.6[a]	1.2	1.1	3.8[a]	2.8[a]	2.3	2.2
Past Year	1.3[a]	0.6	0.6	0.6	2.1[a]	1.5	1.4	1.4
Past Month	0.2[a]	0.2	0.2	0.1	0.7	0.6	0.6	0.6
Inhalants								
Lifetime	10.5	10.7	11.0	10.5	14.4	14.3	14.9	15.1
Past Year	4.4	4.5	4.6	4.5	6.8[a]	7.1	7.8	7.8
Past Month	1.2	1.3	1.2	1.2	3.1	3.2	3.5	3.2
Alcohol								
Lifetime	43.4[a]	42.9[a]	42.0[a]	40.6	57.0[a]	55.8[a]	54.1[a]	52.1
Past Year	34.6[a]	34.3	33.9	33.3	49.4[a]	48.3[a]	47.5[a]	45.3
Past Month	17.6[a]	17.7[a]	17.6[a]	16.5	27.5[a]	27.6[a]	26.9[a]	25.2
Cigarettes								
Lifetime	33.3[a]	31.0[a]	29.2[a]	26.7	39.4[a]	35.7[a]	34.3[a]	32.4
Past Year	20.3[a]	19.0[a]	18.4[a]	17.3	--	--	--	--
Past Month	13.0[a]	12.2[a]	11.9[a]	10.8	14.2[a]	13.5[a]	12.6	12.1

-- Not available.

Note: MTF data for 8th and 10th graders are simple averages of estimates for those two grades. Data for 8th and 10th graders are reported in Johnston, O'Malley, Bachman, and Schulenberg (2006a). Design effects used for variance estimation are reported in Johnston, O'Malley, Bachman, and Schulenberg (2005c).

[a] Difference between estimate and 2005 estimate is statistically significant at the .05 level.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.
University of Michigan, The Monitoring the Future Study, 2002, 2003, 2004, and 2005.

Table 9.2 Comparison of NSDUH and MTF Prevalence Estimates among Young Adults: 2002-2005

Substance/ Time Period	NSDUH Ages 18-25				MTF Ages 19-24			
	2002	2003	2004	2005	2002	2003	2004	2005
Marijuana								
Lifetime	53.8	53.9[a]	52.8	52.4	56.1	56.4	55.6	54.4
Past Year	29.8[a]	28.5	27.8	28.0	34.2[a]	33.0	31.6	31.4
Past Month	17.3	17.0	16.1	16.6	19.8[a]	19.9	18.2	17.0
Cocaine								
Lifetime	15.4	15.0	15.2	15.1	12.9	14.5	14.3[a]	12.6
Past Year	6.7	6.6	6.6	6.9	6.5	7.3	7.8	6.9
Past Month	2.0[a]	2.2	2.1[a]	2.6	2.5	2.6	2.4	2.1
Ecstasy								
Lifetime	15.1[a]	14.8[a]	13.8	13.7	16.0[a]	16.6	14.9[a]	12.4
Past Year	5.8[a]	3.7[a]	3.1	3.1	8.0[a]	5.3	3.3	3.4
Past Month	1.1[a]	0.7	0.7	0.8	1.6[a]	1.0	0.8	0.6
LSD								
Lifetime	15.9[a]	14.0[a]	12.1[a]	10.5	13.9[a]	13.8	10.4[a]	7.9
Past Year	1.8[a]	1.1	1.0	1.0	2.4[a]	1.5	1.2	1.1
Past Month	0.1	0.2	0.3	0.2	0.4	0.2	0.2	0.2
Inhalants								
Lifetime	15.7[a]	14.9[a]	14.0	13.3	11.7[a]	11.4	10.6	9.3
Past Year	2.2	2.1	2.1	2.1	2.2	1.5	2.3	1.6
Past Month	0.5	0.4	0.4	0.5	0.8[a]	0.3	0.4	0.3
Alcohol								
Lifetime	86.7[a]	87.1[a]	86.2	85.7	88.4	87.6	87.2	87.1
Past Year	77.9	78.1	78.0	77.9	83.9	82.3	83.1	82.8
Past Month	60.5	61.4	60.5	60.9	67.7	66.3	67.3	66.8
Cigarettes								
Lifetime	71.2[a]	70.2[a]	68.7[a]	67.3	--	--	--	--
Past Year	49.0[a]	47.6	47.5	47.2	41.8	40.8	41.4	40.2
Past Month	40.8[a]	40.2	39.5	39.0	31.4[a]	29.5	30.2	28.7

-- Not available.

Note: MTF data for persons aged 19 to 24 are simple averages of modal age groups 19-20, 21-22, and 23-24 as reported in Johnston, O'Malley, and Bachman (2003c) and Johnston, O'Malley, Bachman, and Schulenberg (2004a, 2005a,2006b).

Note: Significance testing was not performed between 2003 and 2005 MTF data.

[a] Difference between estimate and 2005 estimate is statistically significant at the .05 level.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.
University of Michigan, The Monitoring the Future Study, 2002, 2003, 2004, and 2005.

Appendix A: Description of the Survey

A.1 Sample Design

The 2005 National Survey on Drug Use and Health (NSDUH)[1] is the first survey in a coordinated 5-year sample design providing estimates for all 50 States plus the District of Columbia for the years 2005 through 2009. The respondent universe is the civilian, noninstitutionalized population aged 12 years old or older residing within the United States and the District of Columbia. Persons excluded from the universe include active-duty military personnel, persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), and residents of institutional group quarters, such as jails and hospitals.

Although there is no planned overlap with the 1999 through 2004 samples, a coordinated design for 2005 through 2009 facilitates 50 percent overlap in second-stage units (area segments) within each successive 2-year period from 2005 through 2009. Because the 2005 design enables estimates to be developed by State in all 50 States plus the District of Columbia, States may be viewed as the first level of stratification as well as a reporting variable.

For the 50-State design, 8 States were designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) with samples large enough to support direct State estimates. In 2005, sample sizes in these States ranged from 3,562 to 3,699. For the remaining 42 States and the District of Columbia, smaller, but adequate, samples were selected to support State estimates using small area estimation (SAE).[2] Sample sizes in these States ranged from 840 to 978 in 2005.

States were first stratified into a total of 900 State sampling (SS) regions (48 regions in each large sample State and 12 regions in each small sample State). These regions were contiguous geographic areas designed to yield the same number of interviews on average.[3] Unlike the 1999 through 2001 NHSDAs and the 2002 through 2004 NSDUHs in which the first-stage sampling units were clusters of census blocks called area segments, the first stage of selection for the 2005 through 2009 NSDUHs was census tracts.[4] This stage was included to contain sample segments within a single census tract to the extent possible.[5]

A total of 48 census tracts per SS region were selected with probability proportional to size. Within sampled census tracts, adjacent census blocks were combined to form the second-

[1] Prior to 2002, the survey was known as the National Household Survey on Drug Abuse (NHSDA).

[2] SAE is a hierarchical Bayes modeling technique used to make State-level estimates for approximately 20 substance-use-related measures. See the *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health* (Wright & Sathe, 2006) for more details.

[3] Areas were defined using 2000 census geography. Dwelling units (DUs) and population counts were obtained from the 2000 census data supplemented with revised population counts from Claritas (http://cluster1.claritas.com/claritas/Default.jsp).

[4] Census tracts are relatively permanent statistical subdivisions of counties and provide a stable set of geographic units across decennial census periods.

[5] Some census tracts had to be aggregated in order to meet the minimum DU requirement of 150 DUs in urban areas and 100 DUs in rural areas.

stage sampling units or area segments. One segment was selected within each sampled census tract with probability proportional to population size to support the 5-year sample and any supplemental studies that the Substance Abuse and Mental Health Services Administration (SAMHSA) may choose to field.[6] Of these segments, 24 were designated for the coordinated 5-year sample and 24 were designated as "reserve" segments. Eight sample segments per SS region were fielded during the 2005 survey year.

These sampled segments were allocated equally into four separate samples, one for each 3-month period (calendar quarter) during the year, so that the survey was essentially continuous in the field. In each of these area segments, a listing of all addresses was made, from which a sample of 175,958 addresses was selected. Of the selected addresses, 146,912 were determined to be eligible sample units. In these sample units (which can be either households or units within group quarters), sample persons were randomly selected using an automated screening procedure programmed in a handheld computer carried by the interviewers. The number of sample units completing the screening was 134,055. Youths aged 12 to 17 years and young adults aged 18 to 25 years were oversampled at this stage. Because of the large sample size, there was no need to oversample racial/ethnic groups, as was done on surveys prior to 1999. A total of 83,805 persons were selected nationwide. Consistent with previous surveys in this series, the final respondent sample of 68,308 persons was representative of the U.S. general population (since 1991, the civilian, noninstitutionalized population) aged 12 or older. In addition, State samples were representative of their respective State populations. More detailed information on the disposition of the national screening and interview sample can be found in Appendix B. Definitions of key terms are provided in Appendix C.

The survey covers residents of households (living in houses/townhouses, apartments, condominiums, etc.), persons in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory workers' camps, halfway houses), and civilians living on military bases. Although the survey covers these types of units (they are given a nonzero probability of selection), the sample sizes of most specific groups are too small to provide separate estimates. Persons excluded from the survey include homeless people who do not use shelters, active military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals. More information on the sample design can be found in the 2005 NSDUH sample design report by Morton et al. (2006) on the Office of Applied Studies (OAS) website (available as a PDF at http://www.oas.samhsa.gov/nhsda/methods.cfm#2k5).

A.2 Data Collection Methodology

The data collection method used in NSDUH involves in-person interviews with sample persons, incorporating procedures that would be likely to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. Confidentiality is stressed in all written and oral communications with potential respondents. Respondents' names are not collected with the data, and computer-assisted interviewing (CAI) methods, including audio

[6] For more details on the 5-year sample, see the sample design report in the *2005 NSDUH Methodological Resource Book* (Morton, Chromy, Hunter, & Martin, 2006).

computer-assisted self-interviewing (ACASI), are used to provide a private and confidential setting to complete the interview.

Introductory letters are sent to sampled addresses, followed by an interviewer visit. A 5-minute screening procedure using a handheld computer involves listing all household members along with their basic demographic data. The computer uses the demographic data in a preprogrammed selection algorithm to select zero to two sample person(s), depending on the composition of the household. This selection process is designed to provide the necessary sample sizes for the specified population age groupings.

Interviewers immediately attempt to conduct the NSDUH interview with each selected person in the household. The interviewer requests the selected respondent to identify a private area in the home to conduct the interview away from other household members. The interview averages about an hour and includes a combination of CAPI (computer-assisted personal interviewing, in which the interviewer reads the questions) and ACASI (which is self-administered by the respondent).

A key feature of the interview is a core/supplement structure. A core set of questions critical for basic trend measurement of prevalence estimates remains in the survey every year and comprises the first part of the interview. Supplemental questions, or modules, that can be revised, dropped, or added from year to year make up the remainder of the interview. The core consists of initial demographic items (which are interviewer-administered) and self-administered questions pertaining to the use of tobacco, alcohol, marijuana, cocaine, crack cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, and sedatives. Supplemental topics in the remaining self-administered sections include (but are not limited to) injection drug use, perceived risks of substance use, substance dependence or abuse, arrests, treatment for substance use problems, pregnancy and health care issues, and mental health issues. Supplemental demographic questions (which are interviewer-administered and follow the ACASI questions) address such topics as immigration, current school enrollment, employment and workplace issues, health insurance coverage, and income. It should be noted that some of the supplemental portions of the interview have remained in the survey, relatively unchanged, every year (e.g., current health insurance coverage, income).

Thus, the interview begins in CAPI mode with the field interviewer (FI) reading the questions from the computer screen and entering the respondent's replies into the computer. The interview then transitions to the ACASI mode for the sensitive questions. In this mode, the respondent can read the questions silently on the computer screen and/or listen to the questions read through headphones and enter his or her responses directly into the computer. At the conclusion of the ACASI section, the interview returns to the CAPI mode with the interviewer completing the questionnaire. Each respondent who completes a full interview is given a $30.00 cash payment as a token of appreciation for his or her time.

No personal identifying information is captured in the CAI record for the respondent. At the end of the day when an interviewer has completed one or more interviews, he or she transmits the data to RTI in Research Triangle Park, North Carolina, via home telephone lines.

A.3 Data Processing

Interviewers initiate nightly data transmissions of interview data and call records on days when they work. Computers at RTI direct the information to a raw data file that consists of one record for each completed interview. Even though editing and consistency checks are done by the CAI program during the interview, additional, more complex, edits and consistency checks are completed at RTI. Cases are retained only if respondents provided data on lifetime use of cigarettes and at least nine other substances in the core section of the questionnaire. An important aspect of subsequent editing routines involves assignment of codes when respondents legitimately were skipped out of questions that definitely did not apply to them (e.g., if respondents never used a drug of interest). For key drug use measures, the editing procedures identify inconsistencies between related variables. Inconsistencies in variables pertaining to the most recent period that respondents used a drug are edited by assigning an "indefinite" period of use (e.g., use at some point in the lifetime, which could mean use in the past 30 days or past 12 months). Inconsistencies in other key drug use variables are edited by assigning missing data codes. These inconsistencies then are resolved through statistical imputation procedures, as discussed below.

A.3.1 Statistical Imputation

For some key variables that still have missing or ambiguous values after editing, statistical imputation is used to replace these values with appropriate response codes. For example, the response is ambiguous if the editing procedures assigned a respondent's most recent use of a drug to "use at some point in the lifetime," with no definite period within the lifetime. In this case, the imputation procedures assign a definite value for when the respondent last used the drug (e.g., in the past 30 days, more than 30 days ago but within the past 12 months, more than 12 months ago). Similarly, if the response is completely missing, the imputation procedures replace missing values with nonmissing ones.

In most cases, missing or ambiguous values are imputed using a methodology called predictive mean neighborhoods (PMN), which was developed specifically for the 1999 survey and used in all subsequent survey years. PMN is a combination of a model-assisted imputation methodology and a random nearest neighbor hot-deck procedure. The hot-deck procedure is set up in such a way that imputed values are made consistent with preexisting nonmissing values for other variables. Whenever feasible, the imputation of variables using PMN is multivariate, in which imputation is accomplished on several response variables at once. Variables requiring imputation using PMN were the core demographic variables, core drug use variables (recency of use, frequency of use, and age at first use), income, health insurance, and noncore demographic variables for work status, immigrant status, and the household roster. A weighted regression imputation was used to impute some of the missing values in the nicotine dependence variables.

In the modeling stage of PMN, the model chosen depends on the nature of the response variable Y. In the 2005 NSDUH, the models included binomial logistic regression, multinomial logistic regression, Poisson regression, and ordinary linear regression, where the models incorporated the sampling design weights.

In general, hot-deck imputation replaces an item nonresponse (missing or ambiguous value) with a recorded response that is donated from a "similar" respondent who has nonmissing data. For random nearest neighbor hot-deck imputation, the missing or ambiguous value is replaced by a responding value from a donor randomly selected from a set of potential donors. Potential donors are those defined to be "close" to the unit with the missing or ambiguous value according to a predefined function called a distance metric. In the hot-deck stage of PMN, the set of candidate donors (the "neighborhood") consists of respondents with complete data who have a predicted mean close to that of the item nonrespondent. In particular, the neighborhood consists of either the set of the closest 30 respondents or the set of respondents with a predicted mean (or means) within 5 percent of the predicted mean(s) of the item nonrespondent, whichever set is smaller. If no respondents are available who have a predicted mean (or means) within 5 percent of the item nonrespondent, the respondent with the predicted mean(s) closest to that of the item nonrespondent is selected as the donor.

In the univariate case, the neighborhood of potential donors is determined by calculating the relative distance between the predicted mean for an item nonrespondent and the predicted mean for each potential donor, then choosing those means defined by the distance metric. The pool of donors is restricted further to satisfy logical constraints whenever necessary (e.g., age at first crack use must not be less than age at first cocaine use).

Whenever possible, missing or ambiguous values for more than one response variable are considered at a time. In this (multivariate) case, the distance metric is a Mahalanobis distance (Manly, 1986) rather than a relative Euclidean distance. Whether the imputation is univariate or multivariate, only missing or ambiguous values are replaced, and donors are restricted to be logically consistent with the response variables that are not missing. Furthermore, donors are restricted to satisfy "likeness constraints" whenever possible. That is, donors are required to have the same values for variables highly correlated with the response. If no donors are available who meet these conditions, these likeness constraints can be loosened. For example, donors for the age at first use variable are required to be of the same age as recipients, if at all possible. Further details on the PMN methodology are provided in RTI International (2005b) and Singh, Grau, and Folsom (2001, 2002).

Although statistical imputation could not proceed separately within each State due to insufficient pools of donors, information about each respondent's State of residence was incorporated in the modeling and hot-deck steps. For most drugs, respondents were separated into three "State usage" categories as follows: respondents from States with high usage of a given drug were placed in one category, respondents from States with medium usage into another, and the remainder into a third category. This categorical "State rank" variable was used as one set of covariates in the imputation models. In addition, eligible donors for each item nonrespondent were restricted to be of the same State usage category (i.e., the same "State rank") as the nonrespondent.

A.3.2 Development of Analysis Weights

The general approach to developing and calibrating analysis weights involved developing design-based weights, d_k, as the product of the inverse of the selection probabilities at each selection stage. Unlike previous NSDUHs with three stages of selection (i.e., selection of

segments, selection of household, and selection of persons), the 2005 NSDUH adapted a new four-stage sample selection scheme. An extra selection stage of census tracts was added before the selection of a segment. Thus, the design-based weights, d_k, for the 2005 NSDUH incorporated the extra layer of sampling selection to reflect the change in sample design. Adjustment factors, $a_k(\lambda)$, then were applied to the design-based weights to adjust for nonresponse, to poststratify to known population control totals, and to control for extreme weights when necessary. In view of the importance of State-level estimates with the 50-State design, it was necessary to control for a much larger number of known population totals. Several other modifications to the general weight adjustment strategy that had been used in past surveys also were implemented for the first time beginning with the 1999 CAI sample.

Weight adjustments were based on a generalization of Deville and Särndal's (1992) logit model. This generalized exponential model (GEM) (Folsom & Singh, 2000b) incorporates unit-specific bounds (ℓ_k, u_k), $k \in s$, for the adjustment factor $a_k(\lambda)$ as follows:

$$a_k(\lambda) = \frac{\ell_k(u_k - c_k) + u_k(c_k - \ell_k)\exp(A_k x_k'\lambda)}{(u_k - c_k) + (c_k - \ell_k)\exp(A_k x_k'\lambda)},$$

where c_k are prespecified centering constants, such that $\ell_k < c_k < u_k$ and $A_k = (u_k - \ell_k) / (u_k - c_k)(c_k - \ell_k)$. The variables ℓ_k, c_k, and u_k are user-specified bounds, and λ is the column vector of p model parameters corresponding to the p covariates x. The λ-parameters are estimated by solving

$$\sum_s x_k d_k a_k(\lambda) - \tilde{T}_x = 0,$$

where $\tilde{T}_x$ denotes control totals that could be either nonrandom, as is generally the case with poststratification, or random, as is generally the case for nonresponse adjustment.

The final weights $w_k = d_k a_k(\lambda)$ minimize the distance function $\Delta(w,d)$ defined as

$$\Delta(w,d) = \sum_{k \in s} \frac{d_k}{A_k}\left\{(a_k - \ell_k)\log\frac{a_k - \ell_k}{c_k - \ell_k} + (u_k - a_k)\log\frac{u_k - a_k}{u_k - c_k}\right\}.$$

This general approach was used at several stages of the weight adjustment process, including (1) adjustment of household weights for nonresponse at the screener level, (2) poststratification of household weights to meet population controls for various demographic groups by State, (3) adjustment of household weights for extremes, (4) poststratification of selected person weights, (5) adjustment of responding person weights for nonresponse at the questionnaire level, (6) poststratification of responding person weights, and (7) adjustment of responding person weights for extremes.

Every effort was made to include as many relevant State-specific covariates (typically defined by demographic domains within States) as possible in the multivariate models used to calibrate the weights (nonresponse adjustment and poststratification steps). Because further subdivision of State samples by demographic covariates often produced small cell sample sizes, it was not possible to retain all State-specific covariates (even after meaningful collapsing of

covariate categories) and still estimate the necessary model parameters with reasonable precision. Therefore, a hierarchical structure was used in grouping States with covariates defined at the national level, at the census division level within the Nation, at the State group within the census division, and, whenever possible, at the State level. In every case, the controls for total population within State and the five age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 or older) within State were maintained except that, in the last step of poststratification of person weights, six age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 to 64, 65 or older) were used. Census control totals by age, race, gender, and Hispanicity were required for the civilian, noninstitutionalized population of each State. Beginning with the 2002 NSDUH, the Population Estimates Branch of the U.S. Bureau of the Census produced the necessary population estimates in response to a special request based on the 2000 census.

Consistent with the surveys from 1999 onward, control of extreme weights through separate bounds for adjustment factors was incorporated into the GEM calibration processes for both nonresponse and poststratification. This is unlike the traditional method of winsorization in which extreme weights are truncated at prespecified levels and the trimmed portions of weights are distributed to the nontruncated cases. In GEM, it is possible to set bounds around the prespecified levels for extreme weights, and then the calibration process provides an objective way of deciding the extent of adjustment (or truncation) within the specified bounds. A step was added to poststratify the household-level weights to obtain census-consistent estimates based on the household rosters from all screened households; these household roster-based estimates then provided the control totals needed to calibrate the respondent pair weights for subsequent planned analyses. An additional step poststratified the selected person sample to conform to the adjusted roster estimates. This additional step takes advantage of the inherent two-phase nature of the NSDUH design. The final step poststratified the respondent person sample to external census data (defined within the State whenever possible, as discussed above). For more detailed information, see the *2004 NSDUH Methodological Resource Book* (RTI International, 2006).

For certain populations of interest, 2 years of NSDUH data were combined to obtain annual averages. The person-level weights for estimates based on the annual averages were obtained by dividing the analysis weights for the 2 specific years by a factor of two.

Appendix B: Statistical Methods and Measurement

B.1 Target Population

An important limitation of estimates of drug use prevalence from the National Survey on Drug Use and Health (NSDUH) is that they are only designed to describe the target population of the survey—the civilian, noninstitutionalized population aged 12 or older. Although this population includes almost 98 percent of the total U.S. population aged 12 or older, it excludes some important and unique subpopulations who may have very different drug use patterns. For example, the survey excludes active military personnel, who have been shown to have significantly lower rates of illicit drug use. Also, persons living in institutional group quarters, such as prisons and residential drug use treatment centers, are not included in NSDUH, yet they have been shown in other surveys to have higher rates of illicit drug use. Also excluded are homeless persons not living in a shelter on the survey date; they are another population shown to have higher than average rates of illicit drug use. Appendix D describes other surveys that provide data for these populations.

B.2 Sampling Error and Statistical Significance

The national estimates, along with the associated standard errors (SEs), were computed using a multiprocedure package, SUDAAN® Software for Statistical Analysis of Correlated Data. SUDAAN was designed for the statistical analysis of data collected using stratified, multistage cluster sampling designs, as well as other observational and experimental studies involving repeated measures or studies subject to cluster correlation effects (RTI International, 2004). The final, nonresponse-adjusted, and poststratified analysis weights were used in SUDAAN to compute unbiased design-based drug use estimates.

The sampling error (i.e., the standard error) of an estimate is the error caused by the selection of a sample instead of conducting a census of the population. The sampling error may be reduced by selecting a large sample and/or by using efficient sample design and estimation strategies, such as stratification, optimal allocation, and ratio estimation.

With the use of probability sampling methods in NSDUH, it is possible to develop estimates of sampling error from the survey data. These estimates have been calculated using SUDAAN for all estimates presented in this report using a Taylor series linearization approach that takes into account the effects of NSDUH's complex design features. The sampling errors are used to identify unreliable estimates and to test for the statistical significance of differences between estimates.

B.2.1 Variance Estimation for Totals

Although the SEs of estimates of means and proportions can be calculated appropriately in SUDAAN using a Taylor series linearization approach, SEs of estimates of totals may be underestimated in situations where the domain size is poststratified to data from the U.S. Census

Bureau. Because of this underestimation, alternatives for estimating SEs of totals were implemented.

Estimates of means or proportions, $\hat{p}_d$, such as drug use prevalence estimates for a domain *d*, can be expressed as a ratio estimate:

$$\hat{p}_d = \frac{\hat{Y}_d}{\hat{N}_d},$$

where $\hat{Y}_d$ is a linear statistic estimating the number of substance users in the domain *d* and $\hat{N}_d$ is a linear statistic estimating the total number of persons in domain *d* (both users and nonusers). The SUDAAN software package is used to calculate direct estimates of $\hat{Y}_d$ and $\hat{N}_d$ and also can be used to estimate their respective SEs. A Taylor series approximation method implemented in SUDAAN provides estimates for $\hat{p}_d$ and its SE.

When the domain size, $\hat{N}_d$, is free of sampling error, an appropriate estimate of the SE for the total number of substance users is

$$\mathrm{SE}(\hat{Y}_d) = \hat{N}_d \mathrm{SE}(\hat{p}_d).$$

This approach is theoretically correct when the domain size estimates, $\hat{N}_d$, are among those forced to match their respective U.S. Census Bureau population estimates through the weight calibration process (Chen et al., 2006). In these cases, $\hat{N}_d$ is not subject to a sampling error induced by the NSDUH design. For a more detailed explanation of the weight calibration process, see Section A.3.2 in Appendix A.

For estimated domain totals, $\hat{Y}_d$, where $\hat{N}_d$ is not fixed (i.e., where domain size estimates are not forced to match the U.S. Census Bureau population estimates), this formulation still may provide a good approximation if it can be assumed that the sampling variation in $\hat{N}_d$ is negligible relative to the sampling variation in $\hat{p}_d$. This is a reasonable assumption for most cases in this study.

For various subsets of estimates, the above approach yielded an underestimate of the variance of a total because $\hat{N}_d$ was subject to considerable variation. In 2000, an approach was implemented to reflect more accurately the effects of the weighting process on the variance of total estimates. This approach consisted of calculating SEs of totals for all estimates in a particular detailed table using the formula above when a majority of estimates in a table were among domains in which $\hat{N}_d$ was fixed during weighting or if it could be assumed that the sampling variation in $\hat{N}_d$ was negligible. Detailed tables in which the majority of estimates were among domains where $\hat{N}_d$ was subject to considerable variability were calculated directly in SUDAAN. Starting with the 2005 NSDUH, a "mixed" method approach was implemented for all the 2005 detailed tables to improve on the accuracy of SEs. This method had been applied to

selected tables in the 2004 NSDUH, but it was implemented across all tables for the 2005 NSDUH. This approach assigns the method of SE calculation to domains within tables so that all estimates among a select set of domains with fixed $\hat{N}_d$ were calculated using the formula above, and all other estimates were calculated directly in SUDAAN, regardless of other estimates within the same table. The set of domains considered controlled (i.e., those with a fixed $\hat{N}_d$) was restricted to main effects and two-way interactions in order to maintain continuity between years. Domains consisting of three-way interactions may be controlled in 1 year but not necessarily in preceding or subsequent years. The use of such SEs did not affect the SE estimates for the corresponding proportions presented in the same sets of tables because all SEs for means and proportions are calculated directly in SUDAAN. As a result of the use of this mixed-method approach, the SEs for the total estimates within many detailed tables were calculated differently from those in prior NSDUH reports.

Table B.1 contains a list of domains with a fixed $\hat{N}_d$. This table includes both the main effects and two-way interactions and may be used to identify the method of SE calculation employed for estimates of totals in the various tables of this report. For example, Table G.13 in Appendix G of this report presents estimates of illicit drug use among persons aged 18 or older within the domains of gender, Hispanic origin and race, education, and current employment. Estimates among the total population (age main effect), males and females (age by gender interaction), and Hispanics and non-Hispanics (age by Hispanic origin interaction) were treated as controlled in this table, and the formula above was used to calculate the SEs. The SEs for all other estimates, including white and black or African American (age by Hispanic origin by race interaction) were calculated directly from SUDAAN. It is important to note that estimates presented in this report for racial groups are among non-Hispanics. For instance, the domain for whites is actually non-Hispanic whites and is therefore a two-way interaction.

B.2.2 Suppression Criteria for Unreliable Estimates

As has been done in past NSDUH reports, direct survey estimates produced for this study that are considered to be unreliable due to unacceptably large sampling errors are not shown in this report and are noted by asterisks (*) in the tables containing such estimates. The criteria used for suppressing all direct survey estimates were based on the relative standard error (RSE) (defined as the ratio of the SE over the estimate), nominal sample size, and effective sample size for each estimate.

Proportion estimates ($\hat{p}$) within the range [$0 < \hat{p} < 1$], rates, and the corresponding estimated number of users were suppressed if

$$\text{RSE}[-\ln(\hat{p})] > .175 \text{ when } \hat{p} \leq .5$$

or

$$\text{RSE}[-\ln(1 - \hat{p})] > .175 \text{ when } \hat{p} > .5.$$

Using a first-order Taylor series approximation to estimate RSE[$-\ln(\hat{p})$] and RSE[$-\ln(1 - \hat{p})$], the following was obtained and used for computational purposes:

$$\frac{\mathrm{SE}(\hat{p})/\hat{p}}{-\ln(\hat{p})} > .175 \text{ when } \hat{p} \leq .5$$

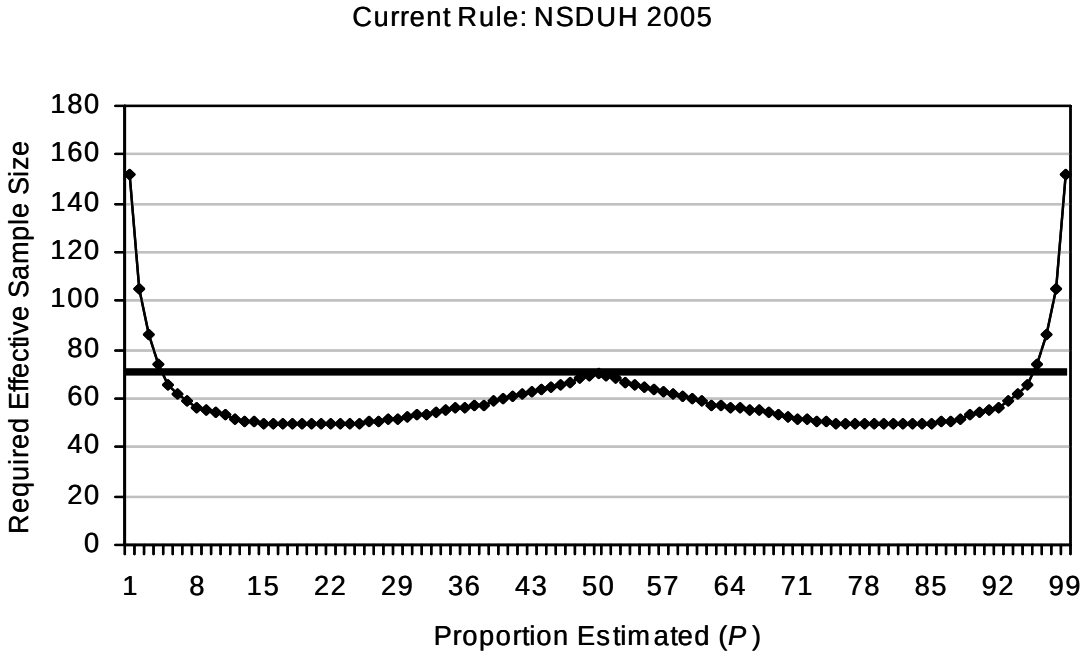
or

$$\frac{\mathrm{SE}(\hat{p})/(1-\hat{p})}{-\ln(1-\hat{p})} > .175 \text{ when } \hat{p} > .5.$$

The separate formulas for $\hat{p} \leq .5$ and $\hat{p} > .5$ produce a symmetric suppression rule (i.e., if $\hat{p}$ is suppressed, then 1 - $\hat{p}$ will be as well). This ad hoc rule requires an effective sample size in excess of 50. When $.05 < \hat{p} < .95$, the symmetric property of the rule produces a local maximum effective sample size of 68 at $\hat{p} = .5$. Thus, estimates with these values of $\hat{p}$ along with effective sample sizes falling below 68 are suppressed. See Figure B.1 for a graphical representation of the required minimum effective sample sizes as a function of the proportion estimated.

A minimum nominal sample size suppression criterion (n = 100) that protects against unreliable estimates caused by small design effects and small nominal sample sizes was employed. Prevalence estimates also were suppressed if they were close to 0 or 100 percent (i.e., if $\hat{p} < .00005$ or if $\hat{p} \geq .99995$).

Figure B.1 Required Effective Sample as a Function of the Proportion Estimated



Estimates of other totals (e.g., number of initiates) along with means and rates that are not bounded between 0 and 1 (e.g., mean age at first use and incidence rates) were suppressed if the RSEs of the estimates were larger than .5. Additionally, estimates of the mean age at first use were suppressed if the sample size was smaller than 10 respondents. Also, the estimated incidence rate and number of initiates were suppressed if they rounded to 0.

The suppression criteria for various NSDUH estimates are summarized in Table B.2 at the end of this appendix.

B.2.3 Statistical Significance of Differences

This section describes the methods used to compare prevalence estimates in this report. Customarily, the observed difference between estimates is evaluated in terms of its statistical significance. Statistical significance is based on the *p* value of the test statistic and refers to the probability that a difference as large as that observed would occur due to random variability in the estimates if there were no difference in the prevalence estimates for the population groups being compared. The significance of observed differences in this report is reported at the .05 level. When comparing prevalence estimates, the null hypothesis (no difference between prevalence estimates) was tested against the alternative hypothesis (there is a difference in prevalence estimates) using the standard difference in proportions test expressed as

$$Z = \frac{\hat{p}_1 - \hat{p}_2}{\sqrt{\text{var}(\hat{p}_1) + \text{var}(\hat{p}_2) - 2\text{cov}(\hat{p}_1, \hat{p}_2)}} ,$$

where $\hat{p}_1$ = first prevalence estimate, $\hat{p}_2$ = second prevalence estimate, $\text{var}(\hat{p}_1)$ = variance of first prevalence estimate, $\text{var}(\hat{p}_2)$ = variance of second prevalence estimate, and $\text{cov}(\hat{p}_1, \hat{p}_2)$ = covariance between $\hat{p}_1$ and $\hat{p}_2$. In cases where significance tests between years were performed, the prevalence estimate from the earlier year (e.g., 2002, 2003, or 2004) becomes the first prevalence estimate and the prevalence estimate from the later year (e.g., 2003, 2004, or 2005) becomes the second prevalence estimate.

Under the null hypothesis, *Z* is asymptotically distributed as a normal random variable. Therefore, calculated values of *Z* can be referred to the unit normal distribution to determine the corresponding probability level (i.e., *p* value). Because the covariance term is not necessarily zero, SUDAAN was used to compute estimates of *Z* along with the associated *p* values using the analysis weights and accounting for the sample design as described in Appendix A. A similar procedure and formula for *Z* were used for estimated totals; however, it should be noted that because it was necessary to calculate the SE outside of SUDAAN for domains forced by the weighting process to match their respective U.S. Census Bureau population estimates, the corresponding test statistics also were computed outside of SUDAAN.

When comparing population subgroups defined by three or more levels of a categorical variable, log-linear chi-square tests of independence of the subgroups and the prevalence variables were conducted first to control the error level for multiple comparisons. If the chi-square test indicated overall significant differences, the significance of each particular pairwise comparison of interest was tested using SUDAAN analytic procedures to properly account for

the sample design. Using the published estimates and SEs to perform independent *t* tests for the difference of proportions usually will provide the same results as tests performed in SUDAAN. However, where the significance level is borderline, results may differ for two reasons: (1) the covariance term is included in SUDAAN tests, whereas it is not included in independent *t* tests; and (2) the reduced number of significant digits shown in the published estimates may cause rounding errors in the independent *t* tests.

As part of a comparative analysis discussed in Chapter 9, prevalence estimates from the Monitoring the Future (MTF) study, sponsored by the National Institute on Drug Abuse (NIDA), were presented for recency measures of selected substances (see Tables 9.1 and 9.2). The analyses focused on prevalence estimates for 8th and 10th graders and prevalence estimates for young adults aged 19 to 24 for 2002 through 2005. Estimates for the 8th and 10th grade students were calculated using MTF data as the simple average of the 8th and 10th grade estimates. Estimates for young adults aged 19 to 24 were calculated using MTF data as the simple average of three modal age groups: 19 and 20 years, 21 and 22 years, and 23 and 24 years. Published results were not available from NIDA for significant differences in prevalence estimates between years for these subgroups, so testing was performed using information that was available.

For the 8th and 10th grade average estimates, tests of differences were performed between 2005 and the 3 prior years because estimates for persons in grade 8 and grade 10 in each of these 4 years were considered independent. Design effects published in Johnston et al. (2005c) for both adjacent and nonadjacent year testing were used to calculate variances so that significance testing could be done. For the 19- to 24-year-old age group, tests of differences were only performed between 2004 and 2005 and between 2002 and 2005. This is because the MTF is a longitudinal study for young adults where respondents are interviewed in alternating years. Therefore, the same young adults could have been interviewed in both 2005 and 2003, and independence between these years cannot be assumed. Weighted sample sizes published in Johnston et al. (2003c, 2004a, 2005a, 2006b) were used to estimate variances because design effects were not available for this subgroup.

As an example, the difference between the 2004 and 2005 averages of prevalence estimates for persons in grades 8 and 10 can be expressed as

$$\bar{p}_2 - \bar{p}_1 ,$$

where $\bar{p}_1 = (\hat{p}_{11} + \hat{p}_{12})/2$, $\hat{p}_{11}$ and $\hat{p}_{12}$ are the prevalence estimates for the 8th and 10th grades, respectively, for 2004; and $\bar{p}_2$ is defined similarly for 2005. The variance of a prevalence estimate $\hat{p}$ can be written as

$$\text{var}(\hat{p}) = \tfrac{1}{n} D\hat{p}(1-\hat{p}),$$

where *n* is the sample size and *D* is the appropriate design effect obtained from the sampling design. In the MTF study, design effects were available for comparisons between adjacent year (i.e., 2004 vs. 2005) estimates and nonadjacent year (i.e., 2002 vs. 2005 and 2003 vs. 2005) estimates; therefore, the variance of the difference between 2 years of estimates for a particular grade can be expressed as

$$\text{var}(\hat{p}_{2i} - \hat{p}_{1i}) = D_i \left(\tfrac{1}{n_{1i}} \hat{p}_{1i}(1-\hat{p}_{1i}) + \tfrac{1}{n_{2i}} \hat{p}_{2i}(1-\hat{p}_{2i}) \right);\ i = 1, 2,$$

where $i = 1$ indexes the 8th grade, $i = 2$ indexes the 10th grade, D_i is the design effect appropriate for comparisons between estimates of the 2 years, and the n_{ji} are the sample sizes corresponding to the indexed year and grade prevalence estimates, $i, j = 1,2$. Because the 8th and 10th grade samples were independently drawn, the variance of the difference between the 8th and 10th grade averages can be expressed as

$$\text{var}(\bar{p}_2 - \bar{p}_1) = \tfrac{1}{4}\{\text{var}(\hat{p}_{21} - \hat{p}_{11}) + \text{var}(\hat{p}_{22} - \hat{p}_{12})\}.$$

The test statistic can therefore be written as

$$Z = \frac{\bar{p}_2 - \bar{p}_1}{\sqrt{\text{var}(\bar{p}_2 - \bar{p}_1)}},$$

where Z is asymptotically distributed as a standard normal random variable.

B.3 Other Information on Data Accuracy

The accuracy of survey estimates can be affected by nonresponse, coding errors, computer processing errors, errors in the sampling frame, reporting errors, and other errors not due to sampling. They are sometimes referred to as "nonsampling errors." These types of errors and their impact are reduced through data editing, statistical adjustments for nonresponse, close monitoring and periodic retraining of interviewers, and improvement in various quality control procedures.

Although these types of errors often can be much larger than sampling errors, measurement of most of these errors is difficult. However, some indication of the effects of some types of these errors can be obtained through proxy measures, such as response rates and from other research studies.

B.3.1 Screening and Interview Response Rate Patterns

In 2005, respondents continued to receive a $30 incentive in an effort to improve response rates over years prior to 2002. Of the 146,912 eligible households sampled for the 2005 NSDUH, 134,055 were screened successfully, for a weighted screening response rate of 91.3 percent (Table B.3). In these screened households, a total of 83,805 sample persons were selected, and completed interviews were obtained from 68,308 of these sample persons, for a weighted interview response rate of 76.2 percent (Table B.4). A total of 10,369 (16.0 percent) sample persons were classified as refusals or parental refusals, 3,088 (3.8 percent) were not available or never at home, and 2,040 (4.0 percent) did not participate for various other reasons, such as physical or mental incompetence or language barrier (see Table B.4, which also shows the distribution of the selected sample by interview code and age group). Among demographic subgroups, the weighted interview response rate was highest among 12 to 17 year olds (87.1

percent), females (77.8 percent), blacks (81.2 percent), in nonmetropolitan areas (79.2 percent), and among persons residing in the South (77.2 percent) (Table B.5).

The overall weighted response rate, defined as the product of the weighted screening response rate and weighted interview response rate, was 69.6 percent in 2005. Nonresponse bias can be expressed as the product of the nonresponse rate ($1 - R$) and the difference between the characteristic of interest between respondents and nonrespondents in the population ($P_r - P_{nr}$). Thus, assuming the quantity ($P_r - P_{nr}$) is fixed over time, the improvement in response rates in 2002 through 2005 over prior years will result in estimates with lower nonresponse bias.

B.3.2 Inconsistent Responses and Item Nonresponse

Among survey participants, item response rates were above 99 percent for most drug use items. However, inconsistent responses for some items were common. Estimates of substance use from NSDUH are based on responses to multiple questions by respondents, so that the maximum amount of information is used in determining whether a respondent is classified as a drug user. Inconsistencies in responses are resolved through a logical editing process that involves some judgment on the part of survey analysts. Additionally, missing or inconsistent responses are imputed using statistical methodology. Editing and imputation of missing responses are potential sources of error.

B.3.3 Validity of Self-Reported Use

Most drug use prevalence estimates, including those produced for NSDUH, are based on self-reports of use. Although studies have generally supported the validity of self-report data, it is well documented that these data often are biased (underreported or overreported) by several factors, including the mode of administration, the population under investigation, and the type of drug (Bradburn & Sudman, 1983; Hser & Anglin, 1993). Higher levels of bias also are observed among younger respondents and those with higher levels of drug use (Biglan, Gilpin, Rorhbach, & Pierce, 2004). Methodological procedures, such as biological specimens (e.g., urine, hair, saliva), proxy reports (e.g., family member, peer), and repeated measures (e.g., recanting), have been used to validate self-report data (Fendrich, Johnson, Sudman, Wislar, & Spiehler, 1999). However, these procedures often are impractical or too costly for community-based epidemiological studies (SRNT Subcommittee on Biochemical Verification, 2002). NSDUH utilizes widely accepted methodological practices for ensuring validity, such as encouraging privacy through audio computer-assisted self-interviewing (ACASI). Comparisons using these methods within NSDUH have been shown to reduce reporting bias (Aquilino, 1994; Turner, Lessler, & Gfroerer, 1992).

B.4 Measurement Issues

Several measurement issues are associated with the 2005 NSDUH that may be of interest and are discussed in this section. Specifically, these issues include the methods for measuring incidence, nicotine (cigarette) dependence, substance dependence and abuse, serious psychological distress (SPD), and depression.

B.4.1 Incidence

In epidemiological studies, incidence is defined as the number of new cases of a disease occurring within a specific period of time. Similarly, in substance use studies, incidence refers to the first use of a particular substance.

In the 2004 NSDUH national results report (Office of Applied Studies [OAS], 2005b), a new measure related to incidence was introduced and has become the primary focus of Chapter 5 in this national results report. The incidence measure is termed "past year initiation" and refers to respondents whose date of first use of a substance was within the 12 months prior to their interview date. This measure is determined by self-reported past year use, age at first use, year and month of recent new use, and the interview date. Prior NSDUH reports have included long-term trends in incidence by calendar year based on these self-reports. Calendar year initiates refer to the number of new substance users reporting first use within a calendar year (between January 1 and December 31 of a specific prior year of a respondent's life) and are determined by the respondents' information on age and month at first use, interview date, and date of birth, as well as date of entry to the United States if respondents indicated they were not born in the United States (for more information on calendar year estimates, see Section B.4.1 in Appendix B of OAS, 2005b). Although calendar year estimates can provide useful indicators of long-term trends, they may be subject to substantial bias, as discussed later in this section. Calendar year estimates are not included in this report.

Beginning in 1999, the survey questionnaire allows for collection of year and month of first use for recent initiates. Month, day, and year of birth also are obtained directly or are imputed for item nonrespondents as part of the data postprocessing. Additionally, the questionnaire call record provides the date of the interview. By imputing a day of first use within the year and month of first use, a specific date of first use, $t_{fu,d,i}$, can be used for estimation purposes.

Past year initiation among persons using a substance in the past year can be viewed as an indicator variable defined as follows:

$$I_{(Past\ Year\ Initiate)}(i) = \begin{cases} 1 & \text{if } \left(DOI_i MOI_i YOI_i - t_{fu,d,i}\right) \le 365 \\ 0 & \text{otherwise} \end{cases},$$

where DOI_i, MOI_i, and YOI_i denote the day, month, and year of the interview, respectively, and $t_{fu,d,i}$ denotes the date of first use.

The calculation of this estimate does not take into account whether a respondent initiated substance use while a resident of the United States. This method of calculation has little effect on past year estimates and allows for direct comparability with other standard measures of substance use because the populations of interest for the measures will be the same (i.e., both measures examine all possible respondents and are not restricted to those initiating substance use only in the United States).

One important note for incidence estimates is the relationship between main categories and subcategories of substances (e.g., illicit drugs would be a main category, and inhalants and marijuana would be subcategories in relation to illicit drugs). For most measures of substance use, any member of a subcategory is by necessity a member of the main category (e.g., if a respondent is a past month user of a particular drug, then he or she is also a past month user of illicit drugs in general). However, this is not the case with regard to incidence statistics. Because an individual can only be an initiate of a particular substance category (main or sub) a single time, a respondent with lifetime use of multiple substances may not, by necessity, be included as a past year initiate of a main category, even if he or she were a past year initiate for a particular subcategory because his or her first initiation of other substances could have occurred earlier.

Because estimates of incidence are based on retrospective reports of age at first drug use by survey respondents, they may be subject to memory-related biases, such as recall decay and telescoping. Recall decay occurs when respondents who initiated many years ago fail to report this use and will tend to result in a downward bias in estimates for earlier years (e.g., 1960s and 1970s). Telescoping refers to misreporting of an event in time. An event can be dated too remote (backward telescoping) or too recent (forward telescoping). Forward telescoping occurs, for example, when an 18-year-old respondent who first used at age 12 reports his or her age at first use as 14. Telescoping such as this will tend to result in an upward bias for estimates for more recent years.

There also is likely to be some underreporting bias due to the tendency for respondents to not report socially unacceptable behavior because of respondents' fear of disclosure. This bias is likely to have the greatest impact on recent estimates, which reflect more recent use and are based heavily on reporting by young respondents for some substances, particularly alcohol, cigarettes, and inhalants. Finally, for drug use that is frequently initiated at age 10 or younger, estimates based on retrospective reports 1 year later underestimate total incidence because 11-year-old (or younger) children are not sampled by NSDUH. Prior analyses showed that alcohol and cigarette (any use) incidence estimates could be affected significantly by this.

An evaluation of NSDUH retrospective estimates of incidence suggested that these types of bias are significant and differ by substance and length of recall (Gfroerer, Hughes, Chromy, Heller, & Packer, 2004). This study showed that, for very recent time periods, such as within the past year or in the prior 2 or 3 calendar years, bias in estimates of marijuana, cocaine, alcohol, and cigarettes appears to be small, but for all other substances there is significant downward bias. Bias for all substances was shown to increase the further back in time the estimates are made, suggesting an association with the length of recall.

Recent analysis on the recall period suggested the presence of both forward and backward telescoping effects when reporting first use of a substance. In particular, it appears that there was a tendency to report very recent events as if they had occurred further back in time, while more remote events may be reported to have occurred more recently. Because past year and calendar year initiation estimates are based on reports occurring in the first 12 months and the first 24 months prior to the interview date, respectively, both may be affected by these telescoping effects in different degrees. Because the past year reflects the most recent time period, past year incidence estimates may be most affected by forward telescoping. This may explain why past year estimates tend to show lower incidence than do calendar year estimates.

On the other hand, calendar year estimates from 2 or 3 years prior to the survey may be more affected by backward telescoping, resulting in upward biased estimates for those years. In the same study, it was observed that for a given survey year and for several substances the most recent calendar year incidence estimate is usually lower than the two previous calendar year estimates, and that calendar year estimates tend to diminish as length of recall increases, probably as a result of recall bias.

Although it is clear that both the calendar year and the past year incidence estimates are affected by a variety of types of bias, both can provide useful epidemiological information for researchers and policymakers. Calendar year estimates, used with caution, can be analyzed to understand historical shifts in substance use as far back as the 1960s, when marijuana use began to become widespread in the United States. To track very recent shifts and patterns in incidence, however, past year incidence estimates have several important advantages and since 2004 have been the primary focus of the NSDUH national results report. The main advantages are as follows:

- Past year incidence estimates reflect a more recent time period than calendar year incidence estimates, thus providing more timely data on emerging patterns of use.

- Past year incidence data can be combined with past year substance use data to provide a more complete and consistent picture of substance users.

In addition to estimates of the number of persons initiating use of a substance in the past year, estimates of the mean age of past year first-time users of these substances were computed. Starting with this 2005 NSDUH report, estimates of the mean age at initiation in the past 12 months have been restricted to persons aged 12 to 49 so that the mean age estimates reported are not influenced by those few respondents who were past year initiates at age 50 or older. As a measure of central tendency, means are influenced heavily by the presence of extreme values in the data, and this constraint should increase the utility of these results to health researchers and analysts by providing a better picture of the substance use initiation behaviors among the civilian, noninstitutionalized population in the United States. This constraint was applied only to estimates of mean age at first use and does not affect estimates of incidence.

Because NSDUH is a survey of persons aged 12 years old or older at the time of the interview, younger individuals in the sample dwelling units are not eligible for selection into the NSDUH sample. Some of these younger persons may have initiated substance use during the past year. As a result, past year initiate estimates suffer from undercoverage when one can think of the estimates as reflecting all initial users regardless of current age. For earlier years, data can be obtained retrospectively based on the age at and date of first use. As an example, persons who were 12 years old on the date of their interview in the 2005 survey may report having initiated use of cigarettes between 1 and 2 years ago; these persons would have been past year initiates reported in the 2004 survey had persons who were 11 years old on the date of the 2004 interview been allowed to participate in the survey. Similarly, estimates of past year use by younger persons (age 10 or younger) can be derived from the current survey, but they apply to initiation in prior years.

To get an impression of the potential undercoverage in the current year, reports of substance use initiation reported in 2005 by persons aged 12 or older were estimated for the years in which these persons would have been 1 to 11 years younger. These estimates do not necessarily reflect behavior by persons 1 to 11 years younger in 2005. A rough adjustment to recognize likely 2005 behaviors was based on a ratio of lifetime users aged 12 to 17 in 2005 to the same estimate for the prior applicable survey year. To illustrate the calculation, consider past year use of alcohol. In the 2005 survey, 4,274,000 persons were estimated to have initiated use of alcohol in the past year based on reports by persons 12 year old or older. In addition, an estimate of 110,552 persons 12 years old in 2005 also reported having initiated use of alcohol between 1 and 2 years earlier. These persons would have been past year initiates in the 2004 survey conducted on the same dates had the 2004 survey covered younger persons. The estimated number of lifetime users currently aged 12 to 17 was 10,305,889 for 2005 and 10,595,539 for 2004, indicating fewer overall initiates of alcohol use among persons aged 17 or younger in 2005. An adjusted estimate of initiation of alcohol use by persons who were 11 years old in 2005 is given by

$$(Estimated\ Past\ Year\ Initiates\ Age\ 11)_{2004} * \frac{(Estimated\ Lifetime Users\ Age\ 12\ to\ 17)_{2005}}{(Estimated\ Lifetime\ Users\ Age\ 12\ to\ 17)_{2004}}.$$

Numerically, this yielded an adjusted estimate of 107,530 persons 11 years old on a 2005 survey date and initiating use of alcohol in the past year:

$$110{,}552 * \frac{10{,}305{,}889}{10{,}595{,}539} = 107{,}530.$$

A similar procedure was used to adjust the estimated number of past year initiates among persons who would have been 10 years old on the date of the interview in 2003 and for younger persons in earlier years. The overall adjusted estimate for past year initiates of alcohol use by persons 11 years of age or younger on the date of the interview was 268,249, or about 6 percent of the estimate based on past year initiation by persons 12 or older only (268,249/4,274,000 = 0.0628).

Based on similar analyses, the estimated undercoverage of past year initiates was about 6 percent for cigarettes, about 1.5 percent for marijuana, and about 26 percent for inhalants.

The undercoverage of past year initiates aged 11 or younger also affects the mean age at first use estimate. An adjusted estimate of the mean age at first use was calculated using a weighted estimate of the mean age at first use based on the current survey and the numbers of persons aged 11 or younger in the past year obtained in the aforementioned analysis for estimating undercoverage of past year initiates. Analysis results showed that the mean age at first use was changed from 16.8 to 16.3 (or a decrease of about 3 percent) for alcohol, from 17.3 to 16.8 (or a decrease of about 3 percent) for cigarettes, from 20.6 to 20.5 (or a decrease of about 0.5 percent) for marijuana, and from 16.1 to 14.6 (or a decrease of about 10.5 percent) for inhalants.

B.4.2 Nicotine (Cigarette) Dependence

The 2005 NSDUH computer-assisted interviewing (CAI) instrumentation included questions designed to measure nicotine dependence among current cigarette smokers. Nicotine dependence is based on criteria derived from the Nicotine Dependence Syndrome Scale (NDSS) (Shiffman, Hickcox, Gnys, Paty, & Kassel, 1995; Shiffman, Waters, & Hickcox, 2004) or the Fagerstrom Test of Nicotine Dependence (FTND) (Fagerstrom, 1978; Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991). The above-mentioned criteria were first used to measure nicotine dependence in NSDUH in 2003.

The conceptual roots of the NDSS (Edwards & Gross, 1976) are similar to those behind the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), concept of dependence (APA, 1994). The 2005 NSDUH contained 19 NDSS questions that addressed five aspects of dependence:

1. Smoking drive (compulsion to smoke driven by nicotine craving and withdrawal)
    a. After not smoking for a while, you need to smoke in order to feel less restless and irritable.
    b. When you don't smoke for a few hours, you start to crave cigarettes.
    c. You sometimes have strong cravings for a cigarette where it feels like you're in the grip of a force you can't control.
    d. You feel a sense of control over your smoking - that is, you can "take it or leave it" at any time.
    e. You sometimes worry that you will run out of cigarettes.
2. Nicotine tolerance
    a. Since you started smoking, the amount you smoke has increased.
    b. Compared to when you first started smoking, you need to smoke a lot more now in order to be satisfied.
    c. Compared to when you first started smoking, you can smoke much, much more now before you start to feel anything.
3. Continuous smoking
    a. You smoke cigarettes fairly regularly throughout the day.
    b. You smoke about the same amount on weekends as on weekdays.
    c. You smoke just about the same number of cigarettes from day to day.
    d. It's hard to say how many cigarettes you smoke per day because the number often changes.
    e. It's normal for you to smoke several cigarettes in an hour, then not have another one until hours later.

4. Behavioral priority (preferring smoking over other reinforcing activities)

    a. You tend to avoid places that don't allow smoking, even if you would otherwise enjoy them.

    b. There are times when you choose not to be around your friends who don't smoke because they won't like it if you smoke.

    c. Even if you're traveling a long distance, you'd rather not travel by airplane because you wouldn't be allowed to smoke.

5. Stereotypy (fixed patterns of smoking)

    a. Do you have any friends who do not smoke cigarettes?

    b. The number of cigarettes you smoke per day is often influenced by other things - how you're feeling, or what you're doing, for example.

    c. Your smoking is not affected much by other things. For example, you smoke about the same amount whether you're relaxing or working, happy or sad, alone or with others.

Each of the five domains listed above can be assessed by a continuous measure, but an average score across all domains also can be obtained for overall nicotine dependence (Shiffman et al., 2004). The NDSS algorithm for calculating this average score was based on the respondent's answers to 17 of the 19 questions listed above. The two items regarding nonsmoking friends (4b and 5a) were excluded due to frequently missing data.

To optimize the number of respondents who could be classified for nicotine dependence, imputation was utilized for all respondents who answered all but 1 of the 17 nicotine dependence questions that were used in the NDSS algorithm. The imputation was based on weighted least square regressions using the other 16 NDSS items as covariates in the model (Grau et al., 2005).

Responses to items 1a-c, 1e, 2a-c, 3a-c, 4a, 4c, and 5c were coded from 1 to 5 where

1 = Not at all true of me
2 = Sometimes true of me
3 = Moderately true of me
4 = Very true of me
5 = Extremely true of me

Responses to items 1d, 3d, 3e, and 5b were reverse coded from 5 to 1 where

5 = Not at all true of me
4 = Sometimes true of me
3 = Moderately true of me
2 = Very true of me
1 = Extremely true of me

The NDSS score was calculated as the sum of the responses to the previous questions divided by 17. The NDSS score was only calculated for current cigarette smokers who had complete data for all 17 questions.

A current cigarette smoker was defined as nicotine dependent if his or her NDSS score was greater than or equal to 2.75. If the NDSS score for a current cigarette smoker was less than 2.75 or the NDSS score was not defined, then the respondent was determined to be nondependent based on the NDSS. The threshold of 2.75 was derived by examining the distribution of scores in other samples of smokers administered the NDSS, including a contrast of scores obtained for nondependent smokers (chippers) versus heavy smokers (Shiffman, Paty, Kassel, Gnys, & Zettler-Segal, 1994).

The FTND is a multi-item measure of dependence, but much of its ability to discriminate dependent smokers derives from a single item that assesses how soon after waking that smokers have their first cigarette (Heatherton, Kozlowski, Frecker, Rickert, & Robinson, 1989). Because most nicotine is cleared from the bloodstream overnight, smokers typically wake in nicotine deprivation, and rapid movement to smoke is considered a sign of dependence. A current cigarette smoker was defined as nicotine dependent based on the FTND if the first cigarette smoked was within 30 minutes of waking up on the days that he or she smoked.

Using both the NDSS and the FTND measures described above, a current cigarette smoker was defined as having nicotine dependence in the past month if he or she met either the NDSS or FTND criteria for dependence.

B.4.3 Illicit Drug and Alcohol Dependence and Abuse

The 2005 NSDUH CAI instrumentation included questions that were designed to measure dependence on and abuse of illicit drugs and alcohol. For these substances,[7] dependence and abuse questions were based on the criteria in the DSM-IV (APA, 1994).

Specifically, for marijuana, hallucinogens, inhalants, and tranquilizers, a respondent was defined as having dependence if he or she met three or more of the following six dependence criteria:

1. Spent a great deal of time over a period of a month getting, using, or getting over the effects of the substance.
2. Used the substance more often than intended or was unable to keep set limits on the substance use.
3. Needed to use the substance more than before to get desired effects or noticed that the same amount of substance use had less effect than before.
4. Inability to cut down or stop using the substance every time tried or wanted to.
5. Continued to use the substance even though it was causing problems with emotions, nerves, mental health, or physical problems.

[7] Substances include alcohol, marijuana, cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, and sedatives.

6. The substance use reduced or eliminated involvement or participation in important activities.

For alcohol, cocaine, heroin, pain relievers, sedatives, and stimulants, a respondent was defined as having dependence if he or she met three or more of seven dependence criteria, including the six standard criteria listed above plus a seventh withdrawal symptom criterion. The seventh withdrawal criterion is defined by a respondent reporting having experienced a certain number of withdrawal symptoms that vary by substance (e.g., having trouble sleeping, cramps, hands tremble).

For each illicit drug and alcohol, a respondent was defined as having abused that substance if he or she met one or more of the following four abuse criteria and was determined not to be dependent on the respective substance in the past year:

1. Serious problems at home, work, or school caused by the substance, such as neglecting your children, missing work or school, doing a poor job at work or school, or losing a job or dropping out of school.
2. Used the substance regularly and then did something that might have put you in physical danger.
3. Use of the substance caused you to do things that repeatedly got you in trouble with the law.
4. Had problems with family or friends that were probably caused by using the substance and continued to use the substance even though you thought the substance use caused these problems.

Criteria used to determine whether a respondent was asked the dependence and abuse questions included responses from the core substance use questions and the frequency of substance use questions, as well as the noncore substance use questions. Unknown responses in the core substance use and frequency of substance use questions were imputed. However, the imputation process did not take into account reported data in the noncore (i.e., substance dependence and abuse) CAI modules. Responses to the dependence and abuse questions that were inconsistent with the imputed substance use or frequency of substance use could have existed. Because different criteria and different combinations of criteria were used as skip logic for each substance, different types of inconsistencies may have occurred for certain substances between responses to the dependence and abuse questions and the imputed substance use and frequency of substance use as described below.

For alcohol and marijuana, respondents were asked the dependence and abuse questions if they reported substance use on more than 5 days in the past year, or if they reported any substance use in the past year but did not report their frequency of past year use. Therefore, inconsistencies could have occurred where the imputed frequency of use response indicated less frequent use than required for respondents to be asked the dependence and abuse questions originally.

For cocaine, heroin, and stimulants, respondents were asked the dependence and abuse questions if they reported past year use in a core drug module or past year use in the noncore

special drugs module. Thus, inconsistencies could have occurred when the response to a core substance use question indicated no use in the past year, but responses to dependence and abuse questions indicated substance dependence or abuse for the respective substance.

In 2005, two new questions were added to the noncore special drugs module about past year methamphetamine use: "Have you ever, even once, used methamphetamine?" and "Have you ever, even once, used a needle to inject methamphetamine?" The responses to these new questions were used in the skip logic for the stimulant dependence and abuse questions. Based on the decisions made during the methamphetamine analysis (see Section B.4.6), respondents who indicated past year methamphetamine use solely from these new special drug use questions (i.e., did not indicate methamphetamine use from the core drug module or other questions in the special drugs module) were categorized as NOT having past year stimulant dependence or abuse. Furthermore, if these same respondents were categorized as not having past year dependence on or abuse of any other substance (e.g., pain relievers, tranquilizers, or sedatives for the psychotherapeutic drug grouping), then they were categorized as NOT having past year dependence on or abuse of psychotherapeutics, illicit drugs, illicit drugs or alcohol, and illicit drugs and alcohol.

Respondents might have provided ambiguous information about past year use of any individual substance, in which case these respondents were not asked the dependence and abuse questions for that substance. Subsequently, these respondents could have been imputed to be past year users of the respective substance. In this situation, the dependence and abuse data were unknown; thus, these respondents were classified as not dependent on or abusing the respective substance. However, such a respondent never actually was asked the dependence and abuse questions.

B.4.4 Serious Psychological Distress

For this 2005 NSDUH report, serious psychological distress (SPD) was measured using the K6 screening instrument for nonspecific psychological distress (Kessler et al., 2003a). In NSDUH reports prior to 2004, the K6 scale was used to measure serious mental illness (SMI). For a discussion of the reasons that the K6 was used to measure SPD instead of SMI for the 2004 and later NSDUH reports, as well as details on a methodological study of the measurement of SMI, see Section B.4.4 of Appendix B in the 2004 NSDUH national results report (OAS, 2005b).

The K6 consists of six questions that ask respondents how frequently they experienced symptoms of psychological distress during the 1 month in the past year when they were at their worst emotionally. The use of this scale for SPD (or SMI prior to 2004) was based on a methodological study designed to evaluate several screening scales for measuring SMI in NSDUH. These scales consisted of a truncated version of the World Health Organization (WHO) Composite International Diagnostic Interview Short Form (CIDI-SF) scale (Kessler, Andrews, Mroczek, Üstün, & Wittchen, 1998), the K10/K6 scale of nonspecific psychological distress (Kessler et al., 2003a), and a truncated version of the WHO Disability Assessment Schedule (WHO-DAS) (Rehm et al., 1999).

The six questions comprising the K6 scale are given as follows:

DSNERV1 Most people have periods when they are not at their best emotionally. Think of 1 month in the past 12 months when you were the most depressed, anxious, or emotionally stressed. If there was no month like this, think of a typical month.

During that month, how often did you feel nervous?

1 All of the time
2 Most of the time
3 Some of the time
4 A little of the time
5 None of the time
DK/REF

Response categories are the same for the following questions:

DSHOPE During that same month when you were at your worst emotionally . . . how often did you feel hopeless?

DSFIDG During that same month when you were at your worst emotionally . . . how often did you feel restless or fidgety?

DSNOCHR During that same month when you were at your worst emotionally . . . how often did you feel so sad or depressed that nothing could cheer you up?

DSEFFORT During that same month when you were at your worst emotionally . . . how often did you feel that everything was an effort?

DSDOWN During that same month when you were at your worst emotionally . . . how often did you feel down on yourself, no good, or worthless?

To create a score, the six items (DSNERV1, DSHOPE, DSFIDG, DSNOCHR, DSEFFORT, and DSDOWN) on the K6 scales were coded from 0 to 4 so that "all of the time" was coded 4, "most of the time" 3, "some of the time" 2, "a little of the time" 1, and "none of the time" 0, with "don't know" and "refuse" also coded 0. Summing across the transformed responses resulted in a score with a range from 0 to 24. Respondents with a total score of 13 or greater were classified as having past year SPD (or SMI prior to 2004). This cut point was chosen to equalize false positives and false negatives.

In the 2003 NSDUH, the mental health module (i.e., the serious mental illness module) contained a truncated version of the CIDI-SF scale, the K10/K6 scale, and a truncated version of the WHO-DAS scale to mirror the questions used by Kessler et al. (2003a). Thus, the module contained a broad array of questions about mental health (i.e., panic attacks, depression, mania, phobias, generalized anxiety, posttraumatic stress disorder, and use of mental health services) that preceded the K6 items, and the four extra questions in the K10 scale were interspersed among the items in the K6 scale. In the 2004 NSDUH, the sample of respondents 18 or older was split evenly between the "long form" module, which included all items in the mental health module used in the 2003 NSDUH (sample A), and a "short form" module consisting only of the

K6 items (sample B). The "short form" version was introduced to reduce interview time, removing questions that were not needed for estimation of SPD, and to provide space for a new module on depression. Inclusion of the "long form" version in half of the sample was to measure the impact on the K6 responses of changing the context of the K6.

Results from the 2004 NSDUH showed large differences between the two samples in both the K6 total score and the proportion of respondents with a K6 total score of 13 or greater. These differences were most pronounced in the 18 to 25 age group. These differences suggest that the K6 scale is not context-independent; that is, respondents appear to respond to the K6 items differently depending on whether the scale is preceded by a broad array of other mental health questions.

Given the difference in K6 reporting between the A (long form) and B (short form) samples, the 2004 SPD estimates presented in the 2004 detailed tables and 2004 NSDUH national results report are based only on the A sample, which used a mental health module identical to that used in 2002 and 2003. In the 2005 NSDUH, only the "short form" SPD module was used; therefore, the 2004 SPD estimates presented in the 2005 detailed tables and in this 2005 NSDUH national results report are based on the B sample, so that 2004 and 2005 estimates are comparable. Note that the 2004 SPD estimates reported in the 2004 detailed tables (OAS, 2005a) are different from the 2004 SPD estimates reported in the 2005 detailed tables, and SPD estimates reported in the 2005 detailed tables are not comparable with estimates reported in previous years.

B.4.5 Major Depressive Episode

Beginning in 2004, modules related to major depressive episode (MDE) derived from DSM-IV (APA, 1994) criteria for major depression were included in the questionnaire. These questions permit estimates to be calculated of the lifetime and past year prevalence of MDE, treatment for MDE, and role impairment resulting from MDE. Separate modules were administered to adults (aged 18 or older) and adolescents (aged 12 to 17). The adult questions were adapted from the depression section of the National Comorbidity Survey–Replication (NCS-R; Harvard School of Medicine, 2005), and the adolescent questions were adapted from the depression section of the National Comorbidity Survey–Adolescent (NCS-A; Harvard School of Medicine, 2005). To make the modules developmentally appropriate for adolescents, there are minor wording differences in a few questions between the adult and adolescent modules. Revisions to the questions in both modules were made primarily to reduce its length and to modify the NCS questions, which are interviewer-administered, to the ACASI format used in NSDUH. In addition, some revisions, based on cognitive testing, were made to improve comprehension. Furthermore, even though titles similar to those used in the NCS were used for the NSDUH modules, the results of these items may not be directly comparable. This is mainly due to differing modes of administration in each survey (ACASI in NSDUH vs. computer-assisted personal interviewing [CAPI] in NCS), revisions to wording necessary to maintain the logical processes of the ACASI environment, and possible context effects resulting from deleting questions not explicitly pertinent to severe depression.

In 2004, a split-sample design was implemented where adults in sample B received the depression module while adult respondents in sample A did not. All adolescents were

administered the adolescent depression module. In 2005, all adult and adolescent respondents were administered their respective depression modules.

According to DSM-IV, a person is defined as having had MDE in his or her lifetime if he or she has had at least five or more of the following nine symptoms nearly every day in the same 2-week period, where at least one of the symptoms is a depressed mood or loss of interest or pleasure in daily activities (APA, 1994): (1) depressed mood most of the day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day; (3) significant weight loss when not sick or dieting, or weight gain when not pregnant or growing, or decrease or increase in appetite; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness; (8) diminished ability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death or suicidal ideation. In addition to lifetime MDE, NSDUH measures past year MDE. Respondents who have had MDE in their lifetime are asked if, during the past 12 months, they had a period of depression lasting 2 weeks or longer while also having some of the other symptoms mentioned. Those reporting past year depression then are asked questions from the Sheehan Disability Scale (SDS) to measure the severity of the past year depression.

NSDUH measures the nine attributes associated with MDE as defined in DSM-IV with the following questions. Note that the questions shown are taken from the adult depression module. A few of the questions in the adolescent module were modified slightly to use wording more appropriate for youths. It should be noted that no exclusions were made for MDE caused by medical illness, bereavement, or substance use disorders.

1. Depressed mood most of the day

The following questions refer to the worst or most recent period of time when the respondent experienced any or all of the following: sadness, discouragement, or lack of interest in most things.

During that [worst/most recent] period of time…

a. … did you feel sad, empty, or depressed **most of the day nearly every day**?
b. … did you feel discouraged about how things were going in your life **most of the day nearly every day**?

2. Markedly diminished interest or pleasure in all or almost all activities most of the day

a. … did you lose interest in almost all things like work and hobbies and things you like to do for fun?
b. … did you lose the ability to take pleasure in having good things happen to you, like winning something or being praised or complimented?

3. Weight

In answering the next questions, think about the [worse/most recent] period of time.

a. Did you have a much smaller appetite than usual nearly every day during that time?

b. Did you have a much **larger** appetite than usual nearly every day?
c. Did you gain weight without trying to during that [worst/most recent] period of time?
    a. … because you were growing?
    b. … because you were pregnant?
    c. How many pounds did you gain?
d. Did you lose weight without trying to?
    a. … because you were sick or on a diet?
    b. How many pounds did you lose?

4. Insomnia or hypersomnia

a. Did you have a lot more trouble than usual falling asleep, staying asleep, or waking too early nearly every night during that [worst/most recent] period of time?
b. During that [worst/most recent] period of time, did you sleep a lot more than usual nearly every night?

5. Psychomotor agitation or retardation

a. Did you talk or move more slowly than is normal for you nearly every day?
b. Were you so restless or jittery nearly every day that you paced up and down or couldn't sit still?

6. Fatigue or loss of energy

a. During that [worst/most recent] period of time, did you feel tired or low in energy nearly every day even when you had not been working very hard?

7. Feelings of worthlessness

a. Did you feel that you were not as good as other people nearly every day?
b. Did you feel totally worthless nearly every day?

8. Diminished ability to think or concentrate or indecisiveness

a. During that [worst/most recent] time period, did your thoughts come much more slowly than usual or seem confused nearly every day?
b. Did you have a lot more trouble concentrating than usual nearly every day?
c. Were you unable to make decisions about things you ordinarily have no trouble deciding about?

9. Recurrent thoughts of death or recurrent suicidal ideation

a. Did you often think about death, either your own, someone else's, or death in general?
b. During that period, did you ever think it would be better if you were dead?
c. Did you think about committing suicide?

The 2005 NSDUH also collects data on role impairment using the SDS, which is a measure of the impact of depression on a person's daily activities based on four domains in a

person's life. Each question uses an 11-point scale, where 0 corresponds to no interference, 1-3 corresponds to mild interference, 4-5 corresponds to moderate interference, 7-9 corresponds to severe interference, and 10 corresponds to very severe interference. The overall role impairment is defined as the highest level of severity of role impairment across all four SDS role domains. Respondents also were asked to report the number of days in the past year in which they were "totally unable to work or carry out normal activities" because of depression. Estimates for role impairment are calculated separately for youths and adults because the four domains are slightly different for the two groups. The questions are listed below.

Adult Depression Module

ASDSHOME Think about the time in the past 12 months when these problems with your mood were **most severe.**

Using the 0 to 10 scale shown below, where 0 means **no** interference and 10 means very **severe** interference, select the number that describes how much these problems interfered with each of the following activities during that period. You can use any number between 0 and 10 to answer. If this activity doesn't apply to you, type 95.

How much did your [depression symptoms] interfere with your home management, like cleaning, shopping, and working around the house, apartment, or yard?

ASDSWORK During the time in the past 12 months when your [depression symptoms] were most severe, how much did this interfere with your ability to work?

ASDSREL How much did your [depression symptoms] interfere with your ability to form and maintain **close** relationships with other people during that period of time?

ASDSSOC How much did [depression symptoms] interfere with your social life during that period of time?

Adolescent Depression Module

YSDSHOME Think about the time in the past 12 months when these problems with your mood were the **worst.**

Using the 0 to 10 scale shown below, where 0 means **no** problems and 10 means very **severe** problems, select the number that describes how much your [depression symptoms] caused problems with each of the following activities during that time. You can use any number between 0 and 10 to answer. If this activity doesn't apply to you, type 95.

How much did your [depression symptoms] cause problems with your chores at home?

YSDSWORK During the time in the past 12 months when your [depression symptoms] were worst, how much did this cause problems with your ability to do well at school or work?

YSDSREL How much did your [depression symptoms] cause problems with your ability to get along with your family during that time?

YSDSSOC How much did your [depression symptoms] cause problems with your social life during that time?

B.4.6 Methamphetamine Use

One challenge in measuring nonmedical use of prescription psychotherapeutic drugs is that drugs that have been manufactured by legitimate pharmaceutical companies under government regulation can become popular as drugs of abuse and may instead be produced illegally. In particular, most methamphetamine that is currently used nonmedically in the United States is produced by clandestine laboratories within the United States or abroad rather than by the legitimate pharmaceutical industry. Given that questions on methamphetamine use are first asked in the core prescription stimulants module, one concern in measuring methamphetamine use is that some methamphetamine users could fail to recognize the drug when it is presented in this context, which could lead to underreporting.

To address this, new questions were added to the noncore special drugs module in the 2005 NSDUH to capture information from respondents who may have used methamphetamine but did not recognize it as a prescription drug and therefore did not report use in the core stimulants module. These new noncore questions differ from the methamphetamine use questions asked in the core stimulants module by asking about methamphetamine use removed from the context of prescription drug use, and including more descriptive information relevant to this drug. Respondents who did not indicate in the stimulants module that they had used methamphetamine received the following item:

> Methamphetamine, also known as crank, ice, crystal meth, speed, glass, and many other names, is a stimulant that usually comes in crystal or powder forms. It can be smoked, "snorted," swallowed or injected. Have you ever, even once, used methamphetamine?

Respondents who answered "Yes" to this question then were asked a question to classify them as past month, past year, or lifetime users.

To assess the impact of the new methamphetamine questions, weighted estimates from 2005 were generated and compared for two different scenarios: (1) only core stimulant data from 2005; and (2) core stimulant data, previous noncore data from the special drugs module, and new methamphetamine variables that were added to the special drugs module in 2005. Comparisons were made for the following lifetime, past year, and past month measures: nonmedical use of methamphetamine, nonmedical use of stimulants, nonmedical use of psychotherapeutics, and illicit drug use (including the nonmedical use measures described previously).

Prevalence estimates for scenario 2 were greater than those using only the core stimulant data. For example, the lifetime prevalence of nonmedical methamphetamine use among persons aged 12 or older increased from 4.3 percent for core data only to 6.4 percent for core plus noncore data. See Table B.6 for a comparison of estimates for 2005 based on these two scenarios. It should be noted that the estimates presented in Table B.6 are based on different data (i.e., core vs. core plus noncore data), but from the same respondents. Given the high correlation resulting from pairs of responses on the same individuals, very small differences are detectable. As can be seen in the table, the difference between the estimate based only on the core data and that with the added noncore data for lifetime use of methamphetamine is significant—both statistically and in terms of its magnitude. However, as methamphetamine use becomes an increasingly smaller part of the broader drug groups (i.e., from stimulants to psychotherapeutics to any illicit drug use), the differences between the core only and core plus noncore estimates become very small in terms of magnitude, but they are still statistically detectable.

On the one hand, then, these findings suggest that estimates of nonmedical use of methamphetamine (and by extension, nonmedical use of stimulants) based only on core data could be underestimating the true population prevalence. However, larger estimates of nonmedical use of methamphetamine based on both core and noncore answers could be an artifact of asking a second set of questions ONLY from persons who answered NO the first time. Repeating questions for any drug only to those who denied use the first time could artificially increase the positive responses, and doing so only for methamphetamine could result in a disproportionate reporting of that drug relative to the others in the survey. In addition, because the respondents reporting methamphetamine use in the new questions essentially have contradicted their prior responses, some may have made a mistake on the new question. Thus, some follow-up items to clarify this inconsistency were added beginning with the 2006 NSDUH. The items sought to identify respondents who had failed to report methamphetamine use in response to the earlier question because they did not consider methamphetamine to be a prescription drug. These are the only "additional" methamphetamine users picked up by the new questions that should be included in prevalence estimates. The new items added in 2006 are as follows:

> Earlier, the computer recorded that you have never used Methamphetamine, Desoxyn or Methedrine. Which answer is correct?
>
> 1 I have never, even once, used Methamphetamine, Desoxyn or Methedrine
> 2 I last used Methamphetamine [time period]
>
> [IF 'YES' TO ABOVE ITEM] Why did you report earlier that you had never used Methamphetamine?
>
> 1 The earlier question asked about prescription drugs, and I didn't think of Methamphetamine as a prescription drug
> 2 I made a mistake when I answered the earlier question about ever using Methamphetamine
> 3 Some other reason

An early review of the unweighted 2006 quarter 1 raw data indicates that approximately half (48.5 percent) of the respondents who indicated methamphetamine use in the special drugs module previously did not report methamphetamine use in the core stimulants module because they did not think of methamphetamine as a prescription drug (see column two in Table B.7). The other half who indicated methamphetamine use on follow-up in the special drugs module either reported in the new consistency checks that they never used methamphetamine (i.e., their earlier answer in the core stimulants module was correct) or that they previously had not reported methamphetamine use for some reason other than not recognizing it in the context of prescription drugs (see columns one and three in Table B.7).

These preliminary analyses of data from the 2006 NSDUH show that it will be important to use data from these new consistency check questions in further investigations of how best to estimate the prevalence of methamphetamine use in NSDUH. In particular, the new 2005 methamphetamine data alone do not provide sufficient information to provide an adjusted estimate of the prevalence of nonmedical methamphetamine use in 2005. For this reason, the methamphetamine use estimates presented in this report and in the detailed tables for 2005 continue to use data based only on the original core stimulant items. Thus, for the purpose of examining trends in nonmedical methamphetamine use, the 2005 estimates remain comparable with estimates generated in prior years.

In the 2005 NSDUH, responses to the new methamphetamine questions added to the noncore special drugs module also were used in the skip logic for questions that were presented in other modules for stimulant dependence and abuse in the past year, driving under the influence of illicit drugs in the past year, and the source of the methamphetamine that persons last used. However, these additional reports of methamphetamine use from these new questions in the special drugs module were not used in 2005 for estimating the prevalence of stimulant dependence or abuse in the past year and driving under the influence of illicit drugs in the past year. Thus, estimates in 2005 for stimulant dependence or abuse and driving under the influence of illicit drugs should be comparable with estimates generated in prior years. In addition, reports of methamphetamine use from these new special drugs questions were not used in analyzing new data in 2005 on how respondents obtained the last methamphetamine that they used.

B.5 Impact of Hurricanes Katrina and Rita on the 2005 NSDUH Sample

Hurricanes Katrina and Rita hit the Gulf Coast in the fall of 2005. At the end of August, Hurricane Katrina caused large-scale damage and destruction in the coastal regions of Louisiana, Mississippi, and Alabama. In September, Hurricane Rita devastated portions of Texas and Louisiana. The impact of the hurricanes on the NSDUH sample was evaluated, and a plan of action was developed.

First, the areas that were most likely to be affected according to the paths of the hurricanes were identified. Field management then assessed the level of damage in the affected quarters 3 and 4 area segments in the NSDUH sample. Because quarter 3 data collection was nearing completion and the quarter 4 sample was already in place, it was too late to draw a new sample as a supplement. However, a 20 percent reserve sample was drawn at the time the sample was selected, and the decision was made to release this additional sample in the States of Louisiana, Mississippi, and Alabama in quarter 4.

In addition to releasing the maximum sample, several other actions were taken. First, conference calls were held with field staff to discuss special procedures. Field staff were reminded to apply the residency rule for eligibility[8] and to pick up displaced persons wherever they currently were residing. Field staff also were instructed to assign a pending status code to housing units that were vacant or damaged and to return midway through the quarter to see whether the dwelling unit had become reoccupied.[9] Finally, temporary housing units were picked up by applying the half-open interval rule.[10]

[8] The residency rule for eligibility requires that a person reside at a selected dwelling unit at least half of the quarter in order to be eligible for the survey.
[9] Standard procedure is to assign a final status code on the initial visit and not return to a vacant unit.
[10] For more details on the 2005 NSDUH sample, see the sample design report in the *2005 NSDUH Methodological Resource Book* (Morton et al., 2006).

Table B.1 Demographic and Geographic Domains Forced to Match Their Respective U.S. Census Bureau Population Estimates through the Weight Calibration Process, 2005

MAIN EFFECTS	TWO-WAY INTERACTIONS
Age Group	
12-17	
18-25	
26-34	**Age Group x Gender**
35-49	(e.g., Males Aged 12 to 17)
50-64	
65 or Older	
All Combinations of Groups Listed Above[1]	**Age Group x Hispanic Origin**
Gender	(e.g., Hispanics or Latinos Aged 18 to 25)
Male	
Female	
Hispanic Origin	**Age Group x Race**
Hispanic or Latino	(e.g., White Aged 26 or Older)
Not Hispanic or Latino	
Race	
White	**Age Group x Geographic Region**
Black or African American	(e.g., Persons Aged 12 to 25 in the Northeast)
Geographic Region	
Northeast	
Midwest	**Age Group x Geographic Division**
South	(e.g., Persons Aged 65 or Older in New England)
West	
Geographic Division	
New England	**Gender x Hispanic Origin**
Middle Atlantic	(e.g., Not Hispanic or Latino Males)
East North Central	
West North Central	
South Atlantic	**Hispanic Origin x Race**
East South Central	(e.g., Not Hispanic or Latino Whites)
West South Central	
Mountain	
Pacific	

[1] Combinations of the age groups (including but not limited to 12 or older, 18 or older, 26 or older, 35 or older, and 50 or older) also were forced to match their respective U.S. Census Bureau population estimates through the weight calibration process.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005.

Table B.2 Summary of 2005 NSDUH Suppression Rules

Estimate	Suppress if:
Prevalence Rate, $\hat{p}$, with Nominal Sample Size, *n*, and Design Effect, *deff*	(1) The estimated prevalence rate, $\hat{p}$, is < 0.00005 or ≥ 0.99995, or (2) $\frac{\text{SE}(\hat{p}) \ / \ \hat{p}}{-\ln(\hat{p})} > 0.175$ when $\hat{p} \le 0.5$, or $\frac{\text{SE}(\hat{p}) \ / \ (1 - \hat{p})}{-\ln(1 - \hat{p})} > 0.175$ when $\hat{p} > 0.5$, or (3) Effective $n < 68$, where Effective $n = \frac{n}{deff}$ or (4) $n < 100$. Note: The rounding portion of this suppression rule for prevalence rates will produce some estimates that round at one decimal place to 0.0 or 100.0 percent but are not suppressed from the tables.
Estimated Number (Numerator of $\hat{p}$)	The estimated prevalence rate, $\hat{p}$, is suppressed. Note: In some instances when $\hat{p}$ is not suppressed, the estimated number may appear as a 0 in the tables. This means that the estimate is greater than 0 but less than 500 (estimated numbers are shown in thousands).
Mean Age at First Use, $\bar{x}$, with Nominal Sample Size, *n*	(1) $\text{RSE}(\bar{x}) > 0.5$, or (2) $n < 10$.
Number of Initiates, $\hat{t}$	(1) The number of initiates, $\hat{t}$, rounds to < 1,000 initiates, or (2) $\text{RSE}(\hat{t}) > 0.5$.

SE = standard error; RSE = relative standard error; deff = design effect.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005.

Table B.3 Weighted Percentages and Sample Sizes for 2004 and 2005 NSDUHs, by Screening Result Code

SCREENING RESULT CODE	SAMPLE SIZE		WEIGHTED PERCENTAGE	
	2004	2005	2004	2005
TOTAL SAMPLE	169,514	175,958	100.00	100.00
Ineligible Cases	26,902	29,046	15.76	16.59
Eligible Cases	142,612	146,912	84.24	83.41
INELIGIBLES	26,902	29,046	15.76	16.59
Vacant	15,204	16,377	56.24	55.56
Not a Primary Residence	4,122	5,310	15.54	18.89
Not a Dwelling Unit	2,062	1,979	7.51	6.57
All Military Personnel	282	251	1.07	0.85
Other, Ineligible	5,232	5,129	19.65	18.12
ELIGIBLE CASES	142,612	146,912	84.24	83.41
Screening Complete	130,130	134,055	90.92	91.33
No One Selected	73,732	76,670	50.86	51.39
One Selected	30,499	30,633	21.53	21.13
Two Selected	25,899	26,752	18.53	18.82
Screening Not Complete	12,482	12,587	9.08	8.67
No One Home	2,207	1,992	1.55	1.27
Respondent Unavailable	259	247	0.18	0.16
Physically or Mentally Incompetent	265	324	0.17	0.20
Language Barrier—Hispanic	51	43	0.04	0.04
Language Barrier—Other	391	317	0.32	0.23
Refusal	8,588	9,197	6.10	6.30
Other, Access Denied	660	699	0.67	0.45
Other, Eligible	10	7	0.01	0.00
Segment Not Accessible	0	0	0.00	0.00
Screener Not Returned	15	17	0.01	0.01
Fraudulent Case	14	10	0.02	0.00
Electronic Screening Problem	22	4	0.02	0.00

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table B.4 Weighted Percentages and Sample Sizes for 2004 and 2005 NSDUHs, by Final Interview Code

FINAL INTERVIEW CODE	PERSONS AGED 12 OR OLDER				PERSONS AGED 12 TO 17				PERSONS AGED 18 OR OLDER			
	Sample Size		Weighted Percentage		Sample Size		Weighted Percentage		Sample Size		Weighted Percentage	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	81,973	83,805	100.00	100.00	25,141	25,840	100.00	100.00	56,832	57,965	100.00	100.00
Interview Complete	67,760	68,308	77.00	76.19	22,309	22,565	88.56	87.10	45,451	45,743	75.66	74.91
No One at Dwelling Unit	1,156	1,306	1.50	1.65	147	206	0.54	0.76	1,009	1,100	1.61	1.75
Respondent Unavailable	1,762	1,782	2.40	2.10	302	332	1.28	1.31	1,460	1,450	2.53	2.20
Break-Off	46	38	0.10	0.06	7	9	0.03	0.04	39	29	0.10	0.07
Physically/Mentally Incompetent	699	827	1.71	1.97	143	165	0.57	0.63	556	662	1.84	2.12
Language Barrier - Hispanic	131	144	0.14	0.15	12	10	0.04	0.03	119	134	0.15	0.17
Language Barrier - Other	398	383	1.23	1.14	27	26	0.09	0.15	371	357	1.37	1.26
Refusal	7,871	8,632	14.52	15.30	583	700	2.17	2.75	7,288	7,932	15.96	16.76
Parental Refusal	1,491	1,737	0.65	0.71	1,491	1,737	6.24	6.80	0	0	0.00	0.00
Other	659	648	0.74	0.72	120	90	0.49	0.44	539	558	0.77	0.76

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table B.5 Response Rates and Sample Sizes for 2004 and 2005 NSDUHs, by Demographic Characteristics

	SELECTED PERSONS		COMPLETED INTERVIEWS		WEIGHTED RESPONSE RATE	
	2004	2005	2004	2005	2004	2005
TOTAL	81,973	83,805	67,760	68,308	77.00%	76.19%
AGE IN YEARS						
12-17	25,141	25,840	22,309	22,565	88.56%	87.10%
18-25	27,408	27,337	23,075	22,764	83.87%	83.06%
26 or Older	29,424	30,628	22,376	22,979	74.22%	73.50%
GENDER						
Male	40,194	41,054	32,697	32,787	75.44%	74.45%
Female	41,779	42,751	35,063	35,521	78.46%	77.80%
RACE/ETHNICITY						
Hispanic	11,020	11,582	9,218	9,535	79.06%	77.80%
White	55,544	56,838	45,557	45,962	76.71%	75.64%
Black	9,562	9,453	8,268	8,093	81.85%	81.21%
All Other Races	5,847	5,932	4,717	4,718	67.21%	69.70%
REGION						
Northeast	16,674	16,994	13,523	13,711	75.14%	73.66%
Midwest	22,920	23,542	18,889	19,154	77.63%	76.42%
South	24,820	25,411	20,807	20,818	78.65%	77.16%
West	17,559	17,858	14,541	14,625	75.38%	76.42%
COUNTY TYPE						
Large Metropolitan	37,103	37,712	30,077	29,960	75.72%	74.42%
Small Metropolitan	27,404	28,263	22,972	23,418	78.12%	77.69%
Nonmetropolitan	17,466	17,830	14,711	14,930	79.23%	79.19%

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table B.6 Nonmedical Use of Methamphetamine, Stimulants, and Psychotherapeutics in Lifetime, Past Year, and Past Month and Illicit Drug Use in Lifetime, Past Year, and Past Month, by Age Group: Percentages, 2005 Core Data Only and 2005 Core & Noncore Data

Time Period/Age Group	NONMEDICAL USE OF METHAMPHETAMINE		NONMEDICAL USE OF STIMULANTS		NONMEDICAL USE OF PSYCHOTHERAPEUTICS[1]		ILLICIT DRUGS[2]	
	Core Data[3]	Core & Noncore Data[4]	Core Data[3]	Core & Noncore Data[4]	Core Data[3]	Core & Noncore Data[4]	Core Data[3]	Core & Noncore Data[4]
LIFETIME	4.258[b]	6.392	7.845[b]	9.607	20.027[b]	20.823	46.084[b]	46.114
AGE								
12-17	1.168[b]	1.981	3.374[b]	3.988	11.887[b]	12.197	27.693[a]	27.724
18-25	5.177[b]	8.385	11.071[b]	13.601	30.345[b]	31.276	59.171	59.211
26 or Older	4.520[b]	6.646	7.891[b]	9.676	19.332[b]	20.171	46.306[a]	46.333
PAST YEAR	0.533[b]	0.820	1.139[b]	1.413	6.238[b]	6.396	14.407[b]	14.442
AGE								
12-17	0.670[b]	1.059	1.983[b]	2.255	8.302[b]	8.414	19.883	19.880
18-25	1.484[b]	2.267	3.563[b]	4.266	15.044[b]	15.334	34.220[a]	34.273
26 or Older	0.348[b]	0.533	0.599[b]	0.798	4.413[b]	4.553	10.186[a]	10.223
PAST MONTH	0.210[b]	0.313	0.439[b]	0.537	2.633[b]	2.711	8.108[b]	8.123
AGE								
12-17	0.261[b]	0.398	0.675[a]	0.761	3.308[a]	3.370	9.903	9.909
18-25	0.596[b]	0.827	1.338[b]	1.556	6.263[b]	6.374	20.141[a]	20.179
26 or Older	0.136[b]	0.212	0.249[b]	0.328	1.905[b]	1.979	5.754	5.766

*Low precision; no estimate reported.

NOTE: These estimates are based on different methods (i.e., core vs. core & noncore data) of assessing the same measures from the same respondents from the 2005 NSDUH. Due to the high within-subject correlation between these estimates and the large sample size, even a small difference between estimates may be statistically significant.

[a] Difference between core estimate and core & noncore estimate is statistically significant at the 0.05 level.

[b] Difference between core estimate and core & noncore estimate is statistically significant at the 0.01 level.

[1] Nonmedical Use of Psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

[2] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[3] Estimates were created by using only core data and are thus directly comparable with the 2004 estimates.

[4] Estimates were created by incorporating core data, preexisting data, and new noncore data from the Special Drugs module.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005.

Table B.7 Results from New Consistency Questions (Added in 2006) among Respondents Who Initially Reported No Methamphetamine Use in Core and Subsequently Reported Methamphetamine Use on Noncore Questions (First Added in 2005): Percentages, Quarter 1 of 2006 Raw Data

Time Period/Age Group	DID NOT USE METHAMPHETAMINE	USED METHAMPHETAMINE	
		Did Not Report Use in Core Because Did Not Think Methamphetamine Was a Prescription Drug	Did Not Report Use in Core for Some Other Reason [1]
LIFETIME	23.9	48.5	27.6
AGE			
12-17	26.9	50.0	23.1
18-25	28.7	44.5	26.8
26 or Older	17.9	52.9	29.3
PAST YEAR	25.3	46.7	28.0
AGE			
12-17	28.6	42.9	28.6
18-25	30.2	44.2	25.6
26 or Older	11.1	55.6	33.3
PAST MONTH	29.4	52.9	17.6
AGE			
12-17	50.0	25.0	25.0
18-25	30.0	50.0	20.0
26 or Older	0.0	100.0	0.0

NOTE: Respondents were asked the new consistency question added in 2006 only if they reported having used methamphetamine in the noncore special drugs questions (first added in 2005) after having initially reported no methamphetamine use in the core stimulants module. The population in this table reflects the population as shown in the difference between the core & noncore and core methamphetamine estimates found in Table B.6. For example, based on raw data from quarter 1 of 2006, 330 respondents reported lifetime use of methamphetamine in the noncore questions (SD17a) after having reported no use in the core. The new consistency question (SD17a1) captured 77 respondents who confirmed that they had never used methamphetamine (SD17a1), 251 respondents who reported lifetime methamphetamine use, and 2 respondents who did not provide further information (don't know/refused).

[1] Other reasons include responses of "made a mistake when answered the earlier question about ever using methamphetamine" and "some other reason."

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, Quarter 1 of 2006.

Appendix C: Key Definitions, 2005

This appendix provides definitions for many of the measures and terms used in this report on the 2005 National Survey on Drug Use and Health (NSDUH). Where relevant, cross-references also are provided. For some key terms, specific question wording, including "feeder questions" that precede the question(s), is provided for clarity.

Abuse

A respondent was defined with abuse of a substance if he or she met one or more of the four criteria for abuse included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994) and did not meet the definition for dependence for that substance. Additional criteria for alcohol and marijuana abuse are that if respondents reported a specific number of days that they used these drugs in the past 12 months, they must have used these drugs on 6 or more days in that period. These questions have been included in the survey since 2000. See Section B.4.3 of Appendix B for additional details.

SEE: "Need for Illicit Drug or Alcohol Use Treatment" and "Prevalence."

Adult Education

SEE: "Education."

Age

Age of the respondent was defined as "age at time of interview." The interview program calculated the respondent's age from the date of birth and interview date. The interview program prompts the interviewer to confirm the respondent's age after it has been calculated.

Alcohol Use

Measures of use of alcohol in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last drank an alcoholic beverage?"

Feeder question: "The next questions are about alcoholic beverages, such as, beer, wine, brandy, and mixed drinks. Listed on the next screen are examples of the types of beverages we are interested in. Please review this list carefully before you answer these questions. These questions are about drinks of alcoholic beverages. Throughout these questions, by a 'drink,' we mean a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. We are not asking about times when you only had a sip or two from a drink. Have you ever, even once, had a drink of any type of alcoholic beverage? Please do not include times when you only had a sip or two from a drink."

SEE: "Binge Use of Alcohol," "Current Use," "Heavy Use of Alcohol," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Alternative Treatment/Support for Mental Health Problems

For adults, alternative treatment/support for mental health problems was defined as treatment, counseling, or support for any problem with emotions, nerves, or mental health in the 12 months prior to the interview from any of the following sources: acupuncturist or acupressurist; chiropractor; herbalist; in-person support group or self-help group; Internet support group or chat room; spiritual or religious advisor, such as a pastor, priest, or rabbi; telephone hotline; massage therapist; or other sources of alternative treatment specified by respondents. Treatment/support for only a substance abuse problem was not included.

SEE: "Prevalence," "Self-Help Group," "Treatment for Mental Health Problems," and "Unmet Need for Treatment for Mental Health Problems."

American Indian or Alaska Native

American Indian or Alaska Native only, not of Hispanic, Latino, or Spanish origin (including North American, Central American, or South American Indian); does not include respondents reporting two or more races. (Respondents reporting that they were American Indians or Alaska Natives and of Hispanic, Latino, or Spanish origin were classified as Hispanic.)

SEE: "Hispanic" and "Race/Ethnicity."

Asian

Asian only, not of Hispanic, Latino, or Spanish origin; does not include respondents reporting two or more races. (Respondents reporting that they were Asian and of Hispanic, Latino, or Spanish origin were classified as Hispanic.) Specific Asian groups that were asked about were Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and "Other Asian."

SEE: "Hispanic" and "Race/Ethnicity."

Baby Boom Cohort

The baby boom cohort refers to persons born in the United States after World War II between 1946 and 1964 (Light, 1988).

SEE: "Age."

Binge Use of Alcohol

Binge use of alcohol was defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Feeder question: "How long has it been since you last drank an alcoholic beverage?"

SEE: "Alcohol Use" and "Heavy Use of Alcohol."

Black

Black/African American only, not of Hispanic, Latino, or Spanish origin; does not include respondents reporting two or more races. (Respondents reporting that they were black or African American and of Hispanic, Latino, or Spanish origin were classified as Hispanic.)

SEE: "Hispanic" and "Race/Ethnicity."

Blunts

Blunts were defined as cigars with marijuana in them. Measures of use of blunts in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last smoked part or all of a cigar with marijuana in it?"

Feeder question: "Sometimes people take tobacco out of a cigar and replace it with marijuana. This is sometimes called a 'blunt.' Have you ever smoked part or all of a cigar with marijuana in it?"

SEE: "Cigar Use," "Current Use," "Lifetime Use," "Marijuana Use," "Past Month Use," "Past Year Use," "Prevalence," "Recency of Use," and "Tobacco Product Use."

Cash Assistance

Cash assistance was defined as receipt of direct monetary payments due to low income, such as Temporary Assistance for Needy Families (TANF), welfare, or other public assistance.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Welfare Assistance."

Cigar Use

Measures of use of cigars (including cigarillos and little cigars) in the respondent's lifetime, the past year, and the past month were

developed from responses to the questions about cigar use in the past 30 days and the recency of use (if not in the past 30 days): "Now think about the past 30 days—that is, from [DATEFILL] up to and including today. During the past 30 days, have you smoked part or all of any type of cigar?" and "How long has it been since you last smoked part or all of any type of cigar?" Responses to questions about use of cigars with marijuana in them (blunts) were not included in these measures.

Feeder question: "The next questions are about smoking cigars. By cigars we mean any kind, including big cigars, cigarillos, and even little cigars that look like cigarettes. Have you ever smoked part or all of any type of cigar?"

SEE: "Blunts," "Cigarette Use," "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Recency of Use," "Smokeless Tobacco Use," and "Tobacco Product Use."

Cigarette Use

Measures of use of cigarettes in the respondent's lifetime, the past year, and the past month were developed from responses to the questions about cigarette use in the past 30 days and the recency of use (if not in the past 30 days): "Now think about the past 30 days—that is, from [DATEFILL] up to and including today. During the past 30 days, have you smoked part or all of a cigarette?" and "How long has it been since you last smoked part or all of a cigarette?"

Feeder question: "These questions are about your use of tobacco products. This includes cigarettes, chewing tobacco, snuff, cigars, and pipe tobacco. The first questions are about cigarettes only. Have you ever smoked part or all of a cigarette?"

SEE: "Cigar Use," "Current Use," "Lifetime Daily Cigarette Use," "Lifetime Use," "Nicotine (Cigarette) Dependence," "Past Month Daily Cigarette Use," "Past Month Use," "Past Year Use," "Prevalence," "Recency of Use," "Smokeless Tobacco Use," and "Tobacco Product Use."

Cocaine Use

Measures of use of cocaine in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any form of cocaine?"

question about recency of use: "How long has it been since you last used any form of cocaine?"

Feeder question: "These questions are about cocaine, including all the different forms of cocaine such as powder, crack, free base, and coca paste. Have you ever, even once, used any form of cocaine?"

SEE: "Crack Use," "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

College Enrollment Status

Respondents aged 18 to 22 were classified as full-time undergraduate students or as some other status (including part-time students, students in other grades, or nonstudents). Respondents were classified as full-time students if they reported that they were attending (or will be attending) their first through fourth year of college or university and that they were (or will be) a full-time student. Respondents whose current enrollment status was unknown were excluded from the analysis.

County Type

Counties were grouped based on the "Rural/Urban Continuum Codes" developed by the U.S. Department of Agriculture (2003). Each county is in either a metropolitan statistical area (MSA) or outside of an MSA (also see Butler & Beale, 1994). Large metropolitan areas have a population of 1 million or more. Small metropolitan areas have a population fewer than 1 million. Nonmetropolitan areas are outside of MSAs and include urbanized counties with a population of 20,000 or more in urbanized areas, less urbanized counties with a population of at least 2,500 but fewer than 20,000 in urbanized areas, and completely rural counties with a population of fewer than 2,500 in urbanized areas. Estimates based on county-type information presented in this report use the 2003 revised definition of an MSA; estimates for 2002 in this report therefore are not directly comparable with those presented in the 2002 NSDUH report.

Crack Use

Measures of use of crack cocaine in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used *crack*?"

Feeder questions: "These questions are about cocaine, including all the different forms of cocaine such as powder, *crack*, free base, and coca paste. Have you ever, even once, used any form of cocaine?"

"The next questions are about *crack*, that is cocaine in rock or chunk form, and not the other forms of cocaine. Have you ever, even once, used *crack*?"

SEE: "Cocaine Use," "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Current Use

Any reported use of a specific drug in the past 30 days.

SEE: "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Delinquent Behavior

Youths aged 12 to 17 were asked a series of six questions: "During the past 12 months, how many times have you . . . stolen or tried to steal anything worth more than $50?" "sold illegal drugs?" "attacked someone with the intent to seriously hurt them?" "gotten into a serious fight at school or work?" "taken part in a fight where a group of your friends fought against another group?" and "carried a handgun?"

SEE: "Gang Fighting," "Prevalence," and "Stealing."

Dependence

A respondent was defined with dependence on illicit drugs or alcohol if he or she met three out of seven dependence criteria (for substances that included questions to measure a withdrawal criterion) or three out of six criteria (for substances that did not include withdrawal questions) for that substance, based on criteria included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (APA, 1994). Additional criteria for alcohol and marijuana dependence since 2000 are that if respondents reported a specific number of days that they used these drugs in the past 12 months, they must have used these drugs on 6 or more days in that period. This definition did not apply to Nicotine (Cigarette) Dependence. See Section B.4.3 of Appendix B for additional details.

SEE: "Need for Alcohol Use Treatment," "Need for Illicit Drug or Alcohol Use Treatment," "Need for Illicit Drug Use Treatment," "Nicotine (Cigarette) Dependence," and "Prevalence."

Depression

SEE: "Major Depressive Episode."

Driving Under the Influence

Respondents were asked whether in the past 12 months they had driven a vehicle while under the influence of alcohol and illegal drugs used together, alcohol only, or illegal drugs only.

SEE: "Prevalence."

Ecstasy Use

Measures of use of Ecstasy or MDMA (methylenedioxy-methamphetamine) in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used *Ecstasy*, also known as MDMA?"

SEE: "Current Use," "Hallucinogen Use," "Lifetime Use," "LSD Use," "Past Month Use," "Past Year Use," "PCP Use," "Prevalence," and "Recency of Use."

Education

This is the measure of educational attainment among respondents who are aged 18 or older. It is based on respondents' reports of their highest grade or year of school that they completed. Response alternatives were presented in terms of single years of education, ranging from 0 if respondents never attended school to 17 if respondents completed 5 or more years at the college or university level. Respondents were classified into four categories based on their answers: less than high school, high school graduate, some college, and college graduate. Persons who completed postgraduate work were classified as college graduates.

Employment

Respondents were asked to report whether they worked in the week prior to the interview, and if not, whether they had a job despite not working in the past week. Respondents who worked in the past week or who reported having a job despite not working were asked whether they usually work 35 or more hours per week. Respondents who did not work in the past week but had a job were asked to look at a card that described why they did not work in the past week despite having a job. Respondents who did not have a job in the past week were asked to look at a different card that described why they did not have a job in the past week.

Full-time "Full-time" in the tables includes respondents who usually work 35 or more hours per week and who worked in the past week or had a job despite not working in the past week.

Part-time "Part-time" in the tables includes respondents who usually work fewer than 35 hours per week and who

worked in the past week or had a job despite not working in the past week.

Unemployed "Unemployed" in the tables refers to respondents who did not have a job, were on layoff, and were looking for work. For consistency with the Current Population Survey definition of unemployment, respondents who reported that they did not have a job but were looking for work needed to report making specific efforts to find work in the past 30 days, such as sending out resumes or applications, placing ads, or answering ads.

Other "Other" includes all other responses, including being a student, someone who is keeping house or caring for children full time, retired, disabled, or other miscellaneous work statuses. Respondents who reported that they did not have a job, were on layoff, and were not looking for work were classified as not being in the labor force. Similarly, respondents who reported not having a job and looking for work also were classified as not being in the labor force if they did not report making specific efforts to find work in the past 30 days.

Ethnicity SEE: "Race/Ethnicity."

Ever Use SEE: "Lifetime Use."

Exposure to Drug Education and Prevention

Youths aged 12 to 17 were asked: "Please indicate if you have had any of these alcohol or drug education classes or experiences in school during the past 12 months . . .
Have you had a special class about drugs or alcohol in school?
Have you had films, lectures, discussions, or printed information about drugs or alcohol in one of your regular classes, such as health or physical education?
Have you had films, lectures, discussions, or printed information about drugs or alcohol outside of one of your regular classes, such as in a special assembly?"

(Youths who reported that they were home schooled in the past 12 months also were asked these questions. Youths who reported that they were home schooled were instructed to think about their home schooling as "school.")

Youths also were asked: "During the past 12 months, have you seen or heard any alcohol or drug prevention messages from sources outside school, such as in posters, pamphlets, and radio or TV ads?"

Family Income

Family income was ascertained by asking respondents: "Of these income groups, which category best represents (your/SAMPLE MEMBER's) total combined family income during [the previous calendar year]? (Income data are important in analyzing the health information we collect. For example, the information helps us to learn whether persons in one income group use certain types of medical care services or have conditions more or less often than those in another group.)"

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

Food Stamps

Food stamps are government-issued coupons that can be used to purchase food. Instead of coupons, some States issue a special card that can be used like a credit card to purchase food in grocery stores.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Welfare Assistance."

Gang Fighting

Youths aged 12 to 17 were asked how many times during the past 12 months they had taken part in a fight where a group of their friends fought against another group. Response alternatives were (1) 0 times, (2) 1 or 2 times, (3) 3 to 5 times, (4) 6 to 9 times, or (5) 10 or more times.

SEE: "Delinquent Behavior" and "Stealing."

Geographic Division

Data are presented for nine geographic divisions within the four geographic regions. Within the ***Northeast Region*** are the *New England Division* (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont) and the *Middle Atlantic*

Division (New Jersey, New York, Pennsylvania). Within the ***Midwest Region*** are the *East North Central Division* (Illinois, Indiana, Michigan, Ohio, Wisconsin) and the *West North Central Division* (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota). Within the ***South Region*** are the *South Atlantic Division* (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia), the *East South Central Division* (Alabama, Kentucky, Mississippi, Tennessee), and the *West South Central Division* (Arkansas, Louisiana, Oklahoma, Texas). Within the ***West Region*** are the *Mountain Division* (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming) and the *Pacific Division* (Alaska, California, Hawaii, Oregon, Washington).

SEE: "Region."

Hallucinogen Use

Measures of use of hallucinogens in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any hallucinogen?"

Feeder questions: "The next questions are about substances called hallucinogens. These drugs often cause people to see or experience things that are not real... Have you ever, even once, used LSD, also called *acid*? Have you ever, even once, used PCP, also called *angel dus*t or phencyclidine? Have you ever, even once, used peyote? Have you ever, even once, used mescaline? Have you ever, even once, used psilocybin, found in mushrooms? Have you ever, even once, used *Ecstasy*, also known as MDMA? Have you ever, even once used any other hallucinogen besides the ones that have been listed?"

SEE: "Current Use," "Ecstasy Use," "Lifetime Use," "LSD Use," "Past Month Use," "Past Year Use," "PCP Use," "Prevalence," and "Recency of Use."

Health Insurance Status

A series of questions was asked to identify whether respondents currently were covered by Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), military health care (such as TRICARE or CHAMPUS), private health insurance, or any kind of health insurance (if respondents reported not being covered by any of the above). If respondents did not currently have health insurance coverage, questions were asked to determine the length of time they were without coverage and the reasons for not being covered.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Medicaid" and "Medicare."

Heavy Use of Alcohol

Heavy use of alcohol was defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on 5 or more days in the past 30 days. Heavy alcohol users also were defined as binge users of alcohol.

Feeder question: "How long has it been since you last drank an alcoholic beverage?"

SEE: "Alcohol Use" and "Binge Use of Alcohol."

Heroin Use

Measures of use of heroin in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used heroin?"

Feeder question: "These next questions are about heroin. Have you ever, even once, used heroin?"

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Hispanic

Hispanic was defined as anyone of Hispanic, Latino, or Spanish origin. Respondents were classified as Hispanic in the race/ethnicity measure regardless of race.

SEE: "American Indian or Alaska Native," "Asian," "Black," "Race/Ethnicity," "Two or More Races," and "White."

Illicit Drugs

Illicit drugs include marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including phencyclidine [PCP], lysergic acid diethylamide [LSD], and Ecstasy [MDMA]), heroin, or prescription-type psychotherapeutics used nonmedically, which include stimulants, sedatives, tranquilizers, and pain relievers. Illicit drug use refers to use of any of these drugs.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Psychotherapeutic Drugs," and "Recency of Use."

Illicit Drugs Other Than Marijuana

These drugs include cocaine (including crack), inhalants, hallucinogens (including phencyclidine [PCP], lysergic acid diethylamide [LSD], and Ecstasy [MDMA]), heroin, or prescription-type psychotherapeutics used nonmedically, which include stimulants, sedatives, tranquilizers, and pain relievers. This measure includes marijuana users who used any of the above drugs in addition to using marijuana, as well as users of those drugs who have not used marijuana.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Psychotherapeutic Drugs," and "Recency of Use."

Incidence

Substance use incidence refers to the use of a substance for the first time (new use). Incidence estimates are based on questions about age at first use of substances, year and month of first use for recent initiates, the respondent's date of birth, and the interview date.

Incidence statistics in this report reflect first use occurring within the 12 months prior to the interview. This is referred to as past year incidence. For these statistics, respondents who are immigrants are included regardless of whether their first use occurred inside or outside the United States.

See Section B.4.1 in Appendix B for additional details.

Income

SEE: "Family Income."

Inhalant Use

Measures of use of inhalants in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any inhalant for kicks or to get high?"

Feeder questions: "These next questions are about liquids, sprays, and gases that people sniff or inhale to get high or to make them feel good... Have you ever, even once, inhaled [INHALANT NAME] for kicks or to get high?" Respondents were asked about the following inhalants: (a) amyl nitrite, "poppers," locker room odorizers, or "rush"; (b) correction fluid, degreaser, or cleaning fluid; (c) gasoline or lighter fluid; (d) glue, shoe polish, or toluene; (e) halothane, ether, or other anesthetics; (f) lacquer thinner or

other paint solvents; (g) lighter gases, such as butane or propane; (h) nitrous oxide or whippets; (i) spray paints; (j) some other aerosol spray; and (k) any other inhalants besides the ones that have been listed.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Large Metro

SEE: "County Type."

Lifetime Daily Cigarette Use

A respondent was defined as having lifetime daily cigarette use if he or she ever smoked part or all of a cigarette every day for at least 30 days.

SEE: "Cigarette Use" and "Past Month Daily Cigarette Use."

Lifetime Use

Lifetime use indicates use of a specific drug at least once in the respondent's lifetime. This measure includes respondents who also reported last using the drug in the past 30 days or past 12 months.

SEE: "Current Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Low Precision

Prevalence estimates based on only a few respondents or with relatively large standard errors were not shown in the tables, but have been replaced with an asterisk (*) and noted as "low precision." These estimates have been omitted because one cannot place a high degree of confidence in their accuracy. See Table B.1 in Appendix B for a complete list of the rules used to determine low precision.

LSD Use

Measures of use of lysergic acid diethylamide (LSD) in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used LSD?"

SEE: "Current Use," "Ecstasy Use," "Hallucinogen Use," "Lifetime Use," "Past Month Use," "Past Year Use," "PCP Use," "Prevalence," and "Recency of Use."

Major Depressive Episode

A person was defined as having had a lifetime major depressive episode (MDE) if he or she had at least five or more of the following nine symptoms in the same 2-week period in the lifetime, in which at least one of the symptoms was a depressed

mood or loss of interest or pleasure in daily activities: (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death or recurrent suicide ideation. This definition is based on the definition found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (APA, 1994). A person was defined as having an MDE in the past year if he or she had a lifetime MDE and a period of time in the past 12 months when he or she felt depressed or lost interest or pleasure in daily activities for 2 weeks or longer, while also having some of the other symptoms defined above for a lifetime MDE. See Section B.4.5 of Appendix B for additional details.

Marijuana Use

Measures of use of marijuana in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used marijuana or hashish?" Responses to questions about use of cigars with marijuana in them (blunts) were not included in these measures.

Feeder question: "The next questions are about marijuana and hashish. Marijuana is also called pot or grass. Marijuana is usually smoked—either in cigarettes called joints, or in a pipe. It is sometimes cooked in food. Hashish is a form of marijuana that is also called *hash*. It is usually smoked in a pipe. Another form of hashish is hash oil. Have you ever, even once, used marijuana or hash?"

SEE: "Blunts," "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Prior Year Marijuana Use," and "Recency of Use."

Medicaid

Medicaid is a public assistance program that pays for medical care for low-income and disabled persons. Respondents were given the name of the Medicaid program in the State where they lived. Respondents aged 12 to 19 who reported that they were covered by the State Children's Health Insurance Program (SCHIP) in their State also were classified as being covered by Medicaid. Respondents aged 12 to 19 were given the name of the SCHIP

program in their State. Respondents aged 65 or older who reported that they were covered by Medicaid were asked to verify that their answer was correct.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Health Insurance Status" and "Medicare."

Medicare

Medicare is a health insurance program for persons aged 65 or older and for certain disabled persons. Respondents under the age of 65 who reported that they were covered by Medicare were asked to verify that their answer was correct.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Health Insurance Status" and "Medicaid."

Mental Health Treatment

SEE: "Treatment for Mental Health Problems."

Methamphetamine Use

Measures of use of methamphetamine (also known as crank, crystal, ice, or speed), Desoxyn®, or Methedrine® in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used methamphetamine, Desoxyn, or Methedrine?" See Section B.4.6 of Appendix B for additional details.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Recency of Use," "Source of Psychotherapeutic Drugs," and "Stimulant Use."

Midwest Region

The States included are those in the East North Central Division—Illinois, Indiana, Michigan, Ohio, and Wisconsin—and the West North Central Division—Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

SEE: "Geographic Division" and "Region."

Native Hawaiian or Other Pacific Islander

Native Hawaiian or Other Pacific Islander, not of Hispanic, Latino, or Spanish origin; does not include respondents reporting two or more races. (Respondents reporting that they were Native Hawaiian or Other Pacific Islander and of Hispanic, Latino, or Spanish origin were classified as Hispanic.)

SEE: "Hispanic" and "Race/Ethnicity."

Need for Alcohol Use Treatment

Respondents were classified as needing treatment for an alcohol use problem if they met at least one of three criteria during the past year: (1) dependence on alcohol; (2) abuse of alcohol; or (3) received treatment for an alcohol use problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

SEE: "Abuse," "Dependence," "Prevalence," "Specialty Substance Use Treatment Facility," and "Treatment for a Substance Use Problem."

Need for Illicit Drug or Alcohol Use Treatment

Respondents were classified as needing treatment for an illicit drug or alcohol use problem if they met at least one of three criteria during the past year: (1) dependence on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for an illicit drug or alcohol use problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

SEE: "Abuse," "Dependence," "Prevalence," "Specialty Substance Use Treatment Facility," and "Treatment for a Substance Use Problem."

Need for Illicit Drug Use Treatment

Respondents were classified as needing treatment for an illicit drug use problem if they met at least one of three criteria during the past year: (1) dependence on illicit drugs; (2) abuse of illicit drugs; or (3) received treatment for an illicit drug use problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

SEE: "Abuse," "Dependence," "Prevalence," "Specialty Substance Use Treatment Facility," and "Treatment for a Substance Use Problem."

Nicotine (Cigarette) Dependence

A respondent was defined with nicotine (cigarette) dependence if he or she met either the dependence criteria derived from the Nicotine Dependence Syndrome Scale (NDSS) or the Fagerstrom Test of Nicotine Dependence (FTND). See Section B.4.2 of Appendix B for additional details.

SEE: "Cigarette Use," "Dependence," and "Prevalence."

Noncash Assistance

Noncash assistance refers to assistance due to low income but not in the form of direct monetary payments, such as help getting a job, placement in an education or job training program, or help with transportation, child care, or housing.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Welfare Assistance."

Nonmedical Use of Psychotherapeutics

This section of the interview instrument deals with nonmedical use of four classes of prescription-type psychotherapeutics: pain relievers, sedatives, stimulants, and tranquilizers.

Measures of use of nonmedical psychotherapeutic agents in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any prescription [pain reliever, sedative, stimulant, or tranquilizer] that was not prescribed for you or that you took only for the experience or feeling it caused?"

Feeder question: "Now we have some questions about drugs that people are supposed to take only if they have a prescription from a doctor. We are only interested in your use of a drug if the drug was not prescribed for you, or if you took the drug only for the experience or feeling it caused."

NOTE: The pill card contains pictures and names of specific drugs within each psychotherapeutic category. For example, pictures and the names of Valium®, Librium®,

and other tranquilizers are shown when the section on tranquilizers is introduced.

SEE: "Current Use," "Lifetime Use," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Sedative Use," "Source of Psychotherapeutic Drugs," "Stimulant Use," and "Tranquilizer Use."

Nonmetro

SEE: "County Type."

Northeast Region

The States included are those in the New England Division—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont—and the Middle Atlantic Division—New Jersey, New York, and Pennsylvania.

SEE: "Geographic Division" and "Region."

OxyContin® Use

Measures of use of the prescription pain reliever OxyContin® in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used OxyContin that was not prescribed for you or that you took only for the experience or feeling it caused?" See Section B.5.1 of Appendix B for additional details.

SEE: "Current Use," "Lifetime Use," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Pain Reliever Use

Measures of use of pain relievers in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any prescription pain reliever that was not prescribed for you, or that you took only for the experience or feeling it caused?"

Feeder question: "These questions are about the use of pain relievers. We are not interested in your use of *over-the-counter* pain relievers such as aspirin, Tylenol, or Advil that can be bought in drug stores or grocery stores without a doctor's prescription. Card A shows pictures of some different types of prescription pain relievers and lists the names of some others. These pictures show only pills, but we are interested in your use of any form of prescription pain relievers that were not prescribed for you or that you took only for the experience or feeling they caused."

The following prescription pain relievers were listed on Pill Card A (Pain Relievers): (1) Darvocet®, Darvon®, or Tylenol® with Codeine; (2) Percocet®, Percodan®, or Tylox®; (3) Vicodin®, Lortab®, or Lorcet®/Lorcet Plus®; (4) Codeine; (5) Demerol®; (6) Dilaudid®; (7) Fioricet®; (8) Fiorinal®; (9) Hydrocodone; (10) Methadone; (11) Morphine; (12) OxyContin®; (13) Phenaphen® with Codeine; (14) Propoxyphene; (15) SK-65®; (16) Stadol® (no picture); (17) Talacen®; (18) Talwin®; (19) Talwin NX®; (20) Tramadol (no picture); and (21) Ultram®.

SEE: "Current Use," "Lifetime Use," "Nonmedical Use of Psychotherapeutics," "OxyContin® Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Sedative Use," "Source of Psychotherapeutic Drugs," "Stimulant Use," and "Tranquilizer Use."

Past Month Daily Cigarette Use

A respondent was defined as having past month daily cigarette use if he or she smoked part or all of a cigarette on each of the past 30 days.

SEE: "Cigarette Use" and "Lifetime Daily Cigarette Use."

Past Month Use

This measure indicates use of a specific drug in the 30 days prior to the interview. Respondents who indicated past month use of a specific drug also were classified as lifetime and past year users.

SEE: "Current Use," "Lifetime Use," "Past Year Use," "Prevalence," and "Recency of Use."

Past Year Incidence

SEE: "Incidence."

Past Year Use

This measure indicates use of a specific drug in the 12 months prior to the interview. This definition includes those respondents who last used the drug in the 30 days prior to the interview. Respondents who indicated past year use of a specific drug also were classified as lifetime users.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Prevalence," and "Recency of Use."

PCP Use

Measures of use of phencyclidine (PCP) in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used PCP?"

SEE: "Current Use," "Ecstasy Use," "Hallucinogen Use," "Lifetime Use," "LSD Use," "Past Month Use," "Past Year Use," "Prevalence," and "Recency of Use."

Perceived Availability

Respondents were asked to assess how difficult or easy it would be for them to get various illicit drugs if they wanted these drugs. Response alternatives were (1) probably impossible, (2) very difficult, (3) fairly difficult, (4) fairly easy, and (5) very easy.

Perceived Need for Alcohol Use Treatment

Respondents were classified as perceiving a need for alcohol use treatment if they reported feeling a need for alcohol use treatment when asked, "During the past 12 months, did you need treatment or counseling for your alcohol use?" or if they indicated feeling a need for additional treatment specifically for alcohol use when asked, "During the past 12 months, for which of the following drugs did you need additional treatment or counseling?"

SEE: "Prevalence" and "Treatment for a Substance Use Problem."

Perceived Need for Illicit Drug or Alcohol Use Treatment

Respondents were classified as perceiving a need for illicit drug or alcohol use treatment if they were classified as either perceiving a need for illicit drug use treatment or perceiving a need for alcohol use treatment.

SEE: "Perceived Need for Alcohol Use Treatment" and "Perceived Need for Illicit Drug Use Treatment."

Perceived Need for Illicit Drug Use Treatment

Respondents were classified as perceiving a need for illicit drug use treatment if they reported feeling a need for treatment for the use of one or more drugs when asked specifically about each individual drug, "During the past 12 months, did you need treatment or counseling for your use of (drug)?" They also were classified as perceiving a need for illicit drug use treatment if they indicated feeling a need for additional treatment specifically for the use of one or more drugs when asked, "During the past 12 months, for which of the following drugs did you need additional treatment or counseling?" The response list of drugs included marijuana/hashish, cocaine or crack, heroin, hallucinogens,

inhalants, pain relievers, tranquilizers, stimulants, sedatives, or some other drug.

SEE: "Prevalence" and "Treatment for a Substance Use Problem."

Perceived Risk/ Harmfulness

Respondents were asked to assess the extent to which people risk harming themselves physically and in other ways when they use various illicit drugs, alcohol, and cigarettes, with various levels of frequency. Response alternatives were (1) no risk, (2) slight risk, (3) moderate risk, and (4) great risk.

Percentages

In this report, all of the 2005 tables contain percentages based on weighted data.

SEE: "Rounding."

Pill Cards

The pill cards contain pictures and names of specific drugs within each psychotherapeutic category. For example, pictures and the names of Valium®, Librium®, and other tranquilizers are shown when the questionnaire section on tranquilizers is introduced. Pill cards have been modified over the years to reflect changes in available psychotherapeutic drugs.

SEE: "Current Use," "Lifetime Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Sedative Use," "Stimulant Use," and "Tranquilizer Use."

Prevalence

Prevalence is a general term used to describe the estimates for lifetime, past year, and past month substance use, dependence or abuse, or other behaviors of interest within a given period (e.g., the past 12 months). The latter include delinquent behavior, driving under the influence of alcohol or drugs, perceived need for alcohol or illicit drug use treatment, serious psychological distress, treatment for mental health problems, treatment for a substance use problem, and unmet need for treatment for mental health problems.

SEE: "Abuse," "Alternative Treatment/Support for Mental Health Problems," "Current Use," "Delinquent Behavior," "Dependence," "Driving Under the Influence," "Need for Illicit Drug or Alcohol Use Treatment," "Nicotine (Cigarette) Dependence," "Perceived Need for Alcohol Use Treatment," "Perceived Need for Alcohol or Illicit Drug

Use Treatment," "Perceived Need for Illicit Drug Use Treatment," "Recency of Use," "Serious Psychological Distress," "Treatment for Mental Health Problems," "Treatment for a Substance Use Problem," and "Unmet Need for Treatment for Mental Health Problems."

Prior Year Marijuana Use

A respondent was defined as engaging in prior year marijuana use if he or she used marijuana or hashish 12 to 23 months prior to the interview date.

SEE: "Marijuana Use."

Psychotherapeutic Drugs

Psychotherapeutic drugs are generally prescription medications that also can be used illicitly to "get high" or for other effects. These include pain relievers, sedatives, stimulants, and tranquilizers.

SEE: "Current Use," "Lifetime Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Recency of Use," "Sedative Use," "Source of Psychotherapeutic Drugs," "Stimulant Use," and "Tranquilizer Use."

Race/Ethnicity

Race/ethnicity is used to refer to the respondent's self-classification as to racial and ethnic origin and identification. For Hispanic origin, respondents were asked, "Are you of Hispanic, Latino, or Spanish origin or descent?" For race, respondents were asked, "Which of these groups best describes you?" Response alternatives were (1) white, (2) black/African American, (3) American Indian or Alaska Native, (4) Native Hawaiian, (5) Other Pacific Islander, (6) Asian, and (7) Other. Categories for race/ethnicity included Hispanic; non-Hispanic groups where respondents indicated only one race (white, black, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Asian); and non-Hispanic groups where respondents reported two or more races. These categories are based on classifications developed by the U.S. Census Bureau.

SEE: "American Indian or Alaska Native," "Asian," "Black," "Hispanic," "Native Hawaiian or Other Pacific Islander," "Two or More Races," and "White."

Recency of Use

The recency question for each drug was the source for the lifetime, past year, and past month prevalence estimates.

The question was essentially the same for all classes of drugs. The question was: "How long has it been since you last used [drug name]?" For the four classes of psychotherapeutics, the phrase "that was not prescribed for you or only for the experience or feeling it caused" was added after the name of the drug.

For tobacco products (cigarettes, snuff, chewing tobacco, or cigars), a question first was asked about use in the past 30 days. If the respondent did not use the product in the past 30 days, the recency question was asked as above, with the response alternatives (1) more than 30 days ago but within the past 12 months; (2) more than 12 months ago but within the past 3 years; and (3) more than 3 years ago. For the remaining drugs, the response alternatives were (1) within the past 30 days; (2) more than 30 days ago but within the past 12 months; and (3) more than 12 months ago.

SEE: "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," and "Prevalence."

Region

There were four regions to consider: Northeast, Midwest, South, and West. These regions are based on classifications developed by the U.S. Census Bureau.

SEE: "Geographic Division," "Midwest Region," "Northeast Region," "South Region," and "West Region."

Rounding

The decision rules for the rounding of percentages were as follows. If the second number to the right of the decimal point was greater than or equal to 5, the first number to the right of the decimal point was rounded up to the next higher number. If the second number to the right of the decimal point was less than 5, the first number to the right of the decimal point remained the same. Thus, a prevalence estimate of 16.55 percent would be rounded to 16.6 percent, while an estimate of 16.44 percent would be rounded to 16.4 percent. Although the percentages in the 2005 tables generally total 100 percent, the use of rounding sometimes produces a total of slightly less than or more than 100 percent.

SEE: "Percentages."

Sedative Use

Measures of use of sedatives in the respondent's lifetime, the past year, and the past month were developed from responses to the

question about recency of use: "How long has it been since you last used any prescription sedative that was not prescribed for you, or that you took only for the experience or feeling it caused?"

Feeder question: "These next questions ask about the use of sedatives or barbiturates. These drugs are also called *downers* or *sleeping pills*. People take these drugs to help them relax or to help them sleep. We are not interested in the use of *over-the-counter* sedatives such as Sominex, Unisom, Nytol, or Benadryl that can be bought in drug stores or grocery stores without a doctor's prescription. Card D shows pictures of different kinds of prescription sedatives and lists the names of some others. These pictures show only pills, but we are interested in your use of any form of prescription sedatives that were not prescribed for you or that you took only for the experience or feeling they caused."

The following prescription sedatives were listed on Pill Card D (Sedatives): (1) Methaqualone (includes Sopor®, Quaalude®) (no picture); (2) Nembutal®, Pentobarbital (no picture), Seconal®, Secobarbital (no picture), or Butalbital (no picture); (3) Restoril® or Temazepam; (4) Amytal®; (5) Butisol®; (6) Chloral Hydrate (no picture); (7) Dalmane®; (8) Halcion®; (9) Phenobarbital; (10) Placidyl®; and (11) Tuinal®.

SEE: "Current Use," "Lifetime Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Source of Psychotherapeutic Drugs," "Stimulant Use," and "Tranquilizer Use."

Self-Help Group

Self-help groups were potential locations of treatment for a substance use problem or alternative treatment or support for mental health problems. Respondents who reported that they received treatment for their use of alcohol or drugs in the past 12 months were asked whether they received treatment in a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous; these groups were not considered specialty substance use treatment facilities. Respondents who reported that they received alternative treatment or support for mental health problems in the past 12 months had the option of reporting that they received alternative treatment from an in-person support group or self-help group.

SEE: "Alternative Treatment/Support for Mental Health Problems," "Specialty Substance Use Treatment Facility,"

"Treatment for Mental Health Problems," and "Treatment for a Substance Use Problem."

Serious Psychological Distress

Serious psychological distress (SPD) is defined as having a score of 13 or higher on the K6 scale, which measures symptoms of psychological distress during the 1 month in the past 12 months when respondents were at their worst emotionally. In 2005, all respondents aged 18 or older were administered a short-form version of the SPD module featuring only the six questions pertaining to the K6 scale. In 2004, half of the respondents aged 18 or older were administered a short-form version of the SPD module, while the remaining adults were administered a long-form version of the SPD module. Due to differences in the 2004 SPD prevalence estimates based on the two versions of the module, only estimates from the short-form module are reported in 2004. Because of these changes, 2004 and 2005 estimates presented in this report are not comparable with 2004 and earlier estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B for additional details.

SEE: "Prevalence."

Significance

In tables in which trends are shown, the levels of significance for the changes between the two most recent survey years are noted as follows: 0.05 and 0.01. A significance level of 0.05 is used in comparing two estimates in the text for demographic subgroups of the most recent survey sample.

Small Metro

SEE: "County Type."

Smokeless Tobacco Use

Measures of use of smokeless tobacco in the respondent's lifetime, the past year, and the past month were developed from responses to the questions about snuff and chewing tobacco use in the past 30 days and the recency of use (if not in the past 30 days): "Now think about the past 30 days—that is, from [DATEFILL] up to and including today. During the past 30 days, have you used snuff, even once?" "How long has it been since you last used snuff?" "Now think about the past 30 days—that is, from [DATEFILL] up to and including today. During the past 30 days, have you used chewing tobacco, even once?" and "How long has it been since you last used chewing tobacco?"

Feeder questions: "These next questions are about your use of snuff, sometimes called dip... Have you ever used snuff, even

once?" and "These next questions are only about chewing tobacco... Have you ever used chewing tobacco, even once?"

SEE: "Cigar Use," "Cigarette Use," "Current Use," "Lifetime Use," "Past Month Use," "Past Year Use," "Prevalence," "Recency of Use," and "Tobacco Product Use."

Source of Psychotherapeutic Drugs

Measures of the source of psychotherapeutic drugs (prescription pain relievers, prescription tranquilizers, prescription stimulants, methamphetamine, and prescription sedatives) used nonmedically and how respondents obtained these drugs the last time they used them nonmedically. For all of these drugs except methamphetamine, response options for the source of the medications were as follows: (a) got a prescription from just one doctor; (b) got prescriptions from more than one doctor; (c) wrote a fake prescription; (d) stole from a doctor's office, clinic, hospital, or pharmacy; (e) got from a friend or relative for free; (f) bought from a friend or relative; (g) took from a friend or relative without asking; (h) bought from a drug dealer or other stranger; (i) bought on the Internet; and (j) got in some other way (includes other sources specified by respondents). Methamphetamine users were presented with options (e) through (j) only.

If respondents last used a psychotherapeutic drug nonmedically in the past 30 days and reported getting that drug from only one source, the source of psychotherapeutic drug measure was based on that answer. For respondents who reported getting a psychotherapeutic drug from multiple sources in the past 30 days or who last misused that drug more than 30 days ago but in the past 12 months, the source of psychotherapeutic drug measure was based on their answer to a question about how they got that drug the last time they used it nonmedically.

Feeder questions: "Earlier, the computer recorded that, during the past 30 days, you used [prescription pain relievers, prescription tranquilizers, prescription stimulants, methamphetamine, prescription sedatives] that were not prescribed for you or that you took only for the experience or feeling it caused. How did you get these [fill in relevant drug name from above]? Please enter all the ways that you got the [fill in relevant drug name from above] you used in the past 30 days."

"Now think about the last time you used [a prescription pain reliever, a prescription tranquilizer, a prescription stimulant,

methamphetamine, a prescription sedative] that was not prescribed for you or that you took only for the experience or feeling it caused. How did you get this [fill in relevant drug name from above]?"

SEE: "Methamphetamine Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Psychotherapeutic Drugs," "Sedative Use," "Stimulant Use," and "Tranquilizer Use."

South Region

The States included are those in the South Atlantic Division—Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia; the East South Central Division—Alabama, Kentucky, Mississippi, and Tennessee; and the West South Central Division—Arkansas, Louisiana, Oklahoma, and Texas.

SEE: "Geographic Division" and "Region."

Specialty Substance Use Treatment Facility

Defined as drug or alcohol rehabilitation facilities (inpatient or outpatient), hospitals (inpatient services only), and mental health centers.

SEE: "Need for Illicit Drug or Alcohol Use Treatment," "Self-Help Group," and "Treatment for a Substance Use Problem."

Stealing

Respondents were asked how many times during the past 12 months they had stolen or tried to steal anything worth more than $50. Response alternatives were (1) 0 times, (2) 1 or 2 times, (3) 3 to 5 times, (4) 6 to 9 times, or (5) 10 or more times.

SEE: "Delinquent Behavior" and "Gang Fighting."

Stimulant Use

Measures of use of stimulants in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any prescription stimulant that was not prescribed for you or that you took only for the experience or feeling it caused?"

Feeder question: "These next questions are about the use of drugs such as amphetamines that are known as stimulants, *upper*s, or *speed*. People sometimes take these drugs to lose weight, to stay awake, or for attention deficit disorders. We are not interested in the use of *over-the-counter* stimulants such as Dexatrim or No-Doz

that can be bought in drug stores or grocery stores without a doctor's prescription. Card C shows pictures of some different kinds of prescription stimulants and lists the names of some others. These pictures show only pills, but we are interested in your use of any form of prescription stimulants that were not prescribed for you or that you took only for the experience or feeling it caused."

The following prescription stimulants were listed on Pill Card C (Stimulants): (1) Methamphetamine (crank, crystal, ice, or speed) (no picture), Desoxyn®, or Methedrine® (no picture); (2) Amphetamines (no picture), Benzedrine®, Biphetamine®, Fastin®, or Phentermine; (3) Ritalin® or Methylphenidate; (4) Cylert®; (5) Dexedrine®; (6) Dextroamphetamine (no picture); (7) Didrex®; (8) Eskatrol®; (9) Ionamin®; (10); Mazanor®; (11) Obedrin-LA® (no picture); (12) Plegine®; (13) Preludin®; (14) Sanorex®; and (15) Tenuate®.

SEE: "Current Use," "Lifetime Use," "Methamphetamine Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Sedative Use," "Source of Psychotherapeutic Drugs," and "Tranquilizer Use."

Substance Use Treatment

SEE: "Treatment for a Substance Use Problem."

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a governmental program that makes assistance payments to low-income, aged, blind, and disabled persons.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Welfare Assistance."

Tobacco Product Use

This measure indicates use of any tobacco product: cigarettes, chewing tobacco, snuff, cigars, and pipe tobacco. Tobacco product use in the past year includes past month pipe tobacco use. Tobacco product use in the past year does not include use of pipe tobacco more than 30 days ago but within 12 months of the interview because the survey did not capture this information. Measures of

tobacco product use in the respondent's lifetime, the past year, or the past month also do not include use of cigars with marijuana in them (blunts).

SEE: "Blunts," "Cigar Use," "Cigarette Use," and "Smokeless Tobacco Use."

Total Family Income

SEE: "Family Income."

Tranquilizer Use

Measures of use of tranquilizers in the respondent's lifetime, the past year, and the past month were developed from responses to the question about recency of use: "How long has it been since you last used any prescription tranquilizer that was not prescribed for you, or that you took only for the experience or feeling it caused?"

Feeder question: "These next questions ask about the use of tranquilizers. Tranquilizers are usually prescribed to relax people, to calm people down, to relieve anxiety, or to relax muscle spasms. Some people call tranquilizers *nerve pills*. Card B shows pictures of some different kinds of prescription tranquilizers. These pictures show only pills, but we are interested in your use of any form of prescription tranquilizers that were not prescribed for you, or that you took only for the experience or feeling they caused."

The following prescription tranquilizers were listed on Pill Card B (Tranquilizers): (1) Klonopin® or Clonazepam; (2) Xanax®, Alprazolam, Ativan®, or Lorazepam; (3) Valium® or Diazepam; (4) Atarax®; (5) BuSpar®; (6) Equanil®; (7) Flexeril®; (8) Librium®; (9) Limbitrol®; (10) Meprobamate; (11) Miltown®; (12) Rohypnol®; (13) Serax®; (14) Soma®; (15) Tranxene®; and (16) Vistaril®.

SEE: "Current Use," "Lifetime Use," "Nonmedical Use of Psychotherapeutics," "Pain Reliever Use," "Past Month Use," "Past Year Use," "Pill Cards," "Prevalence," "Psychotherapeutic Drugs," "Recency of Use," "Sedative Use," "Source of Psychotherapeutic Drugs," and "Stimulant Use."

Treatment for Depression

Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication in the past year for depression.

SEE: "Major Depressive Episode."

Treatment for Mental Health Problems

For adults aged 18 or older, treatment for mental health problems is defined as treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months prior to the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of a mental or emotional condition. Estimates for adults are based only on responses to items in the module on adult mental health service utilization. For youths aged 12 to 17, treatment for mental health problems is defined as receiving treatment or counseling for emotional or behavioral problems from specific mental health or other health professionals in school, home, outpatient, or inpatient settings within the 12 months prior to the interview. Treatment for only a substance use problem is not included for adults or youths.

SEE: "Alternative Treatment/Support for Mental Health Problems," "Prevalence," and "Unmet Need for Treatment for Mental Health Problems."

Treatment for a Substance Use Problem

Respondents were asked if they had received treatment for illicit drug use, alcohol use, or both illicit drug and alcohol use in the past 12 months in any of the following locations: a hospital overnight as an inpatient, a residential drug or alcohol rehabilitation facility where they stayed overnight, a drug or alcohol rehabilitation facility as an outpatient, a mental health facility as an outpatient, an emergency room, a private doctor's office, prison or jail, a self-help group, or some other place.

SEE: "Alcohol Use," "Illicit Drugs," "Need for Illicit Drug or Alcohol Use Treatment," "Prevalence," "Self-Help Group," and "Specialty Substance Use Treatment Facility."

Two or More Races

Respondents were asked to report which racial group describes them. Response alternatives were (1) white, (2) black/African American, (3) American Indian or Alaska Native, (4) Native Hawaiian, (5) Other Pacific Islander, (6) Asian, and (7) Other. Respondents were allowed to choose more than one of these groups. Persons who chose both the "Native Hawaiian" and "Other Pacific Islander" categories (and no additional categories) were classified in a single category: Native Hawaiian or Other Pacific Islander. Otherwise, persons reporting two or more of the above groups and that they were not of Hispanic, Latino, or Spanish origin were included in a "Two or More Races" category. This category does not include respondents who reported more than one

Asian subgroup but who reported "Asian" as their only race. Respondents reporting two or more races and reporting that they were of Hispanic, Latino, or Spanish origin were classified as Hispanic.

SEE: "Hispanic" and "Race/Ethnicity."

Unmet Need for Treatment for Mental Health Problems

Unmet need for treatment for mental health problems is defined as a perceived need for treatment for mental health problems in the past 12 months that was not received. This measure also includes persons who received some treatment for mental health problems in the past 12 months but also reported that they perceived a need for treatment that they did not receive. Unmet need among those who received treatment may be interpreted as delayed or insufficient treatment in the past 12 months.

Feeder question: "During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?"

SEE: "Alternative Treatment/Support for Mental Health Problems," "Prevalence" and "Treatment for Mental Health Problems."

Welfare Assistance

Household participation in one or more government assistance programs during the prior calendar year was defined as one or more family members receiving Supplemental Security Income (SSI), food stamps, cash, or noncash assistance. SSI provides payments to low-income, aged, blind, and disabled persons. Food stamps are government-issued coupons used to purchase food. Cash assistance refers to cash payments through Temporary Assistance for Needy Families (TANF), welfare, or other public assistance. Noncash assistance refers to services, such as help getting a job, placement in an education or job-training program, or help with transportation, child care, or housing.

NOTE: For youths and those respondents who were unable to respond to the insurance or income questions, proxy responses were accepted from a household member identified as being better able to give the correct information about insurance and income.

SEE: "Cash Assistance," "Food Stamps," "Noncash Assistance," and "Supplemental Security Income (SSI)."

West Region

The States included are those in the Mountain Division—Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming; and the Pacific Division—Alaska, California, Hawaii, Oregon, and Washington.

SEE: "Geographic Division" and "Region."

White

White, not of Hispanic, Spanish, or Latino origin; does not include respondents reporting two or more races. (Respondents reporting that they were white and of Hispanic, Latino, or Spanish origin were classified as Hispanic.)

SEE: "Hispanic" and "Race/Ethnicity."

Appendix D: Other Sources of Data

A variety of other surveys and data systems collect data on substance use and mental health problems. It is useful to consider the results of these other studies when discussing the National Survey on Drug Use and Health (NSDUH) data. In doing this, it is important to understand the methodological differences between the different surveys and the impact that these differences could have on estimates of the presence of substance use and mental health problems. This appendix briefly describes several of these other data systems and where possible presents comparisons between NSDUH results and results from the other surveys for 2002, 2003, 2004, and 2005 or other recent time periods. For some comparisons, NSDUH estimates were generated to be consistent with the data collection periods or groups surveyed in other studies. In addition, this appendix describes surveys of populations not covered by NSDUH.

In-depth comparisons of the methodologies of the three major federally sponsored national surveys of youth substance use have been done. In 1997, a comparison between the National Household Survey on Drug Abuse[11] (NHSDA) and Monitoring the Future (MTF) was published (Gfroerer, Wright, & Kopstein, 1997). In 2000, a series of papers comparing different aspects of the NHSDA, MTF, and the Youth Risk Behavior Survey (YRBS) was commissioned by the U.S. Department of Health and Human Services (DHHS). Under contract with the Office of the Assistant Secretary for Planning and Evaluation, Westat, Inc., identified and funded several experts in survey methods to prepare these papers. The papers were published in the *Journal of Drug Issues* (Hennessy & Ginsberg, 2001). The major findings of these studies were as follows:

- The design, implementation, and documentation of all three surveys are of high quality. The surveys exhibit no flaws in the execution of basic survey procedures.

- The goals and approaches of these three surveys are very different, making comparisons between them difficult. The surveys differ significantly in terms of populations covered, sampling methods, modes of data collection, questionnaires, and estimation methods.

- Estimates of substance use are generally highest from the YRBS and lowest from the NHSDA. One possibility for these differences is survey location. NHSDA is conducted in the home, and the other two surveys collect data in school classrooms, away from parents and other family members.

- NHSDA prevalence rates also may be lower because of NHSDA's requirement of active parental consent prior to youth participation. The greater parental involvement in consent procedures in NHSDA, compared with the two school surveys, may suppress youth reporting of substance use.

These findings suggest that differences in survey methodology may affect comparisons of prevalence estimates among youths from various surveys. This appendix investigates the

[11] Beginning with the 2002 survey year, the survey name was changed from the National Household Survey on Drug Abuse (NHSDA) to the National Survey on Drug Use and Health (NSDUH).

similarities and differences among rates from NSDUH and other related surveys. Descriptions of the other surveys are provided when they are first discussed in the appendix.

D.1 Other National Surveys on Illicit Drug Use

Monitoring the Future (MTF)

The Monitoring the Future (MTF) study is a national survey that tracks drug use trends and related attitudes among America's adolescents. This survey is conducted annually by the Institute for Social Research at the University of Michigan through a grant awarded by the National Institute on Drug Abuse (NIDA). The MTF and NSDUH are the Federal Government's largest and primary tools for tracking youth substance use. The MTF is composed of three substudies: (a) an annual survey of high school seniors initiated in 1975; (b) ongoing panel studies of representative samples from each graduating class that have been conducted by mail since 1976; and (c) annual surveys of 8th and 10th graders initiated in 1991. In the spring, students complete a self-administered, machine-readable questionnaire during a regular class period. In 2004, for all three grades combined, 406 public and private schools and about 49,500 students were in the sample; in 2005, for all three grades combined, about 49,300 students in 402 public and private schools were in the sample (Johnston, O'Malley, Bachman, & Schulenberg, 2005c, 2006a).

Comparisons between the MTF estimates and estimates based on students sampled in NSDUH generally have shown NSDUH substance use prevalence levels to be lower than MTF estimates, with differences tending to be more pronounced for 8th graders. To examine estimates that are comparable with MTF data, NSDUH estimates presented here are based on data collected in the first 6 months of the survey year. The lower prevalences in NSDUH may be due to more underreporting in the household setting as compared with the MTF school setting. However, MTF does not survey dropouts, a group that NSDUH has shown to have higher rates of illicit drug use (Gfroerer et al., 1997). In 2004 and 2005, for most comparisons of estimates of lifetime, past year, and past month prevalence of use of marijuana, cocaine, and inhalants among 8th, 10th, and 12th graders between NSDUH and MTF, NSDUH estimates were lower (see Table D.1 at the end of this appendix). However, both surveys showed that use of these three illicit drugs was stable for most measures between 2004 and 2005. The only exception was a decrease in past year marijuana use among 12th graders in NSDUH between 2004 and 2005.

Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is a component of the Centers for Disease Control and Prevention's (CDC's) Youth Risk Behavior Surveillance System (YRBSS), which measures the prevalence of six priority health risk behavior categories: (a) behaviors that contribute to unintentional injuries and violence; (b) tobacco use; (c) alcohol and other drug use; (d) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infections; (e) unhealthy dietary behaviors; and (f) physical inactivity. The YRBSS includes national, State, territorial, and local school-based surveys of high school students conducted every 2 years. The latest YRBS was conducted in 2005 (Eaton et al., 2006). The 2005 national school-based survey used a three-stage cluster sample design to produce a nationally representative sample of students in grades 9

through 12 who attend public and private schools. The 2005 State and local surveys used a two-stage cluster sample design to produce representative samples of students in grades 9 through 12 in their jurisdictions. The 2005 national YRBS sample included 13,953 students in grades 9 through 12 in 159 schools in the 50 States and the District of Columbia. The national survey and all of the State and local surveys were conducted during the spring of 2005, with the exception of one State. This State's surveys were conducted in the fall of 2004. The students completed a self-administered, machine-readable questionnaire during a regular class period.

In general, the YRBS school-based survey has found higher rates of marijuana, cocaine, inhalant, alcohol, and cigarette use for youths than those found in NSDUH (Table D.2) (Eaton et al., 2006; Grunbaum et al., 2004). To examine estimates that are comparable with YRBS data, the NSDUH estimates presented here are based on data collected in the first 6 months of the survey year. For example, past month marijuana use was 22.4 percent in the 2003 national YRBS and 20.2 percent in the 2005 national YRBS compared with 13.2 percent for persons in grades 9 through 12 in January-June in the 2003 NSDUH and 11.2 percent in the 2005 NSDUH. This is likely due to the differences in study design (school-based vs. home-based).

National Longitudinal Study of Adolescent Health (Add Health)

The National Longitudinal Study of Adolescent Health (Add Health) was conducted to measure the effects of family, peer group, school, neighborhood, religious institution, and community influences on health risks, such as tobacco, drug, and alcohol use. Initiated in 1994 under a grant from the National Institute of Child Health and Human Development (NICHD) with cofunding from 17 other Federal agencies, Add Health is the largest, most comprehensive survey of adolescents ever undertaken. Data at the individual, family, school, and community levels were collected in two waves between 1994 and 1996. In Wave 1 (conducted in 1994-95), roughly 90,000 students from grades 7 through 12 at 144 schools around the United States answered brief, machine-readable questionnaires during a regular class period. Interviews also were conducted with about 20,000 students and their parents in the students' homes using a combined computer-assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACASI) design. In Wave 2, students were interviewed a second time in their homes. In 2001 and 2002, 4,882 of the original Add Health respondents, now aged 18 to 26, were re-interviewed in a third wave to investigate the influence that adolescence has on young adulthood. Identifying information was obtained from participants in order to track them over time.

Survey results from the first two waves indicated that nearly one fourth of teenagers had ever smoked marijuana. Nearly 7 percent of 7^{th} and 8^{th} graders used marijuana at least once in the past month as did 15.7 percent of 9^{th} through 12^{th} graders (Resnick et al., 1997). In the 2005 NSDUH, 17.4 percent of youths aged 12 to 17 had ever used marijuana, and 13.3 percent were past month users; in 2004, these percentages were 19.0 and 7.6 percent, respectively.

Partnership Attitude Tracking Study (PATS)

The Partnership Attitude Tracking Study (PATS) is an ongoing national research study that tracks drug use and drug-related attitudes among children, teenagers, and their parents. It is sponsored by the Partnership for a Drug-Free America (PDFA). In the 2002 PATS, 7,084

teenagers in grades 7 through 12 completed self-administered, machine-readable questionnaires during a regular class period with their teacher remaining in the room (PDFA, 2006a). For the first time in 2002, PATS included questions on prescription drug abuse. The 2002 PATS found that 20 percent of youths in grades 7 to 12 had ever used prescription pain killers without a doctor's prescription, 19 percent of adolescents reported lifetime use of inhalants, and 40 percent reported lifetime use of marijuana. In 2003, 7,270 youths completed the survey, and prevalence rates remained very similar to rates in 2002 (PDFA, 2006a). The 2003 PATS found that 21 percent of youths in grades 7 to 12 had ever used prescription drugs, 18 percent had used inhalants, and 39 percent reported using marijuana in their lifetime (PDFA, 2003). The 2004 PATS was conducted with 7,314 youths in grades 7 through 12 and found that 19 percent had used inhalants and 37 percent had used marijuana at least once in their lifetime (PDFA, 2005). The 2005 PATS was conducted with 7,216 youths in grades 7 through 12 and found that 37 percent had used marijuana at least once in their lifetime, 20 percent had used inhalants, and 19 percent had used prescription medications that a doctor did not prescribe for them (PDFA, 2006b).

NSDUH reported notably lower prevalence estimates than PATS. For youths aged 12 to 17, NSDUH estimated the rate of lifetime prescription pain reliever use to be 11.2 percent in both 2002 and 2003, 11.4 percent in 2004, and 9.9 percent in 2005; lifetime inhalant use was 10.5 percent in 2002, 10.7 percent in 2003, 11.0 percent in 2004, and 10.5 percent in 2005. Lifetime marijuana use was 20.6 percent in 2002, 19.6 percent in 2003, 19.0 percent in 2004, and 17.4 percent in 2005. The major difference in these prevalence estimates is likely to be due to the different study designs. The youth portion of PATS is a school-based survey, which may elicit more reporting of sensitive behaviors than the home-based NSDUH. In addition, the PATS survey is conducted with a sample of students in the 7th through 12th grades, which is a slightly older sample than that of the NSDUH 12- to 17-year-old sample.

National Survey of Parents and Youth (NSPY)

The National Survey of Parents and Youth (NSPY) is sponsored by the National Institute on Drug Abuse (NIDA) to evaluate the Office of National Drug Control Policy's (ONDCP's) National Youth Anti-Drug Media Campaign. The survey is specifically designed to evaluate Phase III of the campaign, covering the period between September 1999 and June 2003. Data collection provides estimates of trends in drug use between 2000 and the first half of 2003, as well as changes between 2002 and 2003.

In Phase I (Waves 1 through 3 of data collection), a sample of youths aged 9 to 18 and their parents were recruited to participate in the in-home audio computer-assisted self-interviewing (ACASI) survey. In Phase II (Waves 4 through 7 of data collection), the respondents from Phase I participated in two additional interviews at intervals of 6 to 24 months. In December 2003, ONDCP released the sixth semiannual report of findings that contained data from all three phases (Hornik et al., 2003).

Wave 5's data were collected between January and June 2002 and included 4,040 youths and 2,882 parents. Wave 6's data were collected between July and December 2002 and included 2,267 youths and 1,640 parents. An average of the estimates from Waves 5 and 6 showed that the past year rate of marijuana use among 12 to 18 year olds was 16.4 percent. The corresponding

2002 NSDUH estimate for past year marijuana use among youths aged 12 to 18 was 18.4 percent.

Wave 7's data were collected between January and June 2003 and included 3,587 youths and 2,621 parents. The two surveys produced similar estimates for youths (see Table D.3). For example, wave 7 of NSPY data indicated that 16.7 percent of youths aged 12 to 18 had used marijuana in the past year, and the 2003 NSDUH yielded an estimate of 18.1 percent among this age group for this time period. One explanation for the similarity in estimates is that both surveys used ACASI.

In past waves of NSPY data collection, parents also have been asked about their drug use behaviors; however, parental use was not asked in the Wave 5 or Wave 7 data collections. Lifetime use of marijuana among parents was 53.7 percent in 2001, and past month use was 3.4 percent. According to the full-year data of NSDUH, lifetime use of marijuana among adults aged 18 or older was 42.7 percent in 2002, 43.1 percent in 2003, 42.7 percent in 2004, and 42.8 percent in 2005; past month use was 6.0 percent in 2002 and 2003 and 5.9 percent in 2004 and 2005.

National Longitudinal Alcohol Epidemiologic Survey (NLAES) and National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

The National Longitudinal Alcohol Epidemiologic Survey (NLAES) was conducted in 1991 and 1992 by the U.S. Bureau of the Census for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Face-to-face interviewer-administered interviews were conducted with 42,862 respondents aged 18 or older in the contiguous United States. Despite the survey name, the design was cross-sectional.

The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) was conducted in 2001 and 2002, also by the U.S. Bureau of the Census for NIAAA, using a computerized interviewer-administered interview. The NESARC sample was designed to make inferences for persons aged 18 or older in the civilian, noninstitutionalized population of the United States, including Alaska, Hawaii, and the District of Columbia, and including persons living in noninstitutional group quarters. NESARC is designed to be a longitudinal survey. The first wave was conducted in 2001 and 2002, with a final sample size of 43,093 respondents aged 18 or older. Additional waves of data are planned (Grant, Kaplan, Shepard, & Moore, 2003).

Over the decade from 1992 to 2002, the prevalence of past year marijuana use among adults remained about the same in the two surveys, at about 4.0 percent (Compton, Grant, Colliver, Glantz, & Stinson, 2004). The rate of past year marijuana use among adults was 10.1 percent in the 2003, 2004, and 2005 NSDUHs. The discrepancy between the estimates produced by the surveys is likely due to the differences in administration; NSDUH is self-administered, and the NLAES and NESARC are interviewer-administered.

D.2 Alcohol and Cigarette Use Surveys

National Health Interview Survey (NHIS)

The National Health Interview Survey (NHIS) is a continuing nationwide sample survey that collects data using personal household interviews through an interviewer-administered computer-assisted personal interviewing (CAPI) system. The survey is sponsored by the National Center for Health Statistics (NCHS) and provides national estimates of selected health measures. In the NHIS, current smokers are defined as those who smoked at least 100 cigarettes in the lifetime and are now smoking every day or some days. The survey estimated in 2004 that 20.8 percent of the population were reporting current cigarette smoking (23.3 percent among males and 18.3 percent among females) (NCHS, 2006). Early release of data from the 2005 NHIS shows similar rates in 2005, with 20.9 percent of the population reporting current cigarette smoking (23.9 percent among males and 18.1 percent among females) (Schiller, Martinez, & Barnes, 2006).

In NSDUH, current cigarette smoking is defined as any use in the past month. The NSDUH rate was 26.4 percent in 2004 for those aged 18 or older and 26.5 percent in 2005. Although the two surveys employ different methodologies, NSDUH still produces higher estimates when using the NHIS definition. For example, when using a definition similar to the NHIS definition, NSDUH estimated that 24.6 percent of adults aged 18 or older were current smokers in 2004 and 24.7 percent of adults were current smokers in 2005. See Table D.4 for a comparison of smoking rates between these two surveys by age and gender.

The NHIS defines excessive alcohol drinkers as those who consumed an amount greater than or equal to five drinks in 1 day at least once during the past 12 months. The NHIS rate for excessive alcohol consumption among those aged 18 or older was 19.4 percent in 2003, 18.7 percent in 2004, and 19.5 percent in 2005 (NCHS, 2006). NSDUH defines heavy alcohol use as having five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 5 different days in the past 30 days. The full-year NSDUH rates for heavy drinking among those aged 18 or older were 7.3 percent in 2003, 7.4 percent in 2004, and 7.1 percent in 2005.

Monitoring the Future (MTF)

Compared with NSDUH estimates, MTF estimates of cigarette use were higher among 8th graders, about the same among 10th graders, and somewhat lower among 12th graders. However, both surveys showed slight, but not necessarily significant, decreases in smoking in most grade levels between 2004 and 2005. For example, among 8th graders in the MTF, there was a significant decrease in lifetime smoking estimates from 27.9 percent in 2004 to 25.9 percent in 2005. The NSDUH lifetime smoking rates for 8th graders also decreased significantly from 22.1 percent in 2004 to 17.4 percent in 2005. See Table D.1 for a comparison of the MTF and NSDUH cigarette use estimates by grade level.

Rates of alcohol consumption were higher overall in the MTF sample compared with NSDUH. However, both surveys tended to indicate that rates of alcohol consumption may be declining. For NSDUH, although many of the rates appeared to be decreasing, only the decrease

in lifetime alcohol use among 8th graders between 2004 and 2005 was statistically significant. In the MTF sample, there were statistically significant decreases in lifetime and past year alcohol use among 8th graders, past month use among 10th graders, and past year alcohol use among 12th graders. Both surveys indicated a varying pattern of alcohol consumption by grade level. Table D.1 shows how the MTF estimates of alcohol use compare with NSDUH estimates.

Youth Risk Behavior Survey (YRBS)

As seen with illicit drug use, the YRBS estimates of cigarette use and alcohol consumption were higher than the NSDUH estimates. According to YRBS data, in 2005, 54.3 percent of high school students had tried cigarettes, and 23.0 percent of students had smoked cigarettes during the past 30 days (Eaton et al. 2006). Using only data from January through June, the 2005 NSDUH rates were 39.3 percent for lifetime cigarette use and 17.4 percent for past month cigarette use among students in the 9th through 12th grades (see Table D.2).

Past month alcohol use among 9th to 12th graders in the YRBS was 43.3 percent in the 2005 survey. In contrast, January-June data from NSDUH showed a past month alcohol use rate of 26.2 percent in 2005 among 9th to 12th graders. The lifetime alcohol use rate among students was 58.0 percent using January-June NSDUH data in 2005, while it was 74.3 percent in the YRBS in 2005.

Partnership Attitude Tracking Study (PATS)

Data from PATS show that the prevalence of past month cigarette use for adolescents in grades 7 through 12 was 28 percent in 2002, 26 percent in 2003, 23 percent in 2004, and 22 percent in 2005 (PDFA, 2003, 2005, 2006a, 2006b). The NSDUH prevalence of past month cigarette smoking among youths aged 12 to 17 was 13.0 percent in 2002, 12.2 percent in 2003, 11.9 percent in 2004, and 10.8 percent in 2005. Again, the lower prevalence estimates in NSDUH are likely due to its home-based study design and slightly younger age group.

Even though the PATS estimates were higher than the NSDUH estimates, both surveys showed relatively steady rates of drinking among youths from 2002 to 2005. PATS found that 53 percent of teenagers reported past year alcohol use in 2002, 51 percent in 2003, 50 percent in 2004, and 47 percent in 2005. These estimates compare with NSDUH's estimates of 34.6 percent of youths aged 12 to 17 reporting past year use in 2002, 34.3 percent in 2003, 33.9 percent in 2004, and 33.3 percent in 2005.

The 2002 PATS also found that 36 percent of teenagers reported past month alcohol use and 30 percent reported binge drinking. In the 2003 PATS, 34 percent of youths used alcohol in the past month, while 29 percent reported binge drinking. In the 2004 PATS, about 33 percent of youths used alcohol in the past month, and 28 percent reported binge drinking. In the 2005 PATS, about 31 percent of youths used alcohol in the past month, and 28 percent reported binge drinking. In comparison, the 2002 NSDUH rates for past month alcohol use and binge drinking for 12 to 17 year olds were 17.6 and 10.7 percent, respectively. For the 2003 NSDUH, 17.7 percent of youths reported past month alcohol use, and 10.6 reported binge drinking. In 2004, the NSDUH rates for past month alcohol use and binge drinking were 17.6 and 11.1 percent,

respectively. In 2005, the NSDUH rates for past month alcohol use and binge drinking were 16.5 and 9.9 percent, respectively.

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual, State-based telephone survey of the civilian, noninstitutionalized adult population aged 18 or older and is sponsored by the CDC. In 2002, 2003, 2004, and 2005, BRFSS collected data from all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam using a computer-assisted telephone interviewing (CATI) design. BRFSS collects information on access to health care, health status indicators, health risk behaviors (including cigarette and alcohol use), and the use of clinical preventive services by State. National data are calculated using a median score across States.

Although both BRFSS and NSDUH looked at the percentage of adults who reported having five or more alcoholic drinks on at least one occasion in the past month, the median binge alcohol use rates among adults in the BRFSS sample (16.1 percent in 2002, 16.4 percent in 2003, 14.9 percent in 2004, and 14.4 percent in 2005) (CDC, 2006a) were lower than among adults aged 18 or older in the NSDUH sample (24.0 percent in 2003 and 24.1 percent in 2004 and 2005). Comparisons of estimates of adult binge drinking using combined data from the 1999 and 2001 BRFSS and the 1999 and 2001 NSDUHs showed that BRFSS estimates were considerably lower than NSDUH estimates for the total United States and most States, even among demographic subgroups; however, the differences were not statistically significant. The use of ACASI in NSDUH, which is considered to be more anonymous and yields higher reporting of sensitive behaviors, was offered as an explanation for the lower rates in BRFSS (Miller et al., 2004).

National Longitudinal Study of Adolescent Health (Add Health)

Results from the 1994-95 National Longitudinal Study of Adolescent Health indicated that nearly 3.2 percent of 7th and 8th graders smoked six or more cigarettes a day, as did 12.8 percent of 9th through 12th graders (Resnick et al., 1997). In addition, the Add Health study found that 7.3 percent of 7th and 8th graders used alcohol on 2 or more days in the past month, as did 23.1 percent of 9th through 12th graders.

National Survey of Parents and Youth (NSPY)

Earlier waves of the NSPY collected information on cigarette and alcohol use, but Wave 5 in 2002 and later waves did not. In 2001, this survey estimated that 34.9 percent of youths aged 12 to 18 had used cigarettes at some point in their lifetime, and past month cigarette use was 11.7 percent. The 2002 NSDUH rates of lifetime and past month cigarette use for youths aged 12 to 18 were 38.8 and 16.7 percent, respectively; these rates were 36.2 and 15.8 percent, respectively, in 2003, 35.1 and 15.6 percent in 2004, and 31.8 and 14.2 percent in 2005.

In 2001, the NSPY estimated that 45.9 percent of youths aged 12 to 18 had used alcohol at some point in their lifetime, and the estimate for past month use was 36.5 percent for the same age group. The 2002 NSDUH rates for lifetime and past month alcohol use were 49.1 and 22.2

percent, respectively; the 2003 rates were 49.0 and 22.2 percent; the 2004 rates were 47.7 and 22.4 percent; the 2005 rates were 46.0 and 20.9 percent.

These NSDUH estimates for cigarette and alcohol use in 2002, 2003, 2004, and 2005 are based on data collected from January through June to reflect the same data collection period as the NSPY.

Harvard School of Public Health's College Alcohol Study (CAS)

The Harvard School of Public Health's College Alcohol Study (CAS) is an ongoing survey of students at 4-year colleges and universities in 40 States. The study surveyed a random sample of students at the same colleges in 1993, 1997, 1999, and 2001. The schools and students were selected to provide nationally representative samples of schools and students. In 1993, a national sample of 195 colleges was selected from the American Council on Education's list of accredited 4-year colleges by using probability proportionate to size of enrollment; of the 195 colleges, 140 agreed to participate, for a school-level response rate of 72 percent (Wechsler, Dowdall, Davenport, & Castillo, 1995). Of these 140 colleges, 130 participated in 1997, 128 in 1999, and 120 in 2001. Student-level response rates to the two-stage mail survey were 70 percent in 1993, 59 percent in 1997 and 1999, and 52 percent in 2001. The researchers provided a short survey to nonrespondents in order to better weight the data (Wechsler et al., 2002).

The 2001 survey found that the overall rate of binge drinking was 44.4 percent. The CAS defined binge drinking as the consumption of five or more drinks in a row for men and four or more drinks in a row for women. The study found that 22.8 percent of the students binge drank frequently and that 19.3 percent did not drink at all. The 2003 NSDUH binge drinking rate among full-time undergraduates aged 18 to 22 was 43.5 percent, the 2004 estimate was 43.4 percent, and the 2005 estimate was 44.8 percent. It is useful to note that NSDUH defines binge drinking for both men and women as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Despite using different definitions of binge drinking, the CAS estimate and the NSDUH estimate are similar, but it is important to note that the two studies were conducted in different time periods.

D.3 Other Surveys of Substance Abuse and Dependence

National Comorbidity Surveys (NCS)

The National Comorbidity Survey (NCS) was sponsored by the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the W.T. Grant Foundation. It was designed to measure the prevalence of the illnesses in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) (American Psychiatric Association [APA], 1987) in the general population. The first wave of the NCS was a household survey collecting data from 8,098 respondents aged 15 to 54. These responses were weighted to produce nationally representative estimates. A random sample of 4,414 respondents also were administered an additional module that captured information on nicotine dependence. The interviews took place between 1990 and 1992. The NCS used a modified version of the Composite International Diagnostic Interview (the UM-CIDI) to generate DSM-III-R diagnoses.

There have been several recent extensions to the original NCS, including a 10-year follow-up of the baseline sample (NCS-II), a replication study conducted in 2001 and 2002 with a newly recruited nationally representative sample of 9,282 respondents aged 18 or older (NCS-R), and an adolescent sample with a targeted recruitment of more than 10,000 adolescents (NCS-A) along with their parents and teachers. The NCS-R used an updated version of the CIDI that was designed to capture diagnoses using current DSM-IV criteria (APA, 1994). It should be noted that in several recent NCS-R studies (Kessler et al., 2005a; Kessler, Chiu, Demler, & Walters, 2005b), the diagnosis for abuse also includes those who meet the diagnosis for dependence. In contrast, NSDUH follows DSM-IV guidelines and measures abuse and dependence separately. To make the NCS definition of abuse comparable with that of NSDUH, the rate for dependence must be subtracted from the rate for abuse.

Estimates from the NCS-R indicated that 3.1 percent of persons were alcohol abusers and 1.3 percent were dependent on alcohol in the past year (Kessler et al., 2005b). Excluding those who met the criteria for dependence from those who met the criteria for abuse according to the NCS-R, the resulting rate indicated that 1.8 percent had abused alcohol in the past year. According to the 2002 NSDUH, 4.3 percent of persons aged 18 or older were alcohol abusers in the past year, and 3.7 percent were dependent on alcohol; 7.9 percent were dependent on or abused alcohol. Comparable rates for alcohol abuse, dependence, and abuse or dependence from the 2003 NSDUH were 4.4 percent, 3.3 percent, and 7.7 percent, respectively; in 2004, these rates were 4.3 percent, 3.6 percent, and 8.0 percent, respectively; and in 2005, the rate for alcohol dependence was 4.5 percent and 7.9 percent for alcohol dependence or abuse. Therefore, the past year estimate for those with either alcohol abuse and/or dependence from the NCS-R (3.1 percent) was lower than the estimate from the 2005 NSDUH (7.9 percent).

Based on the NCS-R, 1.4 percent of persons aged 18 or older met the criteria for abuse of illicit drugs, and 0.4 percent met the criteria for dependence on illicit drugs in the past year. In the 2002 NSDUH, 0.9 percent abused illicit drugs, and 1.8 percent were dependent on illicit drugs; 2.7 percent were dependent on or abused illicit drugs. Comparable rates for illicit drug abuse, dependence, and abuse or dependence from the 2003 NSDUH were 0.9 percent, 1.7 percent, and 2.6 percent, respectively; in 2004, these rates were 0.9 percent, 1.9 percent, and 2.8 percent, respectively; and in 2005, these rates were 0.7 percent for alcohol dependence and 2.6 percent for alcohol dependence or abuse. This latter rate was higher than the corresponding estimate in the NCS-R (1.4 percent) for substance abuse, which also includes those with dependence. Similarly, NCS-R indicated that 3.8 percent were dependent on or abused alcohol or illicit drugs in the past year compared with 9.4 percent based on the 2002 NSDUH; this rate was 9.1 percent in the 2003 NSDUH, 9.4 percent in the 2004 NSDUH, and 9.3 in the 2005 NSDUH.

National Longitudinal Alcohol Epidemiologic Survey (NLAES) and National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

The NLAES and NESARC included an extensive set of questions, based on criteria from the DSM-IV (APA, 1994), designed to assess the presence of symptoms of alcohol and drug abuse and dependence in persons' lifetimes and during the prior 12 months. The 1991-92 NLAES found that 7.4 percent of adults were abusing or dependent on alcohol (Grant, 1995). In the 2001-02 NESARC, the rate of alcohol abuse among adults was 4.7 percent, and the rate of alcohol dependence was 3.8 percent. Between 1992 and 2002, the prevalence of alcohol abuse

increased and the prevalence of dependence declined (Grant et al., 2004). In 2002, NSDUH found that 7.9 percent of adults were abusing or dependent on alcohol; in 2003, this rate was 7.7 percent; in 2004, the rate was 8.0 percent; and in 2005, the rate was 7.9 percent. The NLAES and NESARC also found that the prevalence of marijuana dependence or abuse among adults increased from 1.2 percent in 1992 to 1.5 percent in 2002 (Compton et al., 2004). In comparison, the 2002 NSDUH found that 2.7 percent of adults were dependent on or abusing some illicit drug; the rates were 2.6 percent in 2003, 2.8 percent in 2004, and 2.6 percent in 2005. The 2002 and 2003 NSDUHs both estimated that 3.2 million adults (1.5 percent) were dependent on or abusing marijuana; this estimate was 3.5 million (1.6 percent) in 2004 and 3.2 million (1.5 percent) in 2005. Although the estimates from these two surveys are relatively close, one should note that they were conducted using different methodologies.

D.4 Other National Surveys of Mental Illness

Epidemiologic Catchment Area Survey (ECA)

The Epidemiologic Catchment Area (ECA) Study (1981-83) was the first survey to administer a structured psychiatric interview and provide population-based estimates of psychiatric disorders. Prevalences were estimated by collecting data from households and group quarters (e.g., prisons, nursing homes, mental hospitals) in five local catchment areas (Baltimore, Los Angeles, New Haven, North Carolina, and St. Louis) that had been previously designated as Community Mental Health Center catchment areas. There were three waves of data collection with 20,861 respondents; the first and third waves were interviewer-assisted personal interviews, and the second wave was a telephone interview conducted with household participants only (Eaton et al., 1984). The ECA utilized the Diagnostic Interview Schedule (DIS), a structured clinical instrument that can be used by nonclinically trained interviewers to generate DSM-III (APA, 1980) diagnoses of psychiatric and substance use disorders. A supplemental sample of institutional settings, such as nursing homes, psychiatric hospitals, and prisons, also was included to capture those respondents with a high probability of having a mental disorder.

National Comorbidity Surveys (NCS)

The National Comorbidity Survey (NCS) was conducted in response to the limitations of the ECA and a broader need to produce nationally representative data on psychiatric conditions. The first wave of the survey revealed that 48.7 percent of the population had at least one axis I or II disorder in their lifetime. This percentage can be broken down into the following: 21 percent with one disorder, 13 percent with two disorders, and 14 percent with three or more disorders (Kessler, 1994). In 2004, NSDUH estimated that 12.2 percent of persons aged 18 or older were classified as having serious psychological distress (SPD) in the past year; in 2005, the estimate was 11.3 percent (see Section B.4.4 in Appendix B for SPD's comparability with serious mental illness [SMI]).

Preliminary findings from the NCS-R study in 2001-02 indicate that the lifetime and past year prevalence of major depressive disorder was 16.2 and 6.6 percent, respectively. A large percentage of those with lifetime (71.1 percent) and 12-month (78.5 percent) psychiatric disorders also had at least one additional DSM-defined psychiatric disorder, suggesting that the burden of mental disorders is pervasive in the general population (Kessler et al., 2003a, 2003b).

In 2004, NSDUH estimated that 14.8 percent of adults experienced major depressive episode (MDE) in their lifetime, and 8.0 percent experienced MDE in the past year. In 2005, NSDUH estimated that 14.2 percent of adults experienced MDE in their lifetime, and 7.3 percent experienced MDE in the past year.

National Epidemiologic Survey on Alcohol and Alcohol Related Conditions (NESARC)

NESARC was sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and designed to be a longitudinal study with the first wave of data (43,093) collected between 2001 and 2002. Additional waves of data are planned. The study contains comprehensive assessments of drug use, abuse, and dependence, as well as associated mental disorders. Extensive data on the utilization of treatment programs and medical care also are being collected. NESARC is a representative sample of the noninstitutionalized population aged 18 or older residing in the contiguous United States, the District of Columbia, or Hawaii. The design also oversampled young adults aged 18 to 24 and minorities to increase precision, ensure adequate cell sizes for variables with low event rates, and ensure representation of major racial/ethnic categories. DSM-IV (APA, 1994) diagnoses of major mental disorders were generated using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-version 4 (AUDADIS-IV), which is a structured diagnostic interview that captures major DSM-IV axis I and axis II disorders. The 12-month prevalence estimates show that 9.2 percent of respondents experienced an independent (i.e., not attributable to illness or substance use) mood disorder in the past year, whereas 11.0 percent experienced an independent anxiety disorder (Grant et al., 2004).

D.5 Surveys of Populations Not Covered by NSDUH

National Survey of Parents and Youth (NSPY)

The NSPY, described above, is distinct in that it measures drug use and attitudes among youths as young as 9 years. The earlier NSPY results showed that youths aged 9 to 11 were strongly opposed to marijuana use. Wave 3 of the survey estimated that only 0.3 percent of youths aged 9 to 11 had used marijuana in the past year. The corresponding rates for Waves 1 and 2 were 0.8 and 0.0 percent, respectively (ONDCP, 2006).

Washington, DC, Metropolitan Area Drug Study (DC*MADS)

The Washington, DC, Metropolitan Area Drug Study (DC*MADS) was designed (a) to estimate the prevalence, correlates, and consequences of drug abuse among all types of people residing in one metropolitan area of the country during one period of time with a special focus on populations who were underrepresented or unrepresented in household surveys and (b) to develop a methodological model for similar types of research in other metropolitan areas of the country. Sponsored by NIDA and conducted from 1989 to 1995 by RTI International and Westat, Inc., the project included 11 separate but coordinated studies that focused on different population subgroups (e.g., homeless people, institutionalized individuals, adult and juvenile offenders, new mothers, drug use treatment clients) or different aspects of the drug abuse problem (e.g., adverse consequences of drug abuse). DC*MADS provided a replicable methodological approach for developing representative estimates of the prevalence of drug abuse among all population

subgroups, regardless of their residential setting, in a metropolitan area. The key population domains in DC*MADS were homeless people, institutionalized persons, and the household population.

A major finding of DC*MADS was that, when data are aggregated for populations from each of the three domains, the overall prevalence estimates for the use of drugs differ only marginally from those that would be obtained from the household population alone (i.e., from NSDUH), largely because the other populations are very small compared with the household population. However, a somewhat different picture emerged when the numbers of drug users were examined. Adding in the nonhousehold populations resulted in an increase of approximately 14,000 illicit drugs users compared with the corresponding estimates for the household population. About 25 percent of past year crack users, 20 percent of past year heroin users, and one third of past year needle users were found in the nonhousehold population (Bray & Marsden, 1999).

Department of Defense (DoD) Survey of Health Related Behaviors among Military Personnel

The 2002 DoD Survey of Health Related Behaviors among Military Personnel was the 8th in a series of studies conducted since 1980. The sample consisted of 12,756 active-duty Armed Forces personnel worldwide who anonymously completed self-administered questionnaires that assessed substance use and other health behaviors. For the total DoD, during 30 days prior to the survey, heavy alcohol use declined from 20.8 percent in 1980 to 15.4 percent in 1998 and increased significantly to 18.1 percent in 2002; past month cigarette smoking decreased from 51.0 percent in 1980 to 29.9 percent in 1998 and increased significantly to 33.8 percent in 2002; and past month use of any illicit drugs declined from 27.6 percent in 1980 to 2.7 percent in 1998 and also showed a nonsignificant change in 2002 to 3.4 percent (Bray et al., 1999, 2003). In 2002, military personnel had significantly higher rates of heavy alcohol use than their civilian counterparts (16.9 vs. 11.2 percent) when demographic differences between the military and civilian populations were taken into account (civilian data were drawn from the 2001 NSDUH and adjusted to reflect demographic characteristics of the military). Differences in military and civilian heavy alcohol use rates were largest for men aged 18 to 25. Among this age group, the military rate was nearly twice as high as the adjusted civilian rate (32.2 vs. 17.8 percent). Military personnel showed similar rates of cigarette use (31.6 vs. 31.1 percent) compared with civilians. Rates of illicit drug use in the military were significantly lower than those observed for the comparable civilian population when demographic differences between the military and civilian populations were taken into account (3.3 vs. 12.1 percent). Data from the 2005 DoD Survey will be available this year.

Survey of Inmates in State and Federal Correctional Facilities

The 1997 Survey of Inmates in State and Federal Correctional Facilities sampled inmates from a universe of 1,409 State prisons and 127 Federal Prisons for the Bureau of Justice Statistics (BJS). Systematic random sampling was used to select the inmates for the computer-assisted personal interviews. The final numbers interviewed were 14,285 State prisoners and 4,041 Federal prisoners. Among other items, these surveys collected information on the use of drugs in the month before the offense for convicted inmates. Women in State prisons (62.4

percent) were more likely than men (56.1 percent) to have used drugs in the month before the offense (BJS, 1999, 2000). Women also were more likely to have committed their offense while under the influence of drugs (40.4 vs. 32.1 percent of male prisoners). Among Federal prisoners, men (45.4 percent) were more likely than women (36.7 percent) to have used drugs in the past month. Male and female Federal prisoners were equally likely to report the influence of drugs during their offense (22.7 percent of male and 19.3 percent of female prisoners). The survey results indicate substantially higher rates of drug use among State and Federal prisoners as compared with the household population.

Table D.1 Use of Specific Substances in Lifetime, Past Year, and Past Month among 8th, 10th, and 12th Graders in NSDUH and MTF: Percentages, 2004 and 2005

	SURVEY/TIME PERIOD											
	MTF						NSDUH (January – June)					
	Lifetime		Past Year		Past Month		Lifetime		Past Year		Past Month	
Drug/Current Grade Level	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**
Marijuana												
8th grade	16.3	16.5	11.8	12.2	6.4	6.6	9.3	8.0	7.3	6.3	3.6	2.6
10th grade	35.1	34.1	27.5	26.6	15.9	15.2	28.2	24.5	20.9	19.3	10.5	9.0
12th grade	45.7	44.8	34.3	33.6	19.9	19.8	43.1	38.7	31.5[a]	26.8	16.1	15.1
Cocaine												
8th grade	3.4	3.7	2.0	2.2	0.9	1.0	0.7	0.5	0.5	0.4	0.0	0.2
10th grade	5.4	5.2	3.7	3.5	1.7	1.5	2.9	2.7	2.1	2.2	0.8	0.6
12th grade	8.1	8.0	5.3	5.1	2.3	2.3	7.7	6.3	5.4	3.9	1.7	1.1
Inhalants												
8th grade	17.3	17.1	9.6	9.5	4.5	4.2	11.6	11.9	4.8	5.2	1.3	1.4
10th grade	12.4	13.1	5.9	6.0	2.4	2.2	12.1	11.4	4.6	4.6	1.0	1.2
12th grade	10.9	11.4	4.2	5.0	1.5	2.0	11.1	11.3	3.5	3.6	0.3	0.3
Cigarettes												
8th grade	27.9[a]	25.9	--	--	9.2	9.3	22.1[b]	17.4	12.1	10.3	6.3	5.0
10th grade	40.7	38.9	--	--	16.0	14.9	38.3	37.3	24.5	24.1	15.9	15.9
12th grade	52.8[a]	50.0	--	--	25.0	23.2	54.5	50.2	39.1	34.9	28.5[a]	23.9
Alcohol												
8th grade	43.9[b]	41.0	36.7[b]	33.9	18.6	17.1	31.6[a]	27.6	23.8	21.1	8.4	8.0
10th grade	64.2	63.2	58.2	56.7	35.2[a]	33.2	56.5	53.9	47.1	45.5	23.9	22.3
12th grade	76.8	75.1	70.6[a]	68.6	48.0	47/0	72.7	70.7	63.3	62.5	41.5	38.7

-- Not available.

NOTE: NSDUH data have been subset to persons aged 12 to 20 to be more comparable with MTF data.

[a] Difference between estimate and 2005 estimate is statistically significant at the .05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the .01 level.

MTF = Monitoring the Future.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005 (January-June).
The Monitoring the Future Study, University of Michigan, 2004 and 2005.

Table D.2 Lifetime and Past Month Substance Use among Students in Grades 9 to 12 in YRBS and NSDUH: 2003 and 2005

Substance/ Period of Use	YRBS		NSDUH (January – June)	
	2003	2005	2003	2005
Marijuana				
Lifetime Use	40.2	38.4	32.5	28.2
Past Month Use	22.4	20.2	13.2	11.2
Cocaine				
Lifetime Use	8.7	7.6	5.3	3.9
Past Month Use	4.1	3.4	1.2	0.8
Inhalants				
Lifetime Use	12.1	12.4	11.8	12.2
Past Month Use	3.9	--	0.9	1.0
Cigarettes				
Lifetime Use	58.4	54.3	46.0	39.3
Past Month Use	21.9	23.0	20.2	17.4
Alcohol				
Lifetime Use	74.9	74.3	63.1	58.0
Past Month Use	44.9	43.3	29.1	26.2

YRBS = Youth Risk Behavior Survey.

-- Not available.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, January-June for 2003 and 2005.
Centers for Disease Control and Prevention, Youth Risk Behavior Survey, 2003 and 2005.

Table D.3 Past Year and Past Month Marijuana Use among Youths Aged 12 to 18 in NSPY and NSDUH, by Age Group: 2002-2005

Use Measure	Age Group	Percent Reporting Use						
		NSPY			NSDUH			
		2002[1] (Full Year)	2003 (January-June)[2]	2005	2002 (Full Year)	2003 (January-June)	2004 (Full Year)	2005 (Full Year)
Past Year	12 to 13	3.3	4.0	--	3.1	2.3	2.8	2.6
	14 to 16	17.0	18.3	--	19.1	19.5	17.4	15.6
	12 to 18	16.4	16.7	--	18.4	18.1	17.1	16.0
Past Month	12 to 13	1.1	1.8	--	1.4	0.9	1.1	0.9
	14 to 16	8.3	8.2	--	9.4	9.7	9.0	7.9
	12 to 18	8.9	7.9	--	9.8	9.9	9.1	8.4

-- Not available.

[1] NSPY estimates for 2002 are averages of data from Wave 5 (collected between January and June 2002) and Wave 6 (collected between July and December 2002).

[2] NSPY estimates for 2003 are from Wave 7 (collected between January and June 2003).

NSPY = National Survey of Parents and Youth.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.
National Institute on Drug Abuse, National Survey of Parents and Youth, 2002, January–June 2003.

Table D.4 Past Month Cigarette Use among Persons Aged 18 or Older in NHIS and NSDUH, by Gender and Age Group: Percentages, 2004 and 2005

Gender/Age in Years	NHIS		NSDUH	
	2004 (January – September)	2005 (Early Release Data)	2004 (Full Year)	2005 (Full Year)
Total	20.7	20.9	24.6	24.7
18 to 44	23.5	24.1	30.5	30.2
45 to 64	22.3	21.9	23.2	23.4
65 or Older	8.5	8.6	9.0	9.8
Male	23.3	23.4	27.8	27.5
18 to 44	25.8	27.1	33.7	33.5
45 to 64	25.1	25.2	25.8	26.0
65 or Older	10.0	8.9	10.6	9.1
Female	18.3	18.3	21.7	22.0
18 to 44	21.3	21.2	27.3	27.0
45 to 64	19.6	18.8	20.7	21.0
65 or Older	7.3	8.3	7.9	10.3

Note: For the NHIS, *past month cigarette use* is defined as having smoked at least 100 cigarettes in the lifetime and now smoking every day or some days. The analysis excluded those with unknown use status (about 1 percent each year). For NSDUH, *past month cigarette use* is defined as having smoked in the past month. For comparison purposes, the NSDUH definition was adjusted to include those who had smoked in the past month and smoked at least 100 cigarettes in their lifetime.

NHIS = National Health Interview Survey.

Sources: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005 (January – September). National Center for Health Statistics, National Health Interview Survey, 2004 and 2005.

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Appendix F: Sample Size and Population Tables

Table F.1 Survey Sample Size for Respondents Aged 12 or Older, by Gender and Detailed Age Category: 2004 and 2005

Age Category	Total		GENDER			
			Male		Female	
	2004	2005	2004	2005	2004	2005
TOTAL	67,760	68,308	32,696	32,786	35,064	35,522
12	3,558	3,633	1,776	1,824	1,782	1,809
13	3,903	3,791	1,989	1,918	1,914	1,873
14	3,902	3,903	1,980	1,989	1,922	1,914
15	3,790	3,840	1,951	1,907	1,839	1,933
16	3,613	3,784	1,853	1,952	1,760	1,832
17	3,535	3,583	1,814	1,788	1,721	1,795
18	3,252	3,062	1,654	1,575	1,598	1,487
19	2,889	2,894	1,437	1,429	1,452	1,465
20	2,793	2,792	1,335	1,271	1,458	1,521
21	2,799	2,725	1,322	1,282	1,477	1,443
22	2,822	2,784	1,334	1,301	1,488	1,483
23	2,789	2,772	1,298	1,268	1,491	1,504
24	2,893	2,737	1,344	1,303	1,549	1,434
25	2,592	2,745	1,199	1,268	1,393	1,477
26-29	2,982	3,209	1,409	1,521	1,573	1,688
30-34	3,592	3,647	1,654	1,685	1,938	1,962
35-39	3,190	3,164	1,439	1,477	1,751	1,687
40-44	3,397	3,535	1,558	1,622	1,839	1,913
45-49	3,364	3,400	1,582	1,518	1,782	1,882
50-54	1,483	1,511	681	706	802	805
55-59	1,271	1,279	589	592	682	687
60-64	958	1,045	450	494	508	551
65 or Older	2,393	2,473	1,048	1,096	1,345	1,377

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

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Table F.2 Numbers (in Thousands) of Persons Aged 12 or Older, by Gender and Detailed Age Category: 2004 and 2005

Age Category	Total		GENDER			
			Male		Female	
	2004	2005	2004	2005	2004	2005
TOTAL	240,515	243,220	116,483	117,923	124,032	125,297
12	3,974	4,006	1,988	1,975	1,986	2,031
13	4,392	4,225	2,258	2,181	2,134	2,045
14	4,373	4,340	2,210	2,244	2,163	2,096
15	4,293	4,358	2,237	2,178	2,056	2,181
16	4,116	4,314	2,077	2,258	2,039	2,056
17	4,066	4,112	2,106	2,114	1,960	1,998
18	4,596	4,567	2,430	2,450	2,166	2,117
19	3,937	4,293	2,027	2,196	1,909	2,097
20	3,990	4,108	2,006	1,963	1,984	2,145
21	4,080	4,017	1,990	2,048	2,090	1,970
22	4,019	4,055	2,056	2,038	1,963	2,017
23	3,927	3,886	1,909	1,888	2,018	1,998
24	4,047	3,715	1,994	1,856	2,053	1,859
25	3,598	3,844	1,760	1,897	1,838	1,948
26-29	15,345	15,529	7,908	7,929	7,437	7,599
30-34	19,630	19,329	9,463	9,410	10,166	9,919
35-39	20,945	19,939	9,895	10,052	11,051	9,887
40-44	22,678	23,384	11,399	11,440	11,279	11,944
45-49	21,504	21,931	10,700	10,604	10,804	11,327
50-54	19,384	19,715	9,043	9,553	10,341	10,163
55-59	16,401	17,154	8,178	7,953	8,223	9,200
60-64	12,541	13,228	6,125	6,717	6,416	6,511
65 or Older	34,679	35,170	14,722	14,978	19,957	20,191

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table F.3 Survey Sample Size for Respondents Aged 12 or Older, by Age Group and Demographic Characteristics: 2004 and 2005

Demographic Characteristic	Total		AGE GROUP					
			12-17		18-25		26 or Older	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	67,760	68,308	22,301	22,534	22,829	22,511	22,630	23,263
GENDER								
Male	32,696	32,786	11,363	11,378	10,923	10,697	10,410	10,711
Female	35,064	35,522	10,938	11,156	11,906	11,814	12,220	12,552
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	58,372	58,504	18,981	18,999	19,315	18,943	20,076	20,562
White	45,174	45,340	14,176	14,165	14,737	14,521	16,261	16,654
Black or African American	8,290	8,140	3,077	3,065	2,868	2,693	2,345	2,382
American Indian or Alaska Native	860	907	329	316	276	308	255	283
Native Hawaiian or Other Pacific Islander	238	288	62	87	109	119	67	82
Asian	2,125	2,132	578	621	806	779	741	732
Two or More Races	1,685	1,697	759	745	519	523	407	429
Hispanic or Latino	9,388	9,804	3,320	3,535	3,514	3,568	2,554	2,701
GENDER/RACE/HISPANIC ORIGIN								
Male, White, Not Hispanic	21,980	21,971	7,271	7,231	7,174	6,980	7,535	7,760
Female, White, Not Hispanic	23,194	23,369	6,905	6,934	7,563	7,541	8,726	8,894
Male, Black, Not Hispanic	3,698	3,595	1,503	1,501	1,221	1,144	974	950
Female, Black, Not Hispanic	4,592	4,545	1,574	1,564	1,647	1,549	1,371	1,432
Male, Hispanic	4,649	4,789	1,722	1,759	1,717	1,732	1,210	1,298
Female, Hispanic	4,739	5,015	1,598	1,776	1,797	1,836	1,344	1,403
EDUCATION[1]								
< High School	7,892	7,851	N/A	N/A	4,584	4,508	3,308	3,343
High School Graduate	15,259	15,225	N/A	N/A	8,062	7,943	7,197	7,282
Some College	12,985	13,107	N/A	N/A	7,292	7,173	5,693	5,934
College Graduate	9,323	9,591	N/A	N/A	2,891	2,887	6,432	6,704
CURRENT EMPLOYMENT[1]								
Full-Time	24,816	25,400	N/A	N/A	10,657	10,827	14,159	14,573
Part-Time	8,366	8,296	N/A	N/A	5,831	5,584	2,535	2,712
Unemployed	2,491	2,368	N/A	N/A	1,790	1,668	701	700
Other[2]	9,786	9,710	N/A	N/A	4,551	4,432	5,235	5,278

N/A: Not applicable.

[1] Estimates for education and current employment are shown only for persons aged 18 or older.
[2] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table F.4 Numbers (in Thousands) of Persons Aged 12 or Older, by Age Group and Demographic Characteristics: 2004 and 2005

Demographic Characteristic	Total		AGE GROUP					
			12-17		18-25		26 or Older	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	240,515	243,220	25,214	25,355	32,194	32,486	183,106	185,379
GENDER								
Male	116,483	117,923	12,877	12,950	16,172	16,335	87,434	88,638
Female	124,032	125,297	12,337	12,405	16,022	16,151	95,673	96,741
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	209,485	211,087	20,981	20,963	26,475	26,735	162,029	163,389
White	167,051	167,791	15,508	15,399	19,951	20,090	131,592	132,302
Black or African American	28,009	28,597	3,803	3,869	4,358	4,431	19,848	20,298
American Indian or Alaska Native	1,298	1,265	165	163	172	217	961	885
Native Hawaiian or Other Pacific Islander	636	708	65	79	120	136	452	493
Asian	9,933	10,116	1,001	1,055	1,522	1,519	7,411	7,543
Two or More Races	2,559	2,610	440	399	352	342	1,766	1,869
Hispanic or Latino	31,030	32,133	4,233	4,392	5,719	5,751	21,077	21,990
GENDER/RACE/HISPANIC ORIGIN								
Male, White, Not Hispanic	81,039	81,485	7,932	7,873	9,934	10,086	63,173	63,526
Female, White, Not Hispanic	86,012	86,306	7,576	7,526	10,017	10,004	68,419	68,776
Male, Black, Not Hispanic	12,694	13,010	1,949	1,954	2,111	2,087	8,634	8,969
Female, Black, Not Hispanic	15,315	15,587	1,854	1,915	2,247	2,343	11,214	11,329
Male, Hispanic	15,907	16,491	2,161	2,242	3,064	3,063	10,682	11,186
Female, Hispanic	15,123	15,642	2,072	2,150	2,655	2,688	10,395	10,804
EDUCATION[1]								
< High School	36,514	35,702	N/A	N/A	6,671	6,659	29,842	29,043
High School Graduate	68,096	68,517	N/A	N/A	11,054	11,224	57,042	57,293
Some College	54,753	55,222	N/A	N/A	10,319	10,462	44,434	44,760
College Graduate	55,937	58,424	N/A	N/A	4,149	4,140	51,788	54,284
CURRENT EMPLOYMENT[1]								
Full-Time	119,053	120,583	N/A	N/A	15,128	15,335	103,925	105,248
Part-Time	27,538	28,375	N/A	N/A	8,100	8,242	19,438	20,133
Unemployed	7,376	7,604	N/A	N/A	2,575	2,574	4,800	5,030
Other[2]	61,334	61,304	N/A	N/A	6,390	6,335	54,943	54,968

N/A: Not applicable.

[1] Estimates for education and current employment are shown only for persons aged 18 or older.
[2] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table F.5 Survey Sample Size for Respondents Aged 12 or Older, by Age Group and Geographic Characteristics: 2004 and 2005

Geographic Characteristic	Total		AGE GROUP					
			12-17		18-25		26 or Older	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	67,760	68,308	22,301	22,534	22,829	22,511	22,630	23,263
GEOGRAPHIC DIVISION								
Northeast	13,523	13,711	4,361	4,564	4,532	4,546	4,630	4,601
New England	5,409	5,480	1,779	1,795	1,788	1,797	1,842	1,888
Middle Atlantic	8,114	8,231	2,582	2,769	2,744	2,749	2,788	2,713
Midwest	18,889	19,154	6,297	6,339	6,361	6,297	6,231	6,518
East North Central	12,666	12,710	4,302	4,215	4,227	4,155	4,137	4,340
West North Central	6,223	6,444	1,995	2,124	2,134	2,142	2,094	2,178
South	20,807	20,818	6,823	6,884	7,055	6,900	6,929	7,034
South Atlantic	10,853	10,959	3,595	3,606	3,600	3,675	3,658	3,678
East South Central	3,623	3,660	1,147	1,233	1,262	1,179	1,214	1,248
West South Central	6,331	6,199	2,081	2,045	2,193	2,046	2,057	2,108
West	14,541	14,625	4,820	4,747	4,881	4,768	4,840	5,110
Mountain	7,223	7,314	2,357	2,398	2,435	2,390	2,431	2,526
Pacific	7,318	7,311	2,463	2,349	2,446	2,378	2,409	2,584
COUNTY TYPE								
Large Metro	30,077	29,960	9,918	9,852	9,904	9,750	10,255	10,358
Small Metro	22,972	23,418	7,370	7,532	8,215	8,131	7,387	7,755
250K - 1 Mil. Pop.	14,729	15,037	4,845	4,950	5,083	5,085	4,801	5,002
< 250K Pop.	8,243	8,381	2,525	2,582	3,132	3,046	2,586	2,753
Nonmetro	14,711	14,930	5,013	5,150	4,710	4,630	4,988	5,150
Urbanized	6,150	5,893	1,946	1,929	2,184	2,026	2,020	1,938
Less Urbanized	7,043	7,184	2,476	2,539	2,156	2,097	2,411	2,548
Completely Rural	1,518	1,853	591	682	370	507	557	664

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table F.6 Numbers (in Thousands) of Persons Aged 12 or Older, by Age Group and Geographic Characteristics: 2004 and 2005

Geographic Characteristic	Total		AGE GROUP					
			12-17		18-25		26 or Older	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	240,515	243,220	25,214	25,355	32,194	32,486	183,106	185,379
GEOGRAPHIC DIVISION								
Northeast	45,497	45,631	4,536	4,546	5,684	5,710	35,277	35,376
New England	11,947	11,965	1,174	1,175	1,488	1,495	9,284	9,295
Middle Atlantic	33,551	33,666	3,362	3,370	4,196	4,215	25,993	26,081
Midwest	54,212	54,525	5,681	5,666	7,441	7,449	41,089	41,410
East North Central	37,937	38,108	4,008	4,013	5,127	5,123	28,802	28,973
West North Central	16,274	16,417	1,674	1,653	2,314	2,326	12,287	12,437
South	86,141	87,602	9,001	9,065	11,538	11,705	65,602	66,831
South Atlantic	45,192	46,106	4,579	4,637	5,706	5,830	34,906	35,638
East South Central	14,392	14,534	1,449	1,449	1,951	1,949	10,992	11,135
West South Central	26,557	26,962	2,972	2,979	3,881	3,925	19,704	20,058
West	54,665	55,463	5,996	6,078	7,531	7,623	41,138	41,762
Mountain	15,986	16,437	1,745	1,759	2,287	2,347	11,954	12,331
Pacific	38,679	39,027	4,251	4,319	5,244	5,276	29,184	29,432
COUNTY TYPE								
Large Metro	128,322	131,068	13,345	13,667	16,650	17,215	98,327	100,186
Small Metro	71,638	71,608	7,645	7,462	10,604	10,318	53,389	53,828
250K - 1 Mil. Pop.	47,167	47,708	5,103	5,100	6,888	6,777	35,176	35,831
< 250K Pop.	24,471	23,899	2,542	2,361	3,716	3,541	18,213	17,997
Nonmetro	40,555	40,545	4,224	4,227	4,940	4,953	31,390	31,366
Urbanized	16,696	15,380	1,700	1,581	2,303	2,107	12,694	11,692
Less Urbanized	20,291	20,402	2,147	2,142	2,313	2,355	15,830	15,904
Completely Rural	3,568	4,763	377	503	324	491	2,866	3,769

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Appendix G: Selected Prevalence Tables

Table G.1 Types of Illicit Drug Use in Lifetime among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	108,255[b]	110,205	110,057	112,085
Marijuana and Hashish	94,946[a]	96,611	96,772	97,545
Cocaine	33,910	34,891	34,153	33,673
Crack	8,402	7,949	7,840	7,928
Heroin	3,668	3,744	3,145	3,534
Hallucinogens	34,314	34,363	34,333	33,728
LSD	24,516[b]	24,424[b]	23,398	22,433
PCP	7,418[a]	7,107	6,762	6,603
Ecstasy	10,150[b]	10,904	11,130	11,495
Inhalants	22,870	22,995	22,798	22,745
Nonmedical Use of Psychotherapeutics[2]	46,558[a]	47,882	48,013	48,709
Pain Relievers	29,611[b]	31,207	31,768	32,692
OxyContin®	1,924[b]	2,832[b]	3,072[a]	3,481
Tranquilizers	19,267[a]	20,220	19,852	21,041
Stimulants	21,072[b]	20,798[b]	19,982	19,080
Methamphetamine	12,383[b]	12,303[b]	11,726[b]	10,357
Sedatives	9,960	9,510	9,891	8,982
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	70,300	71,128	70,657	71,822

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.2 Types of Illicit Drug Use in Lifetime among Persons Aged 12 or Older: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	46.0	46.4	45.8	46.1
Marijuana and Hashish	40.4	40.6	40.2	40.1
Cocaine	14.4	14.7[a]	14.2	13.8
Crack	3.6	3.3	3.3	3.3
Heroin	1.6	1.6	1.3	1.5
Hallucinogens	14.6[a]	14.5	14.3	13.9
LSD	10.4[b]	10.3[b]	9.7	9.2
PCP	3.2[b]	3.0	2.8	2.7
Ecstasy	4.3[a]	4.6	4.6	4.7
Inhalants	9.7	9.7	9.5	9.4
Nonmedical Use of Psychotherapeutics[2]	19.8	20.1	20.0	20.0
Pain Relievers	12.6[a]	13.1	13.2	13.4
OxyContin®	0.8[b]	1.2[b]	1.3	1.4
Tranquilizers	8.2	8.5	8.3	8.7
Stimulants	9.0[b]	8.8[b]	8.3	7.8
Methamphetamine	5.3[b]	5.2[b]	4.9[b]	4.3
Sedatives	4.2[a]	4.0	4.1	3.7
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	29.9	29.9	29.4	29.5

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.3 Types of Illicit Drug Use in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	35,132	34,993	34,807	35,041
Marijuana and Hashish	25,755	25,231	25,451	25,375
Cocaine	5,902	5,908	5,658	5,523
Crack	1,554	1,406	1,304	1,381
Heroin	404	314	398	379
Hallucinogens	4,749[b]	3,936	3,878	3,809
LSD	999[b]	558	592	563
PCP	235[a]	219	210	164
Ecstasy	3,167[b]	2,119	1,915	1,960
Inhalants	2,084	2,075	2,255	2,187
Nonmedical Use of Psychotherapeutics[2]	14,680	14,986	14,643	15,172
Pain Relievers	10,992	11,671	11,256	11,815
OxyContin®	--	--	1,213	1,226
Tranquilizers	4,849	5,051	5,068	5,249
Stimulants	3,181[a]	2,751	2,918	2,771
Methamphetamine	1,541	1,315	1,440	1,297
Sedatives	981	831	737	750
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	20,423	20,305	19,658	20,109

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.4 Types of Illicit Drug Use in the Past Year among Persons Aged 12 or Older: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	14.9	14.7	14.5	14.4
Marijuana and Hashish	11.0	10.6	10.6	10.4
Cocaine	2.5	2.5	2.4	2.3
Crack	0.7	0.6	0.5	0.6
Heroin	0.2	0.1	0.2	0.2
Hallucinogens	2.0[b]	1.7	1.6	1.6
LSD	0.4[b]	0.2	0.2	0.2
PCP	0.1[a]	0.1	0.1	0.1
Ecstasy	1.3[b]	0.9	0.8	0.8
Inhalants	0.9	0.9	0.9	0.9
Nonmedical Use of Psychotherapeutics[2]	6.2	6.3	6.1	6.2
Pain Relievers	4.7	4.9	4.7	4.9
OxyContin®	--	--	0.5	0.5
Tranquilizers	2.1	2.1	2.1	2.2
Stimulants	1.4[b]	1.2	1.2	1.1
Methamphetamine	0.7[a]	0.6	0.6	0.5
Sedatives	0.4	0.3	0.3	0.3
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	8.7	8.5	8.2	8.3

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.5 Types of Illicit Drug Use in the Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	19,522	19,470	19,071	19,720
Marijuana and Hashish	14,584	14,638	14,576	14,626
Cocaine	2,020[a]	2,281	2,021[a]	2,397
Crack	567	604	467[a]	682
Heroin	166	119	166	136
Hallucinogens	1,196	1,042	929	1,088
LSD	112	133	141	104
PCP	58	56	49	48
Ecstasy	676[a]	470	450	502
Inhalants	635	570	638	611
Nonmedical Use of Psychotherapeutics[2]	6,210	6,336	6,007	6,405
Pain Relievers	4,377	4,693	4,404	4,658
OxyContin®	--	--	325	334
Tranquilizers	1,804	1,830	1,616	1,817
Stimulants	1,218	1,191	1,189	1,067
Methamphetamine	597	607	583	512
Sedatives	436[a]	294	265	272
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	8,777	8,849	8,247	8,963

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.6 Types of Illicit Drug Use in the Past Month among Persons Aged 12 or Older: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	8.3	8.2	7.9	8.1
Marijuana and Hashish	6.2	6.2	6.1	6.0
Cocaine	0.9	1.0	0.8	1.0
Crack	0.2	0.3	0.2	0.3
Heroin	0.1	0.1	0.1	0.1
Hallucinogens	0.5	0.4	0.4	0.4
LSD	0.0	0.1	0.1	0.0
PCP	0.0	0.0	0.0	0.0
Ecstasy	0.3[a]	0.2	0.2	0.2
Inhalants	0.3	0.2	0.3	0.3
Nonmedical Use of Psychotherapeutics[2]	2.6	2.7	2.5	2.6
Pain Relievers	1.9	2.0	1.8	1.9
OxyContin®	--	--	0.1	0.1
Tranquilizers	0.8	0.8	0.7	0.7
Stimulants	0.5	0.5	0.5	0.4
Methamphetamine	0.3	0.3	0.2	0.2
Sedatives	0.2[a]	0.1	0.1	0.1
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	3.7	3.7	3.4	3.7

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.7 Types of Illicit Drug Use in the Past Month among Persons Aged 12 to 17: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	11.6[b]	11.2[b]	10.6	9.9
Marijuana and Hashish	8.2[b]	7.9[b]	7.6[a]	6.8
Cocaine	0.6	0.6	0.5	0.6
Crack	0.1	0.1	0.1	0.1
Heroin	0.0	0.1	0.1	0.1
Hallucinogens	1.0[a]	1.0[a]	0.8	0.8
LSD	0.2[a]	0.2	0.2	0.1
PCP	0.1	0.1	0.0	0.1
Ecstasy	0.5[b]	0.4	0.3	0.3
Inhalants	1.2	1.3	1.2	1.2
Nonmedical Use of Psychotherapeutics[2]	4.0[b]	4.0[b]	3.6	3.3
Pain Relievers	3.2[a]	3.2[a]	3.0	2.7
OxyContin®	--	--	0.3[a]	0.1
Tranquilizers	0.8	0.9[a]	0.6	0.6
Stimulants	0.8	0.9[a]	0.7	0.7
Methamphetamine	0.3	0.3	0.2	0.3
Sedatives	0.2[a]	0.2	0.1	0.1
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	5.7[b]	5.7[b]	5.3	4.9

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.8 Types of Illicit Drug Use in the Past Month among Persons Aged 18 to 25: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	20.2	20.3	19.4	20.1
Marijuana and Hashish	17.3	17.0	16.1	16.6
Cocaine	2.0[b]	2.2	2.1[a]	2.6
Crack	0.2[b]	0.2[a]	0.3	0.3
Heroin	0.1	0.1[b]	0.1	0.2
Hallucinogens	1.9[a]	1.7	1.5	1.5
LSD	0.1	0.2	0.3	0.2
PCP	0.0	0.1	0.1	0.0
Ecstasy	1.1[a]	0.7	0.7	0.8
Inhalants	0.5	0.4	0.4	0.5
Nonmedical Use of Psychotherapeutics[2]	5.4[b]	6.0	6.1	6.3
Pain Relievers	4.1[b]	4.7	4.7	4.7
OxyContin®	--	--	0.4	0.4
Tranquilizers	1.6	1.7	1.8	1.9
Stimulants	1.2	1.3	1.4	1.3
Methamphetamine	0.5	0.6	0.6	0.6
Sedatives	0.2	0.2	0.2	0.2
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	7.9[a]	8.4	8.1	8.8

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.9 Types of Illicit Drug Use in the Past Month among Persons Aged 26 or Older: Percentages, 2002-2005

Drug	2002	2003	2004	2005
ILLICIT DRUGS[1]	5.8	5.6	5.5	5.8
Marijuana and Hashish	4.0	4.0	4.1	4.1
Cocaine	0.7	0.8	0.7	0.8
Crack	0.3	0.3	0.2	0.3
Heroin	0.1	0.0	0.1	0.0
Hallucinogens	0.2	0.1	0.1	0.2
LSD	0.0	0.0	0.0	0.0
PCP	0.0	*	0.0	0.0
Ecstasy	0.1	0.1	0.1	0.1
Inhalants	0.1	0.1	0.1	0.1
Nonmedical Use of Psychotherapeutics[2]	2.0	1.9	1.7	1.9
Pain Relievers	1.3	1.3	1.2	1.3
OxyContin®	--	--	0.1	0.1
Tranquilizers	0.6	0.6	0.5	0.6
Stimulants	0.4	0.3	0.3	0.2
Methamphetamine	0.2	0.2	0.2	0.1
Sedatives	0.2[a]	0.1	0.1	0.1
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	2.7	2.6	2.3	2.6

*Low precision; no estimate reported.
-- Not available.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.10 Illicit Drug Use in Lifetime, Past Year, and Past Month, by Detailed Age Category: Percentages, 2004 and 2005

Age Category	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	45.8	46.1	14.5	14.4	7.9	8.1
12	11.2	11.7	6.7	7.3	2.8	2.5
13	18.4	16.9	11.6	11.4	4.6	4.9
14	25.2[a]	22.6	17.8[a]	15.4	9.0[b]	6.7
15	34.7[b]	30.3	24.6[a]	21.9	12.7	11.1
16	42.5[b]	38.1	31.0	29.4	15.5	15.8
17	48.4	45.9	34.9	33.5	19.1	18.2
18	53.4	51.9	38.8	36.5	21.2	20.5
19	56.6	57.0	38.6	38.8	22.8	22.6
20	59.0	59.8	38.1	38.6	21.3	24.1
21	62.3	59.7	36.6	35.8	21.7	20.7
22	62.9	61.6	35.1	34.0	20.5	20.0
23	59.5[a]	63.5	28.3[b]	33.5	15.4[b]	19.5
24	59.8	60.8	27.6	28.3	16.2	16.6
25	60.5	60.4	26.7	26.7	15.2	16.4
26-29	60.0	59.9	23.5	22.8	13.2	12.9
30-34	54.5	54.1	15.7	17.6	9.4	9.6
35-39	59.4	58.2	14.1	13.6	7.2	7.6
40-44	64.9[a]	61.9	14.4	13.0	7.5	7.2
45-49	61.8	63.5	11.8	11.8	6.8	6.6
50-54	56.3	55.6	9.0	8.3	4.8	5.2
55-59	38.2[a]	44.1	5.1	5.6	2.6	3.4
60-64	24.2	28.2	2.0	3.2	1.1	1.8
65 or Older	8.3[a]	10.9	0.9	1.7	0.4	0.8

*Low precision; no estimate reported.
NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.11 Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	45.8	46.1	14.5	14.4	7.9	8.1
AGE						
12-17	30.0[b]	27.7	21.0[a]	19.9	10.6	9.9
18-25	59.2	59.2	33.9	34.2	19.4	20.1
26 or Older	45.6	46.3	10.2	10.2	5.5	5.8
GENDER						
Male	50.7	50.8	16.9	16.8	9.9	10.2
Female	41.1	41.6	12.2	12.1	6.1	6.1
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	47.3	47.4	14.7	14.5	8.0	8.2
White	49.1	48.9	15.0	14.5	8.1	8.1
Black or African American	43.3	44.7	14.6	16.0	8.7	9.7
American Indian or Alaska Native	58.4	60.9	26.2	21.3	12.3	12.8
Native Hawaiian or Other Pacific Islander	*	54.3	*	15.5	*	8.7
Asian	24.3	28.1	6.9	7.1	3.1	3.1
Two or More Races	54.9[a]	45.8	21.0	19.1	13.3	12.2
Hispanic or Latino	35.4	37.3	12.9	13.9	7.2	7.6

*Low precision; no estimate reported.
NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.12 Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 to 17, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	30.0[b]	27.7	21.0[a]	19.9	10.6	9.9
GENDER						
Male	30.7[b]	28.4	20.6	19.7	10.6	10.1
Female	29.3[b]	26.9	21.5[a]	20.0	10.6	9.7
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	30.0[b]	27.4	21.2[a]	19.9	10.7	10.0
White	30.6[b]	27.3	22.2[b]	20.5	11.1[a]	10.1
Black or African American	28.2	29.9	18.4	20.4	9.3	11.0
American Indian or Alaska Native	50.3	49.5	41.4[a]	29.6	26.0	19.2
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*
Asian	20.4	15.9	13.3[a]	7.6	6.0	3.3
Two or More Races	37.9[a]	29.6	24.6	21.7	12.2	9.7
Hispanic or Latino	30.0	28.9	19.9	19.6	10.2	9.4
GENDER/RACE/HISPANIC ORIGIN						
Male, White, Not Hispanic	30.6[b]	27.9	21.5	20.1	10.8	10.4
Female, White, Not Hispanic	30.7[b]	26.7	22.9[a]	20.9	11.5[a]	9.8
Male, Black, Not Hispanic	29.7	31.0	19.1	20.5	10.5	12.1
Female, Black, Not Hispanic	26.7	28.9	17.6	20.2	8.1	9.9
Male, Hispanic	30.0	31.2	17.9	20.9	10.1	9.7
Female, Hispanic	29.9	26.5	22.1[a]	18.2	10.4	9.1

*Low precision; no estimate reported.
NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.13 Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	47.6	48.2	13.7	13.8	7.6	7.9
GENDER						
Male	53.2	53.6	16.4	16.5	9.8	10.3
Female	42.4	43.2	11.2	11.2	5.6	5.7
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	49.2	49.6	14.0	13.9	7.7	8.0
White	51.0	51.1	14.2	13.9	7.8	7.9
Black or African American	45.7	47.0	14.0	15.3	8.6	9.5
American Indian or Alaska Native	*	62.5	24.0	20.1	10.3	11.9
Native Hawaiian or Other Pacific Islander	*	*	*	13.9	*	8.0
Asian	24.8	29.5	6.2	7.0	2.8	3.1
Two or More Races	58.4	48.8	20.3	18.6	13.6	12.6
Hispanic or Latino	36.2	38.7	11.8	13.0	6.7	7.3
EDUCATION						
< High School	37.2	37.7	14.3	15.4	8.6[a]	9.8
High School Graduate	44.7	46.2	13.7	14.2	7.8	8.6
Some College	53.8	53.8	15.9	15.6	8.7	8.9
College Graduate	51.8	51.7	11.1	10.6	5.6	5.0
CURRENT EMPLOYMENT						
Full-Time	56.4	56.6	14.6	14.7	8.0	8.2
Part-Time	50.2	49.9	18.5	18.0	10.3	10.4
Unemployed	64.1	60.6	28.8	27.8	19.2	17.1
Other[1]	27.3[a]	29.5	8.0	8.3	4.3	5.0

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.

[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

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Table G.14 Nonmedical Use of Methamphetamine in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older and Illicit Drug and Stimulant Dependence or Abuse in the Past Year and Received Last or Current Treatment for Stimulant Use at a Specialty Facility in the Past Year among Persons Aged 12 or Older, by Past Year and Past Month Nonmedical Use of Methamphetamine: Numbers in Thousands, 2002-2005

Methamphetamine Use/Dependence or Abuse/Treatment	2002	2003	2004	2005
TOTAL				
Lifetime Methamphetamine Use	12,383[b]	12,303[b]	11,726[b]	10,357
Past Year Methamphetamine Use	1,541	1,315	1,440	1,297
Past Month Methamphetamine Use	597	607	583	512
Dependence or Abuse of Illicit Drugs[1,2]	7,116	6,835	7,298	6,833
Dependence or Abuse of Stimulants[1]	436	378	470	409
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	146	157	192	170
PAST YEAR METHAMPHETAMINE USERS				
Dependence or Abuse of Illicit Drugs[1,2]	645	562	757	613
Dependence or Abuse of Stimulants[1]	228	199	296	217
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	49	83	79	82
PAST MONTH METHAPHETAMINE USERS				
Dependence or Abuse of Illicit Drugs[1,2]	164[a]	250	346	257
Dependence or Abuse of Stimulants[1]	63	92	130	103
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	13	41	21	15

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[3] Received Substance Use Treatment at a Specialty Facility refers to treatment received at a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop stimulant use, or for medical problems associated with stimulant use.
[4] If respondents reported that they were currently receiving treatment, they were asked questions regarding specific substances for their current treatment; otherwise, questions pertained to the last treatment they received.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.15 Nonmedical Use of Methamphetamine in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older and Illicit Drug and Stimulant Dependence or Abuse in the Past Year and Received Last or Current Treatment for Stimulant Use at a Specialty Facility in the Past Year among Persons Aged 12 or Older, by Past Year and Past Month Nonmedical Use of Methamphetamine: Percentages, 2002-2005

Methamphetamine Use/Dependence or Abuse/Treatment	2002	2003	2004	2005
TOTAL				
Lifetime Methamphetamine Use	5.3[b]	5.2[b]	4.9[b]	4.3
Past Year Methamphetamine Use	0.7[a]	0.6	0.6	0.5
Past Month Methamphetamine Use	0.3	0.3	0.2	0.2
Dependence or Abuse of Illicit Drugs[1,2]	3.0	2.9	3.0	2.8
Dependence or Abuse of Stimulants[1]	0.2	0.2	0.2	0.2
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	0.1	0.1	0.1	0.1
PAST YEAR METHAMPHETAMINE USERS				
Dependence or Abuse of Illicit Drugs[1,2]	41.9	42.8	52.6	47.2
Dependence or Abuse of Stimulants[1]	14.8	15.1	20.5	16.7
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	3.2	6.3	5.5	6.3
PAST MONTH METHAPHETAMINE USERS				
Dependence or Abuse of Illicit Drugs[1,2]	27.5[b]	41.2	59.3	50.2
Dependence or Abuse of Stimulants[1]	10.6[a]	15.1	22.3	20.0
Received Last or Current Treatment for Stimulants at Specialty Facility[3,4]	2.2	6.7	3.6	3.0

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[3] Received Substance Use Treatment at a Specialty Facility refers to treatment received at a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop stimulant use, or for medical problems associated with stimulant use.
[4] If respondents reported that they were currently receiving treatment, they were asked questions regarding specific substances for their current treatment; otherwise, questions pertained to the last treatment they received.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.16 Tobacco Product and Alcohol Use in the Past Month among Persons Aged 12 or Older, by Gender: Numbers in Thousands, 2002-2005

Gender/Substance	2002	2003	2004	2005
TOTAL				
TOBACCO PRODUCTS[1]	71,499	70,757	70,257	71,519
Cigarettes	61,136	60,434	59,896	60,532
Smokeless Tobacco	7,787	7,725	7,154	7,682
Cigars	12,751	12,837	13,727	13,640
Pipe Tobacco	1,816	1,619[b]	1,835	2,190
ALCOHOL	119,820[b]	118,965[b]	120,934[b]	126,028
Binge Alcohol Use[2]	53,787	53,770	54,725	55,090
Heavy Alcohol Use[2]	15,860	16,144	16,689	16,035
MALE				
TOBACCO PRODUCTS[1]	41,991	41,288	41,569	42,175
Cigarettes	32,636	32,263	32,278	32,312
Smokeless Tobacco	7,242	7,096	6,730	7,174
Cigars	10,669	10,372[a]	11,375	11,355
Pipe Tobacco	1,487[a]	1,400[a]	1,579	1,877
ALCOHOL	65,210[b]	65,927[b]	66,317[a]	68,497
Binge Alcohol Use[2]	35,456	35,565	36,195	36,025
Heavy Alcohol Use[2]	12,216	11,958	12,388	12,172
FEMALE				
TOBACCO PRODUCTS[1]	29,509	29,469	28,688	29,344
Cigarettes	28,500	28,171	27,618	28,220
Smokeless Tobacco	545	628	424	508
Cigars	2,082	2,465	2,352	2,285
Pipe Tobacco	330	219	256	313
ALCOHOL	54,610[b]	53,038[b]	54,616[b]	57,531
Binge Alcohol Use[2]	18,331	18,205	18,530	19,065
Heavy Alcohol Use[2]	3,645	4,186	4,301	3,863

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.17 Tobacco Product and Alcohol Use in the Past Month among Persons Aged 12 or Older, by Gender: Percentages, 2002-2005

Gender/Substance	2002	2003	2004	2005
TOTAL				
TOBACCO PRODUCTS[1]	30.4[a]	29.8	29.2	29.4
Cigarettes	26.0[a]	25.4	24.9	24.9
Smokeless Tobacco	3.3	3.3	3.0	3.2
Cigars	5.4	5.4	5.7	5.6
Pipe Tobacco	0.8	0.7[b]	0.8	0.9
ALCOHOL	51.0	50.1[b]	50.3[b]	51.8
Binge Alcohol Use[2]	22.9	22.6	22.8	22.7
Heavy Alcohol Use[2]	6.7	6.8	6.9	6.6
MALE				
TOBACCO PRODUCTS[1]	37.0	35.9	35.7	35.8
Cigarettes	28.7[a]	28.1	27.7	27.4
Smokeless Tobacco	6.4	6.2	5.8	6.1
Cigars	9.4	9.0	9.8	9.6
Pipe Tobacco	1.3	1.2[a]	1.4	1.6
ALCOHOL	57.4	57.3	56.9	58.1
Binge Alcohol Use[2]	31.2	30.9	31.1	30.5
Heavy Alcohol Use[2]	10.8	10.4	10.6	10.3
FEMALE				
TOBACCO PRODUCTS[1]	24.3	24.0	23.1	23.4
Cigarettes	23.4	23.0	22.3	22.5
Smokeless Tobacco	0.4	0.5	0.3	0.4
Cigars	1.7	2.0	1.9	1.8
Pipe Tobacco	0.3	0.2	0.2	0.3
ALCOHOL	44.9	43.2[b]	44.0[a]	45.9
Binge Alcohol Use[2]	15.1	14.8	14.9	15.2
Heavy Alcohol Use[2]	3.0	3.4	3.5[a]	3.1

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.18 Tobacco Product and Alcohol Use in the Past Month among Persons Aged 12 to 17, by Gender: Percentages, 2002-2005

Gender/Substance	2002	2003	2004	2005
TOTAL				
TOBACCO PRODUCTS[1]	15.2[b]	14.4[b]	14.4[b]	13.1
Cigarettes	13.0[b]	12.2[b]	11.9[b]	10.8
Smokeless Tobacco	2.0	2.0	2.3	2.1
Cigars	4.5	4.5	4.8[a]	4.2
Pipe Tobacco	0.6	0.6	0.7	0.6
ALCOHOL	17.6[a]	17.7[a]	17.6[a]	16.5
Binge Alcohol Use[2]	10.7[a]	10.6	11.1[b]	9.9
Heavy Alcohol Use[2]	2.5	2.6	2.7	2.4
MALE				
TOBACCO PRODUCTS[1]	16.0[b]	15.6[a]	15.3	14.2
Cigarettes	12.3[b]	11.9[a]	11.3	10.7
Smokeless Tobacco	3.4	3.7	4.0	3.7
Cigars	6.2	6.2	6.6[a]	5.8
Pipe Tobacco	0.7	0.9	0.9	0.8
ALCOHOL	17.4[a]	17.1	17.2[a]	15.9
Binge Alcohol Use[2]	11.4[a]	11.1	11.6[a]	10.4
Heavy Alcohol Use[2]	3.1	2.9	3.2	3.0
FEMALE				
TOBACCO PRODUCTS[1]	14.4[b]	13.3[a]	13.5[b]	11.9
Cigarettes	13.6[b]	12.5[b]	12.5[b]	10.8
Smokeless Tobacco	0.4	0.3	0.4	0.4
Cigars	2.7	2.7	2.8	2.5
Pipe Tobacco	0.4	0.3	0.5	0.4
ALCOHOL	17.9	18.3	18.0	17.2
Binge Alcohol Use[2]	9.9	10.1	10.5[a]	9.4
Heavy Alcohol Use[2]	1.9	2.3	2.1	1.8

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.19 Tobacco Product and Alcohol Use in the Past Month among Persons Aged 18 to 25, by Gender: Percentages, 2002-2005

Gender/Substance	2002	2003	2004	2005
TOTAL				
TOBACCO PRODUCTS[1]	45.3	44.8	44.6	44.3
Cigarettes	40.8[b]	40.2	39.5	39.0
Smokeless Tobacco	4.8	4.7	4.9	5.1
Cigars	11.0[a]	11.4	12.7	12.0
Pipe Tobacco	1.1[b]	0.9[b]	1.2	1.5
ALCOHOL	60.5	61.4	60.5	60.9
Binge Alcohol Use[2]	40.9	41.6	41.2	41.9
Heavy Alcohol Use[2]	14.9	15.1	15.1	15.3
MALE				
TOBACCO PRODUCTS[1]	52.1	51.7	51.7	51.6
Cigarettes	44.4	44.2	43.5	42.9
Smokeless Tobacco	9.4	8.9	9.5	9.7
Cigars	16.8[a]	17.3	19.7	18.3
Pipe Tobacco	1.7[a]	1.4[b]	2.1	2.3
ALCOHOL	65.2	66.9	64.9	66.3
Binge Alcohol Use[2]	50.2	51.3	50.1	51.7
Heavy Alcohol Use[2]	21.1	21.2	21.2	21.7
FEMALE				
TOBACCO PRODUCTS[1]	38.4	37.8	37.4	36.9
Cigarettes	37.1[a]	36.2	35.5	35.0
Smokeless Tobacco	0.3	0.4	0.4	0.5
Cigars	5.2	5.5	5.8	5.6
Pipe Tobacco	0.4	0.4	0.4	0.6
ALCOHOL	55.7	55.8	56.0	55.4
Binge Alcohol Use[2]	31.7	31.8	32.3	31.9
Heavy Alcohol Use[2]	8.7	9.0	8.8	8.8

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.20 Tobacco Product and Alcohol Use in the Past Month among Persons Aged 26 or Older, by Gender: Percentages, 2002-2005

Gender/Substance	2002	2003	2004	2005
TOTAL				
TOBACCO PRODUCTS[1]	29.9	29.3	28.5	29.0
Cigarettes	25.2	24.7	24.1	24.3
Smokeless Tobacco	3.2	3.2	2.7	3.0
Cigars	4.6	4.5	4.6	4.7
Pipe Tobacco	0.8	0.6	0.7	0.8
ALCOHOL	53.9	52.5[b]	53.0[b]	55.1
Binge Alcohol Use[2]	21.4	21.0	21.1	21.0
Heavy Alcohol Use[2]	5.9	5.9	6.1	5.6
MALE				
TOBACCO PRODUCTS[1]	37.3	36.0	35.7	36.0
Cigarettes	28.3	27.5	27.2	27.0
Smokeless Tobacco	6.3	6.0	5.3	5.8
Cigars	8.5	7.9	8.4	8.6
Pipe Tobacco	1.3	1.2	1.3	1.6
ALCOHOL	61.9	61.5	61.3	62.7
Binge Alcohol Use[2]	30.7	30.1	30.4	29.6
Heavy Alcohol Use[2]	10.0	9.5	9.8	9.3
FEMALE				
TOBACCO PRODUCTS[1]	23.2	23.1	22.0	22.6
Cigarettes	22.5	22.1	21.3	21.9
Smokeless Tobacco	0.5	0.6	0.3	0.4
Cigars	1.0	1.3	1.1	1.1
Pipe Tobacco	0.2	0.1	0.1	0.2
ALCOHOL	46.6	44.3[b]	45.4[b]	48.0
Binge Alcohol Use[2]	13.0	12.6	12.6	13.2
Heavy Alcohol Use[2]	2.2	2.6	2.7[a]	2.3

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.21 Alcohol Use in Lifetime, Past Year, and Past Month among Persons Aged 12 to 20, by Gender: Percentages, 2002-2005

Gender/Alcohol Use	2002	2003	2004	2005
TOTAL				
Lifetime	56.2[b]	55.8[b]	54.9	53.9
Past Year	47.0	46.8	46.6	46.3
Past Month	28.8	29.0	28.7	28.2
Binge Alcohol Use[1]	19.3	19.2	19.6	18.8
Heavy Alcohol Use[1]	6.2	6.1	6.3	6.0
MALE				
Lifetime	56.5[b]	55.0	54.9	53.7
Past Year	46.6	45.6	46.3	45.6
Past Month	29.6	29.9	29.6	28.9
Binge Alcohol Use[1]	21.8	21.7	22.1	21.3
Heavy Alcohol Use[1]	8.1	7.9	8.2	7.6
FEMALE				
Lifetime	56.0[a]	56.6[b]	54.8	54.2
Past Year	47.5	48.0	46.9	46.9
Past Month	28.0	28.1	27.8	27.5
Binge Alcohol Use[1]	16.7	16.5	17.0	16.1
Heavy Alcohol Use[1]	4.2	4.3	4.3	4.3

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.22 Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month, by Detailed Age Category: Percentages, 2004 and 2005

Age Category	TYPE OF ALCOHOL USE					
	Alcohol Use		Binge Alcohol Use		Heavy Alcohol Use	
	2004	2005	2004	2005	2004	2005
TOTAL	50.3[b]	51.8	22.8	22.7	6.9	6.6
12	2.3	2.5	1.1	1.3	0.1	0.1
13	6.1	5.8	2.9	2.6	0.4	0.4
14	12.3	10.6	5.6	5.2	1.0	1.0
15	20.4	19.6	12.7[a]	10.8	2.2	2.4
16	27.7	27.0	18.3	16.8	4.5	4.2
17	37.3[b]	33.2	26.6[b]	22.7	8.1[a]	6.5
18	46.3	44.4	33.1	30.8	11.0	10.6
19	51.5	52.1	37.4	38.1	13.9	14.0
20	56.3	57.6	40.3	39.9	16.3	14.5
21	69.8	69.4	48.2	49.9	19.2	19.8
22	69.1	66.2	46.8	46.6	17.8	19.2
23	63.8[b]	69.5	43.1[b]	47.7	14.3	16.5
24	63.7	64.8	40.3	41.7	13.7	14.3
25	65.7	67.0	41.5	42.0	14.8	14.0
26-29	63.2	63.7	36.8	35.3	10.7	10.7
30-34	58.4[a]	61.6	28.6	31.0	8.3	8.8
35-39	60.6	62.4	29.8	27.7	7.3	7.0
40-44	60.1	60.1	26.9	26.5	8.4	7.2
45-49	57.5	60.2	23.2	23.3	6.9	6.3
50-54	55.6	58.3	18.9	19.0	6.2	5.5
55-59	48.3	50.8	14.1	14.2	4.3	3.3
60-64	49.9	47.5	13.6	11.9	3.7	3.1
65 or Older	35.3[a]	40.0	6.9	8.3	1.8	1.7

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.23 Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Aged 12 to 20, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TYPE OF ALCOHOL USE					
	Alcohol Use		Binge Alcohol Use		Heavy Alcohol Use	
	2004	2005	2004	2005	2004	2005
TOTAL	28.7	28.2	19.6	18.8	6.3	6.0
GENDER						
Male	29.6	28.9	22.1	21.3	8.2	7.6
Female	27.8	27.5	17.0	16.1	4.3	4.3
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	29.2	28.7	19.7	19.0	6.6	6.4
White	32.6	32.3	22.8	22.3	8.1	7.8
Black or African American	19.1	19.0	9.9	9.1	2.0	1.8
American Indian or Alaska Native	24.3	21.7	19.0	18.1	4.7	6.0
Native Hawaiian or Other Pacific Islander	*	12.0	*	8.4	1.1	1.4
Asian	16.4	15.5	8.0	7.4	1.6	1.2
Two or More Races	26.4	24.0	18.0	16.6	6.2	7.1
Hispanic or Latino	26.6	25.9	19.3	17.9	4.7	4.2
GENDER/RACE/HISPANIC ORIGIN						
Male, White, Not Hispanic	33.5	32.6	25.7	24.7	10.4	9.8
Female, White, Not Hispanic	31.6	31.9	19.8	19.7	5.7	5.8
Male, Black, Not Hispanic	20.3	20.4	11.7	11.4	3.4	2.5
Female, Black, Not Hispanic	17.7	17.6	8.1	6.8	0.6	1.1
Male, Hispanic	26.9	27.9	21.1	21.5	6.2	5.9
Female, Hispanic	26.2	23.7	17.5[a]	13.9	3.1	2.5

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

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Table G.24 Cigarette Use in Lifetime, Past Year, and Past Month, by Detailed Age Category: Percentages, 2004 and 2005

Age Category	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	67.3	66.6	29.1	29.1	24.9	24.9
12	7.0	5.8	3.3	3.0	1.1	1.3
13	14.9	14.0	8.2	8.6	4.3	3.4
14	25.1[b]	20.7	15.0[b]	11.9	8.4[b]	6.2
15	34.2[a]	31.0	21.3	19.9	13.5	12.2
16	43.5[a]	40.0	29.0	26.8	19.1	17.6
17	51.1	48.3	34.2	33.1	25.4	23.7
18	59.2	56.4	43.1	42.0	34.8	32.0
19	64.9	63.4	47.1	44.8	37.2	35.7
20	67.8	68.1	49.0	48.6	40.3	39.8
21	71.4	68.9	49.5	50.1	41.2	41.6
22	72.7[a]	69.5	50.2	49.5	42.9	41.8
23	69.6	70.5	47.7	49.4	40.6	41.5
24	72.7	71.5	47.0	46.5	39.7	40.1
25	73.0	72.9	46.7	47.9	40.5	40.7
26-29	72.0	72.6	42.9	42.5	36.8	35.8
30-34	69.6	69.4	34.3	36.1	29.0	30.8
35-39	72.9	70.8	34.1	33.3	29.6	28.9
40-44	77.0[a]	73.9	34.2	33.0	30.4	30.5
45-49	76.4	76.2	30.8	32.8	28.1	29.7
50-54	77.1	75.8	26.9	27.1	24.6	24.5
55-59	74.7	74.1	22.9	22.6	20.8	19.5
60-64	74.8	74.2	19.8	20.8	18.2	19.0
65 or Older	63.3	65.2	10.7	11.4	9.2	10.0

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.25 Cigarette Use in Lifetime, Past Year, and Past Month among Persons Aged 12 to 17, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	29.2[b]	26.7	18.4[a]	17.3	11.9[b]	10.8
GENDER						
Male	28.6[b]	26.3	17.3	16.9	11.3	10.7
Female	29.8[b]	27.2	19.6[b]	17.8	12.5[b]	10.8
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	29.6[b]	26.8	18.8[b]	17.4	12.5[b]	11.1
White	32.0[b]	28.8	21.3[a]	19.8	14.4[b]	12.8
Black or African American	22.6	21.7	11.1	10.6	6.0	6.5
American Indian or Alaska Native	*	40.4	30.5	25.0	17.9	18.0
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*
Asian	13.7	13.3	7.5	6.4	5.4	3.0
Two or More Races	34.5	29.2	20.0	16.7	13.5	11.0
Hispanic or Latino	27.1	26.3	16.4	16.8	9.1	9.1
GENDER/RACE/HISPANIC ORIGIN						
Male, White, Not Hispanic	30.7[a]	28.3	19.3	19.1	13.3	12.5
Female, White, Not Hispanic	33.4[b]	29.4	23.4[b]	20.6	15.7[b]	13.0
Male, Black, Not Hispanic	23.4	21.5	12.0	11.5	6.5	7.4
Female, Black, Not Hispanic	21.7	21.9	10.1	9.6	5.5	5.6
Male, Hispanic	25.8	26.8	15.4	16.9	8.8	9.2
Female, Hispanic	28.4	25.9	17.6	16.6	9.4	9.1

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

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Table G.26 Cigarette Use in Lifetime, Past Year, and Past Month among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TIME PERIOD					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
TOTAL	71.8	71.2	30.3	30.5	26.4	26.5
GENDER						
Male	77.9	76.9	34.3	33.8	29.8	29.5
Female	66.1	65.9	26.6	27.4	23.3	23.8
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	73.9	72.8	30.6	30.6	26.9	26.9
White	77.2	76.5	31.3	31.2	27.6	27.3
Black or African American	62.0	61.0	30.0	30.1	26.2	27.3
American Indian or Alaska Native	81.8	73.4	38.1	44.5	32.9	38.7
Native Hawaiian or Other Pacific Islander	*	*	*	37.5	*	31.1
Asian	46.8	44.3	14.0[a]	18.7	10.9[a]	14.6
Two or More Races	82.3[b]	67.6	47.7	38.6	43.5	34.5
Hispanic or Latino	57.0	59.9	28.4	29.7	23.2	24.2
EDUCATION						
< High School	65.9	65.7	38.5	39.1	34.8	34.8
High School Graduate	72.9	72.0	34.0	35.3	30.4	31.8
Some College	74.9	74.1	33.2	32.4	29.0	28.1
College Graduate	71.1	70.9	17.7	17.9	13.6	13.8
CURRENT EMPLOYMENT						
Full-Time	74.4	73.8	32.9	32.6	28.7	28.3
Part-Time	71.0	70.3	30.2	30.2	25.2	25.2
Unemployed	75.9	72.6	47.7	49.2	44.1	43.8
Other[1]	66.5	66.3	23.2	24.3	20.4	21.5

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.27 Perceived Risk and Availability of Substances among Persons Aged 12 to 17: Percentages, 2002-2005

Risk/Availability[1]	2002	2003	2004	2005
PERCEPTIONS OF GREAT RISK				
Cigarettes				
Smoke One or More Packs Per Day	63.1[b]	64.2[b]	67.5	68.3
Marijuana				
Smoke Once a Month	32.4[b]	34.9	35.0	34.0
Smoke Once or Twice a Week	51.5[b]	54.4	54.7	55.0
Cocaine				
Use Once a Month	50.5[b]	51.4[b]	49.6	48.8
Use Once or Twice a Week	79.8	80.7	79.8	79.9
Heroin				
Try Once or Twice	58.5[b]	58.8[b]	57.0	56.5
Use Once or Twice a Week	82.5	82.6	81.4	81.8
LSD				
Try Once or Twice	52.6	53.4[b]	52.6	51.7
Use Once or Twice a Week	76.2	76.9	76.4	76.1
Alcohol				
Have Four or Five Drinks Nearly Every Day	62.2[a]	61.6[b]	61.8[b]	63.8
Have Five or More Drinks Once or Twice a Week	38.2	38.5	38.1	38.4
PERCEIVED AVAILABILITY				
Fairly or Very Easy to Obtain				
Marijuana	55.0[b]	53.6[b]	52.2[a]	51.0
Cocaine	25.0	25.0	24.4	24.9
Crack	26.5[a]	26.2	25.0	25.3
Heroin	15.8[b]	15.3[b]	14.0	14.0
LSD	19.4[b]	17.6[b]	16.9[a]	15.7
Approached in the Past Month by Someone Selling Drugs	16.7[a]	16.1	16.3	15.5

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Respondents with unknown data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.28 Past Year Initiation of Substance Use among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Substance	2002	2003	2004	2005
ILLICIT DRUGS[1]	2,656	2,627	2,784	2,908
Marijuana and Hashish	2,196	1,973	2,142	2,114
Cocaine	1,032[a]	986	998	872
Crack	337[a]	269	215	230
Heroin	117	92	118	108
Hallucinogens	1,152[b]	886	934	953
LSD	338[a]	200	235	243
PCP	123[a]	105	106	77
Ecstasy	1,206[b]	642	607	615
Inhalants	849	871	857	877
Nonmedical Use of Psychotherapeutics[2]	2,552	2,583	2,836	2,526
Pain Relievers	2,320	2,456	2,422	2,193
OxyContin®	--	--	615	526
Tranquilizers	1,184	1,071[a]	1,180	1,286
Stimulants	783[a]	715	793	647
Methamphetamine	299[b]	260	318[b]	192
Sedatives	209	194	240	247
ILLICIT DRUGS OTHER THAN MARIJUANA[1]	2,569	2,523	2,664	2,768
CIGARETTES	1,940[b]	1,983[b]	2,122	2,282
Daily Cigarette Use[3]	1,016	1,064	1,101	965
SMOKELESS TOBACCO	951[a]	928[b]	999	1,134
CIGARS	2,858[b]	2,736[b]	3,058	3,349
ALCOHOL	3,942[a]	4,082	4,396	4,274

*Low precision, no estimate reported.
-- Not available.
NOTE: Past Year Initiates are defined as persons who used the substance(s) for the first time in the 12 months prior to date of interview.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.
[3] Daily Cigarette Use is defined as ever smoking every day for at least 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.29 Substance Dependence or Abuse for Specific Substances in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Past Year Dependence or Abuse	2002	2003	2004	2005
ILLICIT DRUGS[1]	7,116	6,835	7,298	6,833
Marijuana and Hashish	4,294	4,198	4,469	4,090
Cocaine	1,488	1,515	1,571	1,549
Heroin	214	189	270	227
Hallucinogens	426	321	449	371
Inhalants	180	169	233	221
Nonmedical Use of Psychotherapeutics[2]	2,018	1,923	2,048	1,959
Pain Relievers	1,509	1,424	1,388	1,546
Tranquilizers	509	435	573	419
Stimulants	436	378	470	409
Sedatives	154	158	128	97
ALCOHOL	18,100	17,805	18,654	18,658
ILLICIT DRUGS OR ALCOHOL[1]	22,006	21,586	22,506	22,218
BOTH ILLICIT DRUGS AND ALCOHOL[1]	3,210	3,054	3,445	3,273

*Low precision; no estimate reported.
NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.30 Substance Dependence or Abuse for Specific Substances in the Past Year among Persons Aged 12 or Older: Percentages, 2002-2005

Past Year Dependence or Abuse	2002	2003	2004	2005
ILLICIT DRUGS[1]	3.0	2.9	3.0	2.8
Marijuana and Hashish	1.8	1.8	1.9[a]	1.7
Cocaine	0.6	0.6	0.7	0.6
Heroin	0.1	0.1	0.1	0.1
Hallucinogens	0.2	0.1	0.2	0.2
Inhalants	0.1	0.1	0.1	0.1
Nonmedical Use of Psychotherapeutics[2]	0.9	0.8	0.9	0.8
Pain Relievers	0.6	0.6	0.6	0.6
Tranquilizers	0.2	0.2	0.2	0.2
Stimulants	0.2	0.2	0.2	0.2
Sedatives	0.1	0.1	0.1	0.0
ALCOHOL	7.7	7.5	7.8	7.7
ILLICIT DRUGS OR ALCOHOL[1]	9.4	9.1	9.4	9.1
BOTH ILLICIT DRUGS AND ALCOHOL[1]	1.4	1.3	1.4	1.3

*Low precision; no estimate reported.
NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.31 Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	TYPE OF PAST YEAR DEPENDENCE OR ABUSE					
	Illicit Drugs[1]		Alcohol		Illicit Drugs or Alcohol[1]	
	2004	2005	2004	2005	2004	2005
TOTAL	3.0	2.8	7.8	7.7	9.4	9.1
AGE						
12-17	5.3[a]	4.7	6.0	5.5	8.8[a]	8.0
18-25	8.3	8.4	17.4	17.5	21.2	21.8
26 or Older	1.8	1.6	6.3	6.2	7.3	7.1
GENDER						
Male	3.9[a]	3.5	10.8	10.3	12.7	12.0
Female	2.2	2.1	4.9	5.2	6.2	6.4
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	3.0	2.8	7.7	7.6	9.3	9.1
White	2.9	2.7	8.1	8.0	9.6	9.4
Black or African American	3.7	3.9	6.3	6.4	8.3	8.5
American Indian or Alaska Native	8.0	7.2	14.8	18.3	20.2	21.0
Native Hawaiian or Other Pacific Islander	*	3.0	*	9.5	*	11.0
Asian	1.3	1.2	3.7	3.8	4.7	4.5
Two or More Races	6.5	5.5	9.9	7.5	12.2	10.9
Hispanic or Latino	3.4[a]	2.6	8.0	8.1	9.8	9.3

*Low precision; no estimate reported.
NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.32 Received Substance Use Treatment at Any Treatment Location or at a Specialty Facility in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Location/Substance for Which Treatment Was Received in Past Year	2002	2003	2004	2005
ANY TREATMENT LOCATION				
Illicit Drugs[1]	2,013	1,802[a]	2,192	2,172
Alcohol	2,405	2,359[a]	2,658	2,843
Both Illicit Drugs and Alcohol[1]	1,319	1,255	1,467	1,522
Illicit Drugs or Alcohol[1,2]	3,483	3,327[a]	3,791	3,930
SPECIALTY FACILITY				
Illicit Drugs[1]	1,412	1,103	1,427	1,280
Alcohol	1,549	1,298	1,535	1,626
Both Illicit Drugs and Alcohol[1]	709	595	718	748
Illicit Drugs or Alcohol[1,2]	2,346	1,874[a]	2,327	2,308

*Low precision; no estimate reported.

NOTE: Received Substance Use Treatment refers to treatment received in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use. Treatment at Any Treatment Location includes treatment received at any location, such as a hospital, rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail. Treatment at a Specialty Facility refers to treatment received at a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Estimates include persons who received treatment specifically for illicit drugs or alcohol, as well as persons who received treatment but did not specify for what substance(s).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005

Table G.33 Received Substance Use Treatment at Any Treatment Location or at a Specialty Facility in the Past Year among Persons Aged 12 or Older: Percentages, 2002-2005

Location/Substance for Which Treatment Was Received in Past Year	2002	2003	2004	2005
ANY TREATMENT LOCATION				
Illicit Drugs[1]	0.9	0.8	0.9	0.9
Alcohol	1.0	1.0	1.1	1.2
Both Illicit Drugs and Alcohol[1]	0.6	0.5	0.6	0.6
Illicit Drugs or Alcohol[1,2]	1.5	1.4[a]	1.6	1.6
SPECIALTY FACILITY				
Illicit Drugs[1]	0.6	0.5	0.6	0.5
Alcohol	0.7	0.5	0.6	0.7
Both Illicit Drugs and Alcohol[1]	0.3	0.3	0.3	0.3
Illicit Drugs or Alcohol[1,2]	1.0	0.8[a]	1.0	0.9

*Low precision; no estimate reported.

NOTE: Received Substance Use Treatment refers to treatment received in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use. Treatment at Any Treatment Location includes treatment received at any location, such as a hospital, rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail. Treatment at a Specialty Facility refers to treatment received at a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Estimates include persons who received treatment specifically for illicit drugs or alcohol, as well as persons who received treatment but did not specify for what substance(s).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.34 Needed and Received Treatment for a Substance Use Problem in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2005

Substance/Substance Treatment Status	2002	2003	2004	2005
NEEDED TREATMENT FOR ILLICIT DRUGS[1]	7,748	7,333	8,053	7,550
Received Treatment at a Specialty Facility	1,412	1,103	1,427	1,280
Did Not Receive Treatment at a Specialty Facility	6,335	6,230	6,626	6,269
NEEDED TREATMENT FOR ALCOHOL	18,638	18,215[a]	19,360	19,378
Received Treatment at a Specialty Facility	1,549	1,298	1,535	1,626
Did Not Receive Treatment at a Specialty Facility	17,089	16,917	17,824	17,752
NEEDED TREATMENT FOR ILLICIT DRUGS OR ALCOHOL[1]	22,811	22,165	23,476	23,172
Received Treatment at a Specialty Facility	2,346	1,874[a]	2,327	2,308
Did Not Receive Treatment at a Specialty Facility	20,465	20,290	21,149	20,864

*Low precision; no estimate reported.

NOTE: Respondents were classified as needing treatment for a substance use problem if they met at least one of three criteria during the past year: (1) dependent on the substance; (2) abuse of the substance; or (3) received treatment for the substance use problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

Table G.35 Needed and Received Treatment for a Substance Use Problem in the Past Year among Persons Aged 12 or Older: Percentages, 2002-2005

Substance/Substance Treatment Status	2002	2003	2004	2005
NEEDED TREATMENT FOR ILLICIT DRUGS[1]	3.3	3.1	3.3	3.1
Received Treatment at a Specialty Facility	0.6	0.5	0.6	0.5
Did Not Receive Treatment at a Specialty Facility	2.7	2.6	2.8	2.6
NEEDED TREATMENT FOR ALCOHOL	7.9	7.7	8.0	8.0
Received Treatment at a Specialty Facility	0.7	0.5	0.6	0.7
Did Not Receive Treatment at a Specialty Facility	7.3	7.1	7.4	7.3
NEEDED TREATMENT FOR ILLICIT DRUGS OR ALCOHOL[1]	9.7	9.3	9.8	9.5
Received Treatment at a Specialty Facility	1.0	0.8[a]	1.0	0.9
Did Not Receive Treatment at a Specialty Facility	8.7	8.5	8.8	8.6

*Low precision; no estimate reported.

NOTE: Respondents were classified as needing treatment for a substance use problem if they met at least one of three criteria during the past year: (1) dependent on the substance; (2) abuse of the substance; or (3) received treatment for the substance use problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, and 2005.

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Table G.36 Needed and Received Treatment for an Illicit Drug or Alcohol Problem in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	NEEDED TREATMENT FOR AN ILLICIT DRUG OR ALCOHOL PROBLEM IN THE PAST YEAR						Percentage Who Received Treatment at a Specialty Facility among Persons Who Needed Treatment	
	Total		Received Treatment at a Specialty Facility		Did Not Receive Treatment at a Specialty Facility			
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	9.8	9.5	1.0	0.9	8.8	8.6	9.9	10.0
AGE								
12-17	9.1[a]	8.3	0.7	0.7	8.3[a]	7.6	8.1	8.6
18-25	21.9	22.2	1.7	1.6	20.2	20.6	7.8	7.2
26 or Older	7.7	7.5	0.9	0.9	6.9	6.6	11.3	11.6
GENDER								
Male	13.2	12.6	1.3	1.3	11.9	11.3	10.2	10.2
Female	6.5	6.6	0.6	0.6	5.9	6.0	9.4	9.5
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	9.7	9.5	1.0	0.9	8.7	8.5	9.9	9.7
White	9.9	9.6	0.9	0.8	9.0	8.8	8.6	8.5
Black or African American	9.1	9.6	1.6	1.8	7.6	7.9	17.3	18.4
American Indian or Alaska Native	20.4	21.5	2.1	1.9	18.2	19.7	*	8.7
Native Hawaiian or Other Pacific Islander	*	11.0	*	0.3	8.8	10.7	*	*
Asian	5.3	4.5	0.6	0.0	4.7	4.5	*	1.0
Two or More Races	13.1	11.0	1.6	1.0	11.6	10.0	11.8	8.8
Hispanic or Latino	10.4	9.9	1.0	1.2	9.4	8.8	9.7	11.7

*Low precision; no estimate reported.

NOTE: Respondents were classified as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for an illicit drug or alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

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Table G.37 Perceived Need for Illicit Drug or Alcohol Treatment and Whether Made an Effort to Get Treatment in the Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Treatment for an Illicit Drug or Alcohol Problem, by Demographic Characteristics: Numbers in Thousands, 2004 and 2005

Demographic Characteristic	Total Needing But Not Receiving Treatment[1]		FELT NEED FOR TREATMENT[2]						Did Not Feel Need for Treatment[2]	
			Total		Made Effort		Made No Effort			
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	21,149	20,864	1,233	1,161	441	296	792	865	19,916	19,703
AGE										
12-17	2,103[a]	1,915	69	67	17	13	52	54	2,034[a]	1,848
18-25	6,499	6,699	333	276	115	81	218	195	6,166	6,423
26 or Older	12,547	12,251	831	818	309	203	522	615	11,716	11,433
GENDER										
Male	13,850	13,383	727	751	230	176	496	575	13,124	12,631
Female	7,299	7,482	506	410	210	120	296	290	6,793	7,072

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs or alcohol, but have not received treatment for an illicit drug or alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Felt Need for Treatment includes persons who did not receive but felt they needed treatment for an illicit drug or alcohol problem, as well as persons who received treatment at a location other than a specialty facility but felt they needed additional treatment.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.38 Perceived Need for Illicit Drug or Alcohol Treatment and Whether Made an Effort to Get Treatment in the Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Treatment for an Illicit Drug or Alcohol Problem, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	Total Needing But Not Receiving Treatment[1]		FELT NEED FOR TREATMENT[2]						Did Not Feel Need for Treatment[2]	
			Total		Made Effort		Made No Effort			
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	100.0	100.0	5.8	5.6	2.1	1.4	3.7	4.1	94.2	94.4
AGE										
12-17	100.0	100.0	3.3	3.5	0.8	0.7	2.5	2.8	96.7	96.5
18-25	100.0	100.0	5.1	4.1	1.8	1.2	3.4	2.9	94.9	95.9
26 or Older	100.0	100.0	6.6	6.7	2.5	1.7	4.2	5.0	93.4	93.3
GENDER										
Male	100.0	100.0	5.2	5.6	1.7	1.3	3.6	4.3	94.8	94.4
Female	100.0	100.0	6.9	5.5	2.9	1.6	4.1	3.9	93.1	94.5

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs or alcohol, but have not received treatment for an illicit drug or alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Felt Need for Treatment includes persons who did not receive but felt they needed treatment for an illicit drug or alcohol problem, as well as persons who received treatment at a location other than a specialty facility but felt they needed additional treatment.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.39 Serious Psychological Distress in the Past Year among Persons Aged 18 or Older, by Age Group and Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	Total		AGE GROUP					
			18-25		26-49		50 or Older	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	12.2[a]	11.3	20.2[b]	18.6	14.0[a]	12.5	6.9	7.1
GENDER								
Male	9.4	8.4	16.2[a]	14.4	9.9	9.0	5.9	5.0
Female	14.8	14.0	24.3	22.9	18.0[a]	15.8	7.8	9.0
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	12.2[a]	11.2	21.0[b]	19.0	14.4[b]	12.6	6.7	7.1
White	12.2	11.4	21.8[b]	19.8	15.0[a]	13.3	6.4	7.0
Black or African American	11.9	10.7	17.3	15.9	12.3	10.6	8.4	8.0
American Indian or Alaska Native	10.8[a]	21.1	*	17.8	*	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*
Asian	9.2	7.2	17.5	16.9	8.2	6.7	*	*
Two or More Races	22.4	16.8	*	25.8	19.8	20.2	*	11.2
Hispanic or Latino	12.2	11.7	16.7	16.8	11.6	11.6	9.4	7.5
EDUCATION								
< High School	14.9	14.2	23.8[b]	18.1	17.6	15.7	8.7	11.1
High School Graduate	12.5[a]	10.9	19.4	19.4	15.3[b]	12.2	6.9	6.2
Some College	13.8	12.6	20.4	19.3	14.7	14.2	8.3	6.7
College Graduate	8.6	8.7	16.4	15.4	10.4	9.9	4.5	6.0
CURRENT EMPLOYMENT								
Full-Time	10.8[a]	9.8	18.3	17.1	11.6[a]	10.1	5.2	5.5
Part-Time	14.2	12.7	21.6	20.6	16.0	12.7	5.9	5.6
Unemployed	21.7	20.1	23.6	21.0	21.2	22.7	*	*
Other[1]	12.9	12.6	21.6	18.9	23.2	21.7	8.1	8.6

*Low precision; no estimate reported.

NOTE: Estimates for 2004 in this table are based on a subsample of respondents aged 18 or older. Due to the use of alternative 2004 subsample data, these 2004 estimates may differ from 2004 estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

NOTE: Serious Psychological Distress (SPD) is defined as having a score of 13 or higher on the K6 scale. Due to questionnaire changes, these 2004 and 2005 estimates are not comparable with 2004 and earlier estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 (subsample) and 2005.

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Table G.40 Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 18 or Older, by Past Year Serious Psychological Distress, Gender, and Age Group: Percentages, 2004 and 2005

Gender/Age	Total		SERIOUS PSYCHOLOGICAL DISTRESS[1]			
			Yes		No	
	2004	2005	2004	2005	2004	2005
TOTAL	3.0[a]	2.6	10.2	8.7	2.0	1.8
18-25	8.6	8.4	17.9	16.8	6.3	6.5
26-49	3.2[a]	2.5	9.3	8.0	2.2	1.7
50 or Older	0.6	0.5	3.5	1.9	0.4	0.4
MALE	4.1[b]	3.4	16.1[a]	11.4	2.9	2.7
18-25	11.7	10.5	25.9	21.7	9.0	8.6
26-49	4.0	3.2	14.0	10.3	3.0	2.5
50 or Older	1.1	0.7	*	1.7	0.6	0.6
FEMALE	2.0	1.9	6.7	7.1	1.2	1.0
18-25	5.5	6.3	12.5	13.7	3.3	4.0
26-49	2.4	1.8	6.8	6.7	1.4	0.8
50 or Older	0.3	0.4	*	2.1	0.3	0.2

*Low precision; no estimate reported.

NOTE: Estimates for 2004 in this table are based on a subsample of respondents aged 18 or older. Due to the use of alternative 2004 subsample data, these 2004 estimates may differ from 2004 estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.

[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Serious Psychological Distress (SPD) is defined as having a score of 13 or higher on the K6 scale. Due to questionnaire changes, these 2004 and 2005 estimates are not comparable with 2004 and earlier estimates published in prior NSDUH reports. See Section B.4.5 of Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 (subsample) and 2005.

Table G.41 Received Mental Health Treatment/Counseling in the Past Year among Persons Aged 18 or Older, by Past Year Serious Psychological Distress and Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	Total		SERIOUS PSYCHOLOGICAL DISTRESS[1]			
			Yes		No	
	2004	2005	2004	2005	2004	2005
TOTAL	13.1	13.0	41.6[a]	45.3	9.1	8.8
AGE						
18-25	10.7	11.2	26.9[a]	30.5	6.6	6.8
26-49	15.3[a]	13.9	47.8	48.9	10.0	8.9
50 or Older	11.3	12.5	42.9	52.7	9.0	9.4
GENDER						
Male	8.9	8.9	31.0[a]	36.9	6.6	6.3
Female	17.0	16.8	47.9	50.0	11.6	11.3
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	13.8	13.7	43.5[a]	47.6	9.7	9.4
White	15.1	15.1	46.3[a]	50.9	10.7	10.4
Black or African American	8.6	8.9	34.1	35.7	5.1	5.7
American Indian or Alaska Native	*	15.4	*	*	*	11.9
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*
Asian	4.8	4.0	*	*	3.9	2.8
Two or More Races	22.8	14.4	*	*	*	9.8
Hispanic or Latino	7.9	7.8	27.9	30.4	5.2	4.8
EDUCATION						
< High School	12.5	10.9	36.8	39.2	8.2	6.2
High School Graduate	11.7	11.6	37.9	42.6	8.0	7.9
Some College	14.4	14.5	45.4	47.4	9.5	9.8
College Graduate	13.9	14.3	47.8	52.7	10.7	10.7
CURRENT EMPLOYMENT						
Full-Time	11.1	10.5	37.2	38.7	8.0	7.4
Part-Time	14.0	14.9	37.3	44.4	10.1	10.7
Unemployed	16.8	17.4	41.3	43.2	10.0	10.9
Other[2]	16.2	16.4	51.2	56.3	11.0	10.7

*Low precision; no estimate reported.

NOTE: Estimates for 2004 in this table are based on a subsample of respondents aged 18 or older. Due to the use of alternative 2004 subsample data, these 2004 estimates may differ from 2004 estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

NOTE: Mental Health Treatment/Counseling is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Estimates were based only on responses to items in the Adult Mental Health Service Utilization module.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.

[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Serious Psychological Distress (SPD) is defined as having a score of 13 or higher on the K6 scale. Due to questionnaire changes, these 2004 and 2005 estimates are not comparable with 2004 and earlier estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings*.

[2] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 (subsample) and 2005.

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Table G.42 Had at Least One Major Depressive Episode (MDE) in Lifetime or Past Year among Persons Aged 12 to 17, and Receipt of Treatment in the Past Year for Depression among Persons Aged 12 to 17 with an MDE in Lifetime or Past Year, by Hispanic Origin and Race: Percentages, 2004 and 2005

Hispanic Origin and Race	Lifetime MDE[1]		Receipt of Treatment in Past Year among Persons with Lifetime MDE[2]		Past Year MDE[1]		Receipt of Treatment in Past Year among Persons with Past Year MDE[2]	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	14.0	13.7	35.3	33.8	9.0	8.8	40.3	37.8
Not Hispanic or Latino	13.7	13.6	36.1	35.2	8.9	8.7	41.0	39.0
White	13.9	13.9	39.7	36.2	9.2	9.1	44.9[a]	39.3
Black or African American	12.9	13.5	25.1	31.7	7.7	7.6	28.9	39.3
American Indian or Alaska Native	12.0	9.3	*	*	7.8	6.1	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*
Asian	13.0	9.1	*	*	8.3	6.0	*	*
Two or More Races	17.9	19.0	*	*	11.7	10.5	*	*
Hispanic or Latino	15.2	14.1	31.4	27.5	9.1	9.1	36.8	31.8

*Low precision; no estimate reported.

NOTE: Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Respondents with unknown data for the respective Lifetime or Past Year MDE measure were excluded.
[2] Treatment is defined as seeing or talking to a medical doctor or other professional or using prescription medication in the past year for depression. Respondents with unknown treatment data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.

Table G.43 Had at Least One Major Depressive Episode (MDE) in Lifetime or Past Year among Persons Aged 18 or Older, and Receipt of Treatment in the Past Year for Depression among Persons Aged 18 or Older with an MDE in Lifetime or Past Year, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristic	Lifetime MDE[1]		Receipt of Treatment in Past Year among Persons with Lifetime MDE[2]		Past Year MDE[1]		Receipt of Treatment in Past Year among Persons with Past Year MDE[2]	
	2004	2005	2004	2005	2004	2005	2004	2005
TOTAL	14.8	14.2	52.7	51.1	8.0[a]	7.3	65.1	65.6
GENDER								
Male	9.8	10.4	43.8	41.5	5.6	5.2	55.2	55.6
Female	19.4[a]	17.8	56.9	56.4	10.3	9.3	70.1	70.9
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	15.5	14.7	52.6	52.2	8.2[a]	7.3	66.0	67.7
White	16.3	15.6	53.5	53.2	8.4[a]	7.6	67.2	69.8
Black or African American	11.7	10.5	49.8	48.1	7.1	6.5	59.8	56.4
American Indian or Alaska Native	9.8	15.6	*	*	8.1	9.4	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*
Asian	9.4	8.3	*	*	5.0	3.6	*	*
Two or More Races	28.6[a]	17.6	*	50.6	17.9	10.1	*	*
Hispanic or Latino	10.1	11.3	53.3[a]	41.8	6.5	7.0	57.8	50.2
EDUCATION								
< High School	11.5	11.5	54.8	53.7	8.0	7.3	63.5	59.5
High School Graduate	13.3	13.0	49.8	50.5	7.6	7.0	58.0	64.8
Some College	18.7[a]	16.5	53.4	51.9	10.5[b]	8.4	66.4	64.8
College Graduate	15.1	15.2	54.0	49.8	6.1	6.5	75.2	71.9
CURRENT EMPLOYMENT								
Full-Time	14.8[a]	13.5	47.5	45.0	7.6[b]	6.3	58.7	59.6
Part-Time	17.3	15.9	51.1	53.1	8.8	8.2	65.1	67.0
Unemployed	19.1	20.6	48.2	52.0	11.3	14.4	*	59.7
Other[3]	13.0	14.1	66.4	61.5	8.0	8.0	79.4	75.7
MARITAL STATUS								
Married	12.1	11.8	53.6	50.8	5.8	5.3	73.2	72.9
Widowed	11.6	12.3	*	63.2	7.1	6.0	*	*
Divorced or Separated	23.1	20.9	56.3	57.2	13.4	11.8	65.3	69.5
Never Married	17.3	16.7	47.1	45.3	10.4	10.0	51.7	52.0

*Low precision; no estimate reported.

NOTE: Estimates for 2004 in this table are based on a subsample of respondents aged 18 or older, while 2005 estimates are based on all respondents aged 18 or older. See Section B.4.5 in Appendix B of the *Results from the 2005 National Survey on Drug Use and Health: National Findings.*

NOTE: Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.

[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Respondents with unknown data for the respective Lifetime or Past Year MDE measure were excluded.

[2] Treatment is defined as seeing or talking to a medical doctor or other professional or using prescription medication in the past year for depression. Respondents with unknown treatment data were excluded.

[3] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 (subsample) and 2005.

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Table G.44 Substance Dependence or Abuse in the Past Year among Persons Aged 12 to 17, by Past Year Major Depressive Episode (MDE): Percentages, 2004 and 2005

Dependence/Abuse	Total[1]		PAST YEAR MAJOR DEPRESSIVE EPISODE[2]			
			Yes		No	
	2004	2005	2004	2005	2004	2005
DEPENDENCE OR ABUSE[3]						
Illicit Drugs[4]	5.3[a]	4.7	14.5	13.4	4.4[a]	3.8
Marijuana	3.9	3.6	9.7	9.8	3.3	3.0
Illicit Drugs Other Than Marijuana[4]	2.3	2.0	7.5	6.1	1.8	1.6
Alcohol	6.0	5.5	12.3	13.5	5.4[a]	4.8
Illicit Drugs or Alcohol[4]	8.8[a]	8.0	20.0	19.8	7.7[a]	6.9
Both Illicit Drugs and Alcohol[4]	2.5	2.2	6.9	7.0	2.1	1.7
DEPENDENCE[3]						
Illicit Drugs[4]	2.9	2.7	8.8	8.2	2.3	2.1
Marijuana	2.0	2.0	5.6	5.6	1.6	1.7
Illicit Drugs Other Than Marijuana[4]	1.3	1.1	4.6	3.6	0.9	0.8
Alcohol	2.1	2.2	5.6	6.5	1.8	1.7
Illicit Drugs or Alcohol[4]	4.3	4.1	11.6	12.2	3.5	3.3
Both Illicit Drugs and Alcohol[4]	0.8	0.8	2.8	2.6	0.6	0.6

*Low precision; no estimate reported.

[a] Difference between estimate and 2005 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2005 estimate is statistically significant at the 0.01 level.

[1] Estimates in the Total column represent persons aged 12 to 17, including those with unknown past year MDE information.
[2] Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[3] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[4] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.