2000 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE

SAMPLING ERROR REPORT

Contract No. 283-98-9008
RTI Project No. 7190
Deliverable No. 19

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1. Introduction

As part of any survey data analysis, a good understanding of the resulting standard errors (SEs) and design effects, corresponding to a key set of outcome variables and other variables, is important for a number of reasons: (1) to evaluate how well the sample was designed in light of the target and realized precisions and design effects, (2) for obtaining confidence intervals (CIs) for cross-sectional estimates (and for change estimates in the case of repeated surveys), (3) to obtain quick estimates of SEs for any user-specified outcome variable through generalized variance function (GVF) modeling based on a set of key outcome variables, and (4) to be able to incorporate realized design effects for future survey redesign.

This report compares the estimated (or realized) precisions of a key set of estimates with the targets for the 2000 National Household Survey on Drug Abuse (NHSDA). The comparison was made with targets specified by the sponsor, the Substance Abuse and Mental Health Services Administration (SAMHSA) and with the predicted precision that statisticians from RTI International anticipated during the design of the survey. In addition, tables of realized design effects are also given. This report also contains SE tables based on GVF that can be used for estimating the SEs of estimates (prevalences of drug recency of use in various domains, bounded between 0 and 1) from the 2000 NHSDA.

This report is organized as follows. Section 2 summarizes the 2000 sample design. Section 3 describes the calculation of relative standard errors (RSEs) and design effects. Section 4 presents tables that compare the observed precision with the expected precision. Section 5 compares median and mean design effects. Section 6 presents median and mean design effects for specific analysis domains. Section 7 gives tables of generalized SEs that can be used for estimating the SEs when direct estimates are unavailable. Finally, concluding remarks are given in Section 8.

2. Overview of the 2000 Sample Design

2.1 Target Population

The respondent universe for the 2000 NHSDA was the civilian, noninstitutionalized population aged 12 years or older residing within the United States and the District of Columbia. Consistent with the NHSDA designs since 1991, the 2000 NHSDA universe included residents of noninstitutional group quarters (e.g., shelters, rooming houses, dormitories, and group homes), residents of Alaska and Hawaii, and civilians residing on military bases. Survey coverage before the 1991 NHSDA was limited to residents of the coterminous 48 States and it excluded residents of group quarters and all persons (including civilians) living on military bases. Persons excluded from the 2000 universe included those with no fixed household address (e.g., homeless transients not in shelters) and residents of institutional group quarters, such as jails and hospitals.

2.2 Design Overview

The Substance Abuse and Mental Health Services Administration implemented major changes in the way the NHSDA would be conducted beginning in 1999 and continuing through subsequent years. The 1999 survey was the first conducted using computer-assisted interviewing (CAI) methods. This survey also marked the first year in a transition to improved State estimates based on minimum sample sizes per State. In addition, it was also the first year that cigarette brand information was obtained for the Centers for Disease Control and Prevention (CDC). To obtain the required precision at the State level and to improve the precision of cigarette brand data for youth at the national level, the total sample size was increased by 2,500 youths aged 12 to 17 to a total of 70,000. This large sample size allowed SAMHSA to continue reporting adequately precise demographic subgroups at the national level without needing to oversample specially targeted demographics, as was required in the past. This large sample is referred to as the "main sample" or the "CAI sample." The achieved sample for the 2000 CAI sample was 71,764 persons.

2.2.1 5-Year Design

A coordinated 5-year sample design was developed. The 2000 main sample is a subsample of the 5-year sample. Although there is no overlap with the 1998 sample, a coordinated design for 1999-2003 facilitated 50% overlap in first-stage units (area segments) between each two successive years from 1999 through 2003. This design was intended to increase

the precision of estimates in year-to-year trend analyses because of the expected positive correlation resulting from the overlapping sample between successive NHSDA years.

The 1999-2003 design provides for estimates by State in all 50 States plus the District of Columbia. States may therefore be viewed as the first level of stratification as well as a reporting variable. Eight States, referred to as the "large" States,[1] had a sample designed to yield 3,600 to 4,630 respondents per State for the 2000 survey. This sample size was considered adequate to support direct State estimates. The remaining 43 States[2] had a sample designed to yield 900 to 1,030 respondents per State in the 2000 survey. In these 43 States adequate data were available to support reliable State estimates based on small area estimation methodology. The youth supplement was allocated to the larger population States to increase precision of smoking-related estimates for youth at the national level.

Field interviewer (FI) regions were formed within each State. Based on a composite size measure, States were geographically partitioned into roughly equal size regions. In other words, regions were formed such that each area yielded, in expectation, roughly the same number of interviews during each data collection period, thus distributing the workload equally among NHSDA interviewers. The smaller States were partitioned into 12 FI regions, whereas the eight "large" states were divided into 48 regions. Therefore, the partitioning of the United States resulted in the formation of a total of 900 FI regions.

For the first stage of sampling, each of the FI regions was partitioned into noncompact clusters[3] of dwelling units by aggregating adjacent Census blocks. Consistent with the terminology used in previous NHSDAs, these geographic clusters of blocks are referred to as *segments*. A sample *dwelling unit* in the NHSDA refers to either a housing unit or a group-quarters listing unit such as a dormitory room or a shelter bed. To support the overlapping sample design and any special supplemental samples or field tests that SAMHSA may wish to conduct,

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[1]For the 1999-2003 NHSDAs, the "large" states are California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas.

[2]For reporting and stratification purposes, the District of Columbia is treated the same as a State and no distinction is made in the discussion.

[3]Noncompact clusters (selection from a list) differ from compact clusters in that not all units within the cluster are included in the sample. While compact cluster designs are less costly and more stable, a noncompact cluster design was used because it provides for greater heterogeneity of dwellings within the sample. Also, social interaction (contagion) among neighboring dwellings is sometimes introduced with compact clusters (Kish, 1965).

segments were formed to contain a minimum of 175 dwelling units[4] on average. In prior years, this average minimum segment dwelling unit size was only 90**.**

Before selecting sample segments, additional implicit stratification was achieved by sorting the first-stage sampling units by a metropolitan statistical area (MSA)/socioeconomic status (SES) indicator[5] and by the percent of the population that is non-Hispanic and white. From this well-ordered sample frame, 96[6] segments per FI region were selected with probabilities proportionate to a composite size measure and with minimum replacement. The selected segments were then randomly assigned to a survey year and quarter of data collection as will be described in Section 2.4. Twenty-four of these segments were designated for the coordinated 5-year sample, while the other 72 were designated as "reserve" segments.

2.2.2 Main Sample

The main sample refers to the main study in contrast to the validity study sample which was also selected in 2000. Once sample segments for the 2000 NHSDA main study were selected, specially trained field household listers visited the areas and obtained complete and accurate lists of all eligible dwelling units within the sample segment boundaries. These lists served as the frames for the second stage of sample selection.

The primary objective of the second stage of sample selection (listing units) was to determine the minimum number of dwelling units needed in each segment to meet the targeted sample sizes for all age groups. Thus, listing unit sample sizes for the segment were determined using the age group with the largest sampling rate, which we refer to as the "driving" age group. Using 1990 Census data adjusted to more recent data from Claritas, State- and age-specific sampling rates were computed. These rates were then adjusted by the segment's probability of selection, the subsegmentation inflation factor,[7] if any, the probability of selecting a person in the

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[4]Dwelling unit counts were obtained from the 1990 Decennial Census data supplemented with revised population counts from Claritas.

[5]Four categories are defined as: (1) MSA/low SES, (2) MSA/high SES, (3) Non-MSA/low SES, and (4) Non-MSA/high SES.

[6]The 1999-2003 sample was planned such that 48 segments per FI region would be selected. In the implementation, however, an additional 48 segments were added to support any supplemental or field test samples.

[7]Segments found to be very large in the field are partitioned into *subsegments*. Then, one subsegment is chosen at random with probability proportional to size to be fielded. The subsegmentation inflation factor accounts for the narrowing down of the segment.

age group (equal to the maximum or 0.99 for the driving age group), and an adjustment for the "maximum of two" rule[8]. In addition to these factors, historical data from the 1999 and 2000 NHSDAs were used to compute predicted screening and interviewing response rate adjustments. The final adjusted sampling rate was then multiplied by the actual number of dwelling units found in the field during counting and listing activities. The product represents the segment's listing unit sample size.

Some constraints were put on the listing unit sample sizes. For example, to ensure adequate sample for the overlapping design and/or for supplemental studies, the listing unit sample size could not exceed 100 or half of the actual listing unit count. Similarly, if five unused listing units remained in the segment, a minimum of five listing units per segment was required for cost efficiency.

Using a random start point and interval-based (systematic) selection, the actual listing units were selected from the segment frame. After dwelling unit selections were made, an interviewer visited each selected dwelling unit to obtain a roster of all persons residing in the dwelling unit. As in previous years, during the data collection period, if an interviewer encountered any new dwelling unit in a segment or found a dwelling unit that was missed during the original counting and listing activities, then the new/missed dwellings were selected into the 2000 NHSDA using the half-open interval selection technique[9]. The selection technique eliminates any frame bias that might be introduced because of errors and/or omissions in the counting and listing activities and also eliminates any bias that might be associated with using "old" segment listings.

Using the roster information obtained from an eligible member of the selected dwelling unit, 0, 1, or 2 persons were selected for the survey. Sampling rates were preset by age group and State. Roster information was entered directly into the electronic screening instrument, which automatically implemented this third stage of selection based on the State and age group sampling parameters.

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[8]Brewer's Selection Algorithm never allows for greater than two persons per household to be chosen. Thus, sampling rates are adjusted to satisfy this constraint.

[9]In summary, this technique states that, if a dwelling unit is selected for the 2000 study and an interviewer observes any new or missed dwelling units between the selected dwelling unit and the dwelling unit appearing immediately after the selection on the counting and listing form, then all new/missed dwellings falling in this interval will be selected. If a large number of new/missed dwelling units are encountered (generally greater than ten), then a sample of the missing dwelling units will be selected.

One exciting consequence of using an electronic screening instrument in the NHSDA is the ability to impose a more complicated person-level selection algorithm on the third stage of the NHSDA design. In 1999 and continuing through 2000, one feature that was included in the design was that *any* two survey-eligible people within a dwelling unit had some chance of being selected, i.e., all survey eligible pairs of people had some nonzero chance of being selected. This design feature was of interest to NHSDA researchers because, for example, it allows analysts to examine how the drug use propensity of one individual in a family relates to the drug use propensity of other family members residing in the same dwelling unit (e.g., the relationship of drug use between a parent and child).

3. Computing Relative Standard Errors and Design Effects

As mentioned in Section 1, there are several objectives for calculating RSEs and design effects for the 2000 NHSDA. One is to provide a mechanism for comparing the expected precision of the 2000 design with the precision actually obtained. A second objective is to provide government analysts and other users of the NHSDA data with a methodology for determining a quick approximation of the precision of estimates obtained from the 2000 survey. The third objective is to build CIs of estimates of level and change. Finally, magnitudes of design effects are useful for future redesign of the survey.

The RSE of a domain-*d* prevalence estimate is the SE of the estimate divided by the estimate, that is,

$$RSE(\hat{P}_d) = SE(\hat{P}_d)/\hat{P}_d \,. \qquad \textbf{(1)}$$

The design effect for a prevalence estimate is its variance divided by the variance that would be observed if simple random sampling (SRS) had been used. Hence, the SE of the estimated prevalence can be written as follows:

$$SE(\hat{P}_d) = [DEFF(d)\hat{P}_d[1-\hat{P}]/n_d]^{1/2} , \qquad \textbf{(2)}$$

where $DEFF(d)$ and n_d are the median (or mean as the case may be) design effect and sample size of domain-d respectively.

By substituting a prevalence rate of 0.10 into formulas (1) and (2), the RSE becomes

$$RSE(\hat{P} = .10) = [(DEFF(d) * 9/n_d)]^{1/2} \,. \qquad \textbf{(3)}$$

This shows that for the specified prevalence rate of 0.10, the RSE is purely a function of the design effect and sample size. In the tables given in this report, RSEs are expressed as percentages; that is, the right-hand side of Equation (3) is multiplied by 100.

Mean and median design effects were used for many of the calculations in this report. Design effects were calculated based on drug use variables displayed in the 2000 NHSDA sample design report (Bowman, Chromy, Odom, & Penne, 2002).

As noted previously, the design effect is the ratio of the design-based variance estimate divided by the variance estimate that would have been obtained from an SRS of the same size. Therefore, the design effect summarizes the effects of stratification, clustering, and unequal weighting on the variance of a complex sample design. Because clustering and unequal weighting are expected to increase the variance and generally dominate the stratification effect, the design effect is generally expected to be greater than 1. However, design effects were sometimes less than 1 for prevalence rates near 0.

Note that the design effect is based on the with-replacement variance estimate as obtained from the SUrvey DAta ANalysis program (SUDAAN) which properly accounts for clustering, stratification, and unequal weighting. In the 1999 sampling error report, design effect was based on the maximum-of-three rule for computing design-based SEs under the premise that the precision loss anticipated due to clustering and unequal probability sampling offsets any gain due to stratification (i.e., the design effect should be at least 1). The three SEs correspond to the SUDAAN assumption of with replacement (wr) primary sampling units (PSUs), stratified simple random sample, and simple random sample. Note that for 2000 NHSDA onwards, it was decided to use only the standard SUDAAN WR PSU-based SE for the sake of simpler interpretation, as well for easier computation of the SE of functions of estimates, such as differences and ratios.

Design effects associated with prevalence estimates below 0.00005 or above 1 (an ad hoc rule representing 0 or 1 in practice) or prevalence estimates exhibiting low precision were not used for determining the medians. To identify estimates with low precision, the suppression rule used in earlier years was applied. Specifically, design effects or the corresponding prevalence estimates were not included if the corresponding RSE of $-\ln(p)$ satisfies

$$RSE[-\ln(p)] > 0.175 \quad \text{when } p \leq .5$$

or

$$RSE[-\ln(1-p)] > 0.175 \quad \text{when } p > .5.$$

A rationale for this rule is that for a prevalence estimate of 0.10, the minimum required effective sample size (or the sample size under SRS) is around 50 (55.43 to be exact) when the maximum tolerable value of RSE $(-\ln(p)) = 0.175$. This can be derived as follows: under SRS, RSE(p) is equal to the square root of $p(1-p)/np$, and using Taylor series, SE $(-\ln(p))$ is approximately

SE(p)/p, i.e., RSE(p). Therefore, under SRS, RSE(-ln(p)) is approximately RSE(p)/(-ln(p)). Then substituting p = 0.1, and RSE(-ln(p)) = 0.175, gives n = 55.43 under SRS. For complex designs, this can be interpreted as the minimum required effective sample size. In other words, if *deff*(p) is 2, the minimum required sample size is the design effect times the effective sample size (i.e., 111).

It may be remarked that for a given sample size, the RSE increases as p decreases, and for a given p, it increases as the sample size decreases. The above discussion pertains to $p < .5$. For $p > .5$, RSE(p) is not symmetric about $p = .5$ although SE (p) is. Clearly, precision requirements should be identical for p or 1-p. Therefore, it is convenient to use the convention that the suppression rule for $p < .5$ is also applied for $p > .5$ by replacing p with 1-p.

4. Comparing Observed Precision with Expected Precision

The sample design optimization for the 2000 NHSDA used the revised 9 key classes of NHSDA outcomes. These outcomes included recency-of-use estimates, treatment received for alcohol and illicit drug use, and dependency on alcohol and illicit drug use. Specifically, the outcomes used for 2000 were:

- cigarette use in the past month,
- alcohol use in the past month,
- any illicit drug use in the past month,
- any illicit drug use other than marijuana in the past month,
- cocaine use in the past month,
- dependent on illicit drugs in the past year,
- dependent on alcohol and not illicit drugs in the past year,
- received treatment for illicit drug use in the past year, and
- received treatment for alcohol, but not illicit drugs, in the past year.

Precision requirements for the 2000 designs were specified in terms of targeted RSEs on a prevalence of 10% for age, race/ethnicity, and total domains and in terms of minimum sample sizes. The estimates and SEs for the above outcomes were scaled to a prevalence of 10% as given by formula (3) in Section 3.

In this section, two benchmarks in the 2000 NHSDA are compared to the estimated achieved precision of important outcome measures. One is derived from requirements specified by SAMHSA, and the other is the predicted precision that statisticians at RTI International anticipated during the design of the survey.

Due to changes in the variable definitions made in the treatment and dependent modules for 2000 NHSDA, it was not possible to use exactly the same dependent and treatment outcome variables that were used in defining benchmarks in the 2000 NHSDA Sample Design Plan (Chromy, Bowman, & Penne, 1999),. It was also not possible to make these outcome variables identical to what was used in the 1999 sampling error report. Consequently, corresponding outcome variables for the 2000 NHSDA that are as similar as possible to the ones used in the sample design plan were created. Table 4.1 shows the comparison to the nine-outcomes from the sample design plan.

4.1 Precision Requirements

Initial requirements for the sample were defined in terms of the following:

- minimum sample sizes of 3,600 persons per State in eight large States and 900 persons in the remaining 43 States; and
- equal allocation of the sample across the three age groups: 12 to 17, 18 to 25, and 26 or older within each State.

In addition, for national estimates, the SAMHSA-specified, precision requirements were that the expected relative standard error on a prevalence of 10% not exceed:

- 3.40% for total population statistics;
- 5.0% for statistics in four age group domains: 12 to 17, 18 to 25, 26 to 34, and 35 or older;
- 11.0% for statistics computed among Hispanics in four age group domains: 12 to 17, 18 to 25, 26 to 34, and 35 or older;
- 11.0% for statistics computed among non-Hispanic blacks in four age group domains: 12 to 17, 18 to 25, 26 to 34, and 35 or older; and
- 5.0% for statistics computed among non-Hispanic, non-blacks in four age group domains: 12 to 17, 18 to 25, 26 to 34, and 35 or older.

A tobacco brand interview supplement and an additional national sample of 2,500 youths aged 12 to 17 were added to the NHSDA sample to allow for estimation of tobacco brand usage by youths.

The 2000 sample reflects SAMHSA's objective to develop more reliable State-level estimates using small area estimation procedures. To achieve this objective, the targeted sample size by State was set to be at least 900 completed interviews; in eight States, the target was set at 3,600 completed interviews[10]. The larger overall sample makes it possible to get adequate precision for Hispanic and non-Hispanic black populations without any targeted oversampling of areas of high concentration of these populations or any oversampling through screening for these target populations

[10]Due to a supplement of 2,500 cases at the national level for persons aged 12 to 17, the actual targets in the more populous states were increased to absorb this additional sample in the most effective way to improve the precision of national estimates for the 12- to 17-year-old age group.

4.2 Observed Versus Expected Precision

Table 4.1 presents observed results compared with projections for sample sizes, design effects, and associated RSEs, by race/ethnicity and age group. The projected RSEs are averages over the nine outcome variables as given in the 2000 sample design report (Bowman et al., 2002). Note that using formula (3), the RSEs for all the outcome variables are scaled to the generic prevalence of 0.10. The projected design effect was derived as average over the design effects for the nine variables corresponding to the projected RSEs via formula (3) for various domains. For the observed RSE, as in the 1999 report, mean design effects for the nine outcomes listed above were substituted into formula (3) to obtain mean RSEs for a prevalence of 0.10. We use the mean here for comparison purposes instead of the median since the mean was used for the purpose of sample allocation. Also, because the design effect is proportional to RSE^2 or relative variance, it is probably more meaningful to compute projected RSE over all nine outcomes as root mean relative variance rather than mean RSE. However, the difference between the two is only marginal. All of the nine prevalence estimates contributed to the means in Table 4.1; none was suppressed because of low precision. Although the observed design effects and RSEs are generally higher than the projected, the targeted RSEs were met in every domain but one. The higher observed RSE value in this domain (blacks 26 to 34 years old) is probably due to the fact that the observed sample size is much lower (16.2%) than expected. However, even with a small sample size, the RSE was only over the target by 8.7%. Also, observe that the projected sample sizes were reasonably met under the design.

Table 4.1 Estimated Precision Compared with Targeted and Projected Precision, by Race/Ethnicity and Age Group

Race/ Ethnicity	Age Group	Sample Size			Mean Design Effect			Mean Relative Standard Error at p=10%			
		Projected	Observed	% Off	Projected	Observed	% Off	Projected	Target[1]	Observed[2]	% Off[3]
Total	Total	70,000	71,764	2.5	3.10	3.23	4.2	1.98	3.40	2.00	-41.2
	12 -17	25,000	25,717	2.9	1.62	1.71	5.5	2.41	5.00	2.44	-51.3
	18 -25	22,500	22,613	0.5	1.68	1.89	12.8	2.59	5.00	2.74	-45.3
	26 -34	9,352	9,552	2.1	1.5	1.71	14.0	3.79	5.00	4.00	-20.0
	35+	13,148	13,882	5.6	1.42	1.78	25.4	3.10	5.00	3.40	-32.1
Hispanic	Total	7,493	9,393	25.4	2.73	2.88	5.4	5.69	.	5.16	
	12 -17	3,049	3,671	20.4	1.42	1.57	10.6	6.47	11.00	6.20	-43.7
	18 -25	2,410	3,325	38.0	1.44	2.07	44.1	7.34	11.00	7.42	-32.6
	26 -34	1,086	1,397	28.6	1.30	1.79	37.4	10.39	11.00	10.61	-3.6
	35+	947	1,000	5.6	1.28	1.19	-7.4	11.00	11.00	10.13	-7.9
Black	Total	8,853	8,720	-1.5	3.38	3.30	-2.4	5.85	.	5.79	
	12 -17	3,335	3,479	4.3	1.46	1.37	-6.4	6.27	11.00	5.93	-46.1
	18 -25	2,997	2,784	-7.1	1.60	1.42	-10.9	6.92	11.00	6.77	-38.4
	26 -34	1,306	1,095	-16.2	1.46	1.79	22.3	10.02	11.00	11.96	8.7
	35+	1,210	1,362	12.6	1.23	1.52	23.2	9.58	11.00	9.98	-9.3
White	Total	53,662	53,651	0.0	2.91	3.11	7.0	2.18	.	2.27	
	12 -17	18,620	18,567	-0.3	1.59	1.78	11.7	2.78	5.00	2.92	-41.6
	18 -25	17,093	16,504	-3.4	1.74	1.86	6.7	3.03	5.00	3.17	-36.6
	26 -34	6,959	7,060	1.5	1.39	1.57	13.1	4.24	5.00	4.47	-10.6
	35+	10,991	11,520	4.8	1.36	1.86	36.8	3.33	5.00	3.81	-23.9

[1]Some values of the target precision are missing as they were not specified in the sample design report (Bowman et al., 2002).
[2]Calculated using Equation (2) with the observed sample size and the mean observed design effect.
[3]Percent relative difference from the target RSE.
Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

5. Comparison of Median and Mean Design Effects

The mean is more sensitive to outliers and is generally larger than the median. Table 5.1 compares the median and mean of 56 design effects for three age groups and the total in the 2000 design. Comparison is also given for the four race/Hispanicity categories although they were not used as stratification variables when selecting persons within households.

The median and design effect estimates were based on estimates from the following:

- *15 illicit drug use categories:* any illicit drug use, marijuana/hashish, cocaine, crack, inhalants, hallucinogens, LSD, PCP, heroin, nonmedical use of any psychotherapeutic, nonmedical use of stimulants, nonmedical use of sedatives, nonmedical use of tranquilizers, nonmedical use of analgesics, any illicit drug except marijuana; and
- *3 licit drug use categories:* cigarettes, alcohol, and smokeless tobacco.

These were applied for each of *three recency-of-use categories*: ever used, used in past year, and used in past month.

The estimates of past month heavy drinking and binge drinking were also included in the licit drug use category, bringing the total number of estimates used for the mean versus median comparisons to 56. The median and the mean design effects were calculated from the above estimates for the total population, by age and by race/ethnicity. As seen from Table 5.1, contrary to expectation, the mean design effect turns out to be larger than the median design effect in only three out of the eight domains, but in one of the domains (other race/ethnicity) it is relatively large (over 5%) compared to under 1% in other two domains.

Table 5.1 Comparison of Median and Mean Design Effects of 56 Outcomes

Outcome	Median Design Effect	Mean Design Effect	Difference (Mean-Median)	Percent Difference[1]
Total	3.04	3.02	-0.02	-0.73
Age				
12-17	1.60	1.61	0.01	0.66
18-25	1.95	1.95	0.01	0.27
26+	1.88	1.83	-0.04	-2.30
Race/Ethnicity				
White	2.88	2.80	-0.09	-2.97
Black	3.31	3.16	-0.14	-4.30
Hispanic	3.21	3.20	-0.01	-0.19
Other	3.62	3.81	0.19	5.34

[1] Computed as 100*(Mean-Median)/Median.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

6. Use of Domain-Specific Design Effects for Approximating Standard Error

This section presents one of the two approaches considered for approximating SE estimates when published estimates or computer software are unavailable. The first approach is based on median domain design effects considered in this section, while Section 7 presents SE estimates based on a prediction equation obtained from modeling design effects.

Domains were defined by cross-classifications of age and gender, by race/ethnicity, population density, geographic division of residence, adult education, current employment, and State. The 56 types of drug and recency categories given in Section 5 were used for the estimates on which the medians were computed. Design effects associated with percentage estimates exhibiting low precision as defined in Section 3 were not used. The median design effects were computed separately for the three classifications: lifetime illicit drug use (Table 6.1), past year and past month illicit drug use (Table 6.2), and licit drug use (Table 6.3). Note that design effects for lifetime are expected to be quite different from those for past year and past month; therefore, it is desirable to keep the two separate. However, this was not done for licit drugs, because of the small number of drug use variables available for computing the median for each domain (a total of only 11). This is a limitation of this method based on medians, unlike the generalized variance function (GVF) method used in Section 7. These tables can be used to calculate an approximate variance estimate for a particular domain as follows:

$$var(p_d)_{appx} = DEFF_{d,MED} * [p_d(1-p_d)/n_d] , \quad \textbf{(4)}$$

where

p_d = estimated proportion for domain d,

n_d = sample size for domain d, and

$DEFF_{d,MED}$ = median design effect for domain d.

The approximate SE estimate for p_d, $SE(p_d)_{appx}$, is the square root of $var(p_d)_{appx}$. These tables give the median design effects for the 8 large States, and the median of the 43 State medians for the remaining States. Results for the smaller States are given for reference only. Although design effects are of the same order as that for the larger States (because the sample design is the same for all States), the above approximate formula is not recommended for use with smaller States

because of the instability of the prevalence estimates. The small area estimation methodology should be used, as in the case of 1999 NHSDA. To get an idea of the magnitude of drug-specific design effects used in computing the median design effect over the drugs, Table 6.4 lists the 56 individual design effects for each of the age groups and the national total.

Table 6.1 Median Design Effects of Lifetime Illicit Drug Use, by Age Group, Gender, and Demographic Characteristics

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26+	Male	Female	
Total	1.59	2.05	1.99	3.83	3.62	3.92
Gender						
Male	1.55	1.79	1.94	NA	NA	3.83
Female	1.50	1.99	1.88	NA	NA	3.62
Age						
12 to 17 years	NA	NA	NA	1.55	1.50	1.59
18 to 25 years	NA	NA	NA	1.79	1.99	2.05
26+	NA	NA	NA	1.94	1.88	1.99
Race/Ethnicity						
White	1.68	1.91	1.87	3.61	3.17	3.52
Black	1.31	1.67	2.03	3.66	4.65	3.78
Hispanic	1.54	2.21	2.27	4.23	3.82	4.74
Other	1.83	2.78	3.06	3.44	5.69	5.93
Population Density						
Large metropolitan	1.34	1.83	1.82	3.92	3.36	3.72
Small metropolitan	1.51	1.89	1.89	3.56	3.41	3.82
Nonmetropolitan	1.92	1.89	2.05	3.72	3.18	3.83
Census Division						
New England	2.43	2.41	2.53	4.10	3.39	4.29
Middle Atlantic	1.34	1.88	1.41	2.94	2.44	2.78
East North Central	1.61	1.77	1.47	2.86	2.42	3.00
West North Central	1.76	2.07	1.88	2.79	4.37	3.90
South Atlantic	1.67	1.71	1.77	4.03	3.01	3.64
East South Central	1.68	1.43	1.75	3.12	2.24	2.77
West South Central	1.58	1.39	1.50	2.98	2.55	2.94
Mountain	1.49	1.89	1.75	3.19	2.80	3.10
Pacific	1.34	2.13	1.97	4.60	4.33	4.60
County Type						
Large metropolitan	1.40	1.83	1.85	3.86	3.39	3.82
Small metropolitan >250,000	1.46	1.64	1.80	3.28	3.06	3.49
Small metropolitan <250,000	2.20	1.96	2.10	4.21	3.63	4.17
Nonmetropolitan >20,000	1.76	1.65	2.44	3.77	3.68	4.53
Nonmetropolitan 2,500-19,999	1.67	2.08	1.66	3.38	3.00	3.17
Nonmetropolitan <2,500	2.95	2.20	2.73	4.71	3.56	5.53
Adult Education[1]						
Less than high school	NA	1.78	1.89	2.42	2.87	2.83
High school graduate	NA	1.85	1.87	2.83	2.64	2.78
Some college	NA	1.97	2.10	3.23	3.22	3.19
College graduate	NA	1.81	1.97	2.61	2.47	2.45
Current Employment[2]						
Full-time	NA	1.79	2.02	3.03	2.65	2.93
Part-time	NA	1.94	2.01	3.40	3.37	3.32
Unemployed	NA	1.60	2.21	3.51	3.49	3.58
Other[3]	NA	1.87	1.68	2.19	2.25	2.39

See notes at end of table. (continued)

Table 6.1 (continued)

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26+	Male	Female	
State						
California	1.20	1.73	1.57	4.08	3.88	4.06
Florida	1.27	1.61	1.58	3.44	2.91	3.30
Illinois	1.06	1.60	1.40	2.49	2.35	3.01
Michigan	1.01	1.24	1.41	2.63	1.88	2.58
New York	1.13	1.65	1.41	2.85	2.17	2.45
Ohio	1.11	1.31	1.15	2.22	2.11	2.18
Pennsylvania	1.06	1.53	1.40	2.30	3.00	2.62
Texas	1.47	1.36	1.62	3.11	2.71	3.04
All Other[4]	1.16	1.30	1.23	2.37	1.92	2.38

NA = not applicable.

Note: These design effects apply to the following drugs: any illicit drug use, marijuana/hashish, cocaine, crack, inhalants, hallucinogens, LSD, PCP, heroin, nonmedical use of any psychotherapeutics, nonmedical use of sedatives, nonmedical use of tranquilizers, nonmedical use of pain relievers, and any illicit drug except marijuana.

[1]Data on adult education are not applicable for 12 to 17 year olds.
[2]Data on current employment are not applicable for 12 to 17 year olds.
[3]Retired, disabled, homemaker, student or "other."
[4]Median of the median design effects for the 43 States.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 6.2 Median Design Effects of Past Year and Past Month Illicit Drug Use, by Age Group, Gender, and Demographic Characteristics

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26+	Male	Female	
Total	1.58	1.83	1.80	2.24	2.42	2.45
Gender						
Male	1.50	1.66	1.73	NA	NA	2.24
Female	1.52	1.91	1.82	NA	NA	2.42
Age						
12 to 17	NA	NA	NA	1.50	1.52	1.58
18 to 25	NA	NA	NA	1.66	1.91	1.83
26+	NA	NA	NA	1.73	1.82	1.80
Race/Ethnicity						
White	1.53	1.80	1.79	2.24	2.20	2.32
Black	1.31	1.44	1.45	1.74	1.54	2.16
Hispanic	1.45	2.11	1.51	1.78	1.59	1.87
Other	1.85	2.23	1.43	1.74	2.37	2.48
Population Density						
Large metropolitan	1.29	1.64	1.58	2.19	2.35	2.11
Small metropolitan	1.61	1.83	1.88	2.45	2.29	2.51
Nonmetropolitan	1.92	2.06	1.58	1.62	1.62	2.03
Census Division						
New England	2.06	2.07	2.25	3.37	1.73	2.89
Middle Atlantic	1.20	1.90	1.28	2.09	0.99	2.00
East North Central	1.37	1.43	1.30	1.75	1.31	1.85
West North Central	1.51	2.04	1.76	1.37	1.98	2.14
South Atlantic	1.41	1.47	1.53	2.28	1.72	1.95
East South Central	1.54	1.43	1.00	1.13	0.77	1.33
West South Central	1.50	1.53	1.03	1.03	1.01	1.11
Mountain	1.75	2.32	1.42	1.52	1.73	1.80
Pacific	1.21	2.08	1.79	2.84	3.59	2.84
County Type						
Large metropolitan	1.31	1.68	1.58	2.08	2.43	2.10
Small metropolitan >250,000	1.48	1.74	1.68	2.49	1.38	2.45
Small metropolitan <250,000	2.56	1.87	2.04	2.32	1.68	2.63
Nonmetropolitan >20,000	1.56	2.01	0.88	1.20	1.23	1.29
Nonmetropolitan 2,500-19,999	1.73	1.98	1.42	1.33	1.49	1.76
Nonmetropolitan <2,500	2.58	1.96	1.49	1.52	1.22	1.51
Adult Education[1]						
Less than high school	NA	1.64	1.70	1.49	1.91	1.90
High school graduate	NA	1.76	1.68	2.01	2.03	2.10
Some college	NA	2.05	1.47	1.43	1.38	1.69
College graduate	NA	1.62	1.83	2.03	1.82	2.08

Table 6.2 (continued)

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26+	Male	Female	
Current Employment[2]						
Full-time	NA	1.73	1.82	1.89	1.88	2.06
Part-time	NA	1.88	1.37	1.42	1.65	1.80
Unemployed	NA	1.59	1.05	1.35	1.36	1.47
Other[3]	NA	1.76	1.69	1.42	2.20	1.87
State						
California	1.07	1.70	1.38	2.60	2.91	2.51
Florida	1.23	1.24	1.32	1.85	0.46	1.74
Illinois	1.00	1.30	1.31	1.39	1.18	1.91
Michigan	0.99	1.16	0.78	0.96	0.71	0.82
New York	1.02	1.40	1.32	1.59	0.92	1.57
Ohio	1.17	1.35	0.82	0.78	1.14	0.84
Pennsylvania	1.27	2.03	1.59	1.98	1.38	2.55
Texas	1.42	1.35	0.87	0.83	0.75	0.94
All Other[4]	1.15	1.26	0.93	0.91	0.81	1.02

NA = Not applicable.

Note: These design effects apply to the following drugs: any illicit drug use, marijuana/hashish, cocaine, crack, inhalants, hallucinogens, LSD, PCP, heroin, nonmedical use of any psychotherapeutics, nonmedical use of sedatives, nonmedical use of tranquilizers, nonmedical use of pain relievers, and any illicit drug except marijuana.

[1]Data on adult education are not applicable for 12 to 17 year olds.
[2]Data on current employment are not applicable for 12 to 17 year olds.
[3]Retired, disabled, homemaker, student or "other."
[4]Median of the median design effects for the 43 States.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 6.3 Median Design Effects of Licit Drug Use Estimates, by Age Group, Gender, and Demographic Characteristics

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26 to 34	Male	Female	
Total	1.77	2.29	1.96	3.80	3.77	3.71
Gender						
Male	1.68	1.98	1.98	NA	NA	3.80
Female	1.63	2.02	2.12	NA	NA	3.77
Age in Years						
12 to 17	NA	NA	NA	1.68	1.63	1.77
18 to 25	NA	NA	NA	1.98	2.02	2.29
26+	NA	NA	NA	1.98	2.12	1.96
Race/Ethnicity[1]						
White	1.73	2.11	1.98	3.40	3.54	3.49
Black	1.53	1.69	1.94	3.52	4.23	3.79
Hispanic	1.74	2.00	2.13	4.02	4.38	4.02
Other	1.97	2.35	2.16	5.72	5.26	4.45
Population Density						
Large metropolitan	1.62	2.23	1.94	3.54	3.48	3.33
Small metropolitan	1.82	2.00	2.23	3.57	4.05	4.10
Nonmetropolitan	1.97	2.04	2.28	3.72	3.84	4.26
Census Division						
New England	2.07	2.43	2.57	3.04	3.45	5.08
Middle Atlantic	1.59	2.15	1.33	2.33	2.60	2.18
East North Central	1.68	1.60	1.75	2.63	2.74	3.07
West North Central	1.74	1.96	2.11	2.96	2.72	3.55
South Atlantic	1.49	1.70	2.02	3.88	3.85	3.77
East South Central	1.93	1.42	1.52	3.50	2.76	2.57
West South Central	1.86	1.76	1.71	3.40	3.58	3.28
Mountain	1.80	2.34	1.98	3.69	2.71	4.00
Pacific	1.44	2.67	2.32	5.15	4.52	4.74
County Type						
Large metropolitan	1.54	2.27	1.86	3.51	3.39	3.28
Small metropolitan >250,000	1.87	1.97	2.21	3.43	4.19	3.89
Small metropolitan <250,000	2.16	2.19	2.27	3.40	3.90	4.25
Nonmetropolitan >20,000	2.00	2.24	2.42	3.86	3.65	4.33
Nonmetropolitan 2,500-19,999	1.94	2.14	2.22	3.70	3.74	4.31
Nonmetropolitan <2,500	2.05	1.76	2.13	3.49	4.33	4.13

See notes at end of table.

(continued)

Table 6.3 (continued)

Demographic Characteristics	Age Group			Gender		Total
	12 to 17	18 to 25	26 to 34	Male	Female	
Adult Education[2]						
Less than high school	NA	1.89	1.92	3.36	3.35	3.02
High school graduate	NA	1.84	1.86	2.71	2.86	2.73
Some college	NA	2.13	2.13	2.89	3.05	3.09
College graduate	NA	1.91	2.00	2.70	2.43	2.37
Current Employment[3]						
Full-time	NA	1.90	2.16	2.92	2.96	2.92
Part-time	NA	1.90	1.98	3.41	3.06	3.11
Unemployed	NA	1.63	1.81	2.98	2.96	3.05
Other[4]	NA	2.14	1.92	2.39	2.80	2.73
State						
California	1.37	1.76	1.56	4.66	3.87	3.35
Florida	1.39	1.68	1.45	3.14	2.45	3.10
Illinois	1.03	1.41	1.63	2.39	2.88	2.88
Michigan	1.14	1.44	1.31	2.15	2.06	2.15
New York	1.11	1.41	1.37	2.14	1.70	2.12
Ohio	1.04	1.54	1.37	2.22	2.10	2.18
Pennsylvania	1.37	1.69	1.24	1.92	2.51	2.35
Texas	1.65	1.51	1.78	3.29	3.28	3.27
All Other[4]	1.29	1.41	1.30	2.19	2.05	2.32

NA = Not applicable.

Note: These design effects apply to the following drugs: cigarettes, alcohol, smokeless tobacco, binge drinking, and heavy drinking.

[1]Data on adult education are not applicable for 12 to 17 year olds.
[2]Data on current employment are not applicable for 12 to 17 year olds.
[3]Retired, disabled, homemaker, student or "other."
[4]Median of the median design effects for the 43 States.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 6.4 Design Effects, by Age for the Outcomes Used in the Medians in Tables 6.1, 6.2, and 6.3

Outcome	Age Group			Total
	12 to 17	18 to 25	26+	
Illicit Drugs, Lifetime Recency				
Any illicit drug	1.78	2.42	1.91	3.82
Marijuana	1.65	2.43	1.92	3.85
Cocaine	1.99	1.91	1.88	3.92
Crack	1.33	1.74	2.06	4.18
Inhalants	1.40	2.13	1.69	3.02
Hallucinogens	1.59	2.41	1.65	3.30
LSD	1.73	2.18	1.69	3.37
PCP	1.43	1.66	2.18	4.43
Heroin	1.24	2.08	2.39	4.79
Nonmedical use of psychotherapeutics	1.81	1.79	2.11	3.92
Nonmedical use of stimulants	1.56	1.76	1.90	3.61
Nonmedical use of sedatives	1.35	1.85	2.06	4.45
Any illicit except marijuana	1.75	2.20	1.99	3.96
Nonmedical use of tranquilizers	1.58	2.05	2.09	4.26
Nonmedical use of pain relievers	1.77	1.71	2.19	3.85
Illicit Drugs, Past Year Recency				
Any illicit drug	1.67	2.34	1.93	3.05
Marijuana	1.58	2.36	1.93	2.99
Cocaine	2.15	1.72	1.52	2.20
Crack	1.27	1.43	1.35	2.05
Inhalants	1.45	2.01	1.62	1.36
Hallucinogens	1.68	2.17	1.47	1.60
LSD	1.72	1.75	1.82	1.43
PCP	1.30	1.41	1.33	1.02
Heroin	1.36	1.68	1.58	2.21
Nonmedical use of psychotherapeutics	1.58	1.72	1.88	2.55
Nonmedical use of stimulants	1.71	2.03	1.85	2.15
Nonmedical use of sedatives	1.23	2.07	1.88	2.69
Any illicit except marijuana	1.71	2.04	1.74	2.46
Nonmedical use of tranquilizers	1.35	1.86	2.23	3.11
Nonmedical use of pain relievers	1.54	1.67	1.87	2.42

See notes at end of table.

(continued)

Table 6.4 (continued)

Outcome	Age Group			Total
	12 to 17	18 to 25	26+	
Illicit Drugs, Past Month Recency				
Any illicit drug	1.67	2.23	1.80	2.69
Marijuana	1.68	2.20	1.71	2.49
Cocaine	2.42	1.99	2.09	3.35
Crack	1.46	1.42	1.56	2.91
Inhalants	1.42	1.81	2.00	2.33
Hallucinogens	1.91	1.69	1.24	1.36
LSD	1.82	1.94	1.17	1.18
PCP	1.07	1.15	0.57	0.61
Heroin	1.33	1.62	1.72	2.93
Nonmedical use of psychotherapeutics	1.60	1.96	1.89	2.70
Nonmedical use of stimulants	1.56	1.68	1.81	2.44
Nonmedical use of sedatives	1.40	1.69	1.84	2.61
Any illicit except marijuana	1.60	1.86	1.81	2.53
Nonmedical use of tranquilizers	1.17	1.76	2.02	3.14
Nonmedical use of pain relievers	1.58	1.99	1.70	2.37
Licit Drugs, Lifetime Recency				
Alcohol	1.80	2.50	2.16	3.63
Cigarettes	1.89	2.33	2.09	3.71
Smokeless tobacco	1.91	1.75	1.92	3.74
Licit Drugs, Past Year Recency				
Alcohol	1.76	2.50	2.42	4.65
Cigarettes	1.78	2.18	2.15	4.02
Smokeless tobacco	1.80	1.59	1.77	3.20
Licit Drugs, Past Month Recency				
Alcohol	1.58	2.42	2.42	4.78
Cigarettes	1.75	2.21	1.96	3.79
Smokeless tobacco	1.44	1.52	1.72	3.31
Binge drinking	1.48	2.29	1.77	3.40
Heavy drinking	1.77	2.44	1.70	3.00

Source: SAMHSA, Office of Applied Studies, National Household Study on Drug Abuse, 2000.

7. Generalized Variance Functions (Model-Based Prediction)

For a drug recency-of-use variable, when a median design effect for a domain under investigation is not listed in Tables 6.1, 6.2, or 6.3, an alternative SE approximation based on GVF is recommended. This approximation uses a prediction equation obtained from modeling the estimated l*n*(*RSE*) or l*n*(*CV*). Here, l*n*(*CV*) is treated as the dependent variable in a linear regression model, and the model parameters are estimated using ordinary least squares. In years prior to 1999, logs of estimated design effects, l*n*(*deff*), were modeled. As noted in 1999 (Wheeless, Gordek, & Singh, 2001), with the same set of predictors, it turns out that a transformed log design effect, l*n*(*RSE*), gives a much higher R^2, although the predicted values, rather curiously, do not change. It happens because the transformed dependent variable continues to be a linear function of the original variable and the predictor variables. This provides a good justification of the previously used model. Note that Wolter (1985) also suggested modeling l*n*(*CV*) for obtaining a GVF.

The definition of the design effect is the basis for the regression model that was used for obtaining estimates of the design-based SEs in 1998 and previous years:

$$deff(p) = var(p) / [p(1-p)/n],$$

where

$var(p)$ = design-based variance estimate of p, and
$[p(1-p)/n]$ = simple random sample (SRS) variance estimate of p.

The above equation can be rewritten as

$$CV^2(p) = deff(p)\,[(1-p)/np].$$

Taking the log of both sides of the above equation leads to the following log-linear model:

$$\ln[CV^2(p)] = \beta_0 + \beta_1 \ln(p) + \beta_2 \ln(1-p) + \beta_3 \ln(n), \qquad (5)$$

where

$\beta_0, \beta_1, \beta_2, \beta_3$ = regression coefficients for the intercept, l*n*(p), l*n*(1-p), and l*n*(n), respectively.

Here, β_0 corresponds to the ln design effect, which is treated approximately as constant. However, other terms in the model help to pick up departures from this assumption. Notice that the previously used model is given by

$$\ln[deff(p)] = \beta_0' + \beta_1' \ln(p) + \beta_2' \ln(1-p) + \beta_3' \ln(n). \quad (6)$$

Because the dependent variable given by the realized values of the left-hand side of Equation (6) is a linear function of the left-hand side of Equation (5) and the covariates, it gives predicted variances identical to model Equation (5). However, it has a much lower R^2 (0.26 vs. 0.96 for illicit, and 0.43 vs. 0.98 for licit). Besides much higher R^2, use of Equation (5) instead of (6) led to an alternative model given by the following:

$$\log[CV^2(p) - (1-p)/np] = \beta_0'' + \beta_1'' \log(p) + \beta_2'' \log(1-p) + \beta_3'' \log(n). \quad (7)$$

The model in Equation (7) has the property that predicted design effects are always greater than 1, although R^2 is somewhat lower, 0.84 for illicit, and 0.79 for licit. This alternative model would be desirable if it is believed that the design is such that effects of clustering and unequal weighting outweigh effects of stratification. In our experience with the NHSDA data, in terms of the closeness to the design-based SEs, there is no clear preference between the predicted SEs based on Equations (5) and (7). However, Equation (5) tends to be conservative relative to Equation (7).

Using the models given in Equations (5) and (7), separate models were fit for the illicit and licit drug recency outcome variables. The input data for the simple regression model fitting consists of n, p, and $CV^2(p)$, where n denotes the total number of data points (i.e., the number of estimates) corresponding to various drug use by domains. For our application, a total of 29,222 (19,831 for illicit, and 9,391 for licit) estimates were used. From these, 2,953 estimates were dropped because of low precision, and 5,898 were omitted as the the design effect was ≤ 1, resulting in a total of 20,381 estimates overall. It was decided to drop the estimates with design effect ≤ 1 to avoid undue influence of this extreme subset in GVF modeling. This was also desirable because design effect in practice is generally expected to be greater than 1. The total of 29,222 can be obtained from Table 6.2 as 56 drugs times 87 domains including the 51 States times the 6 columns corresponding to age and gender minus 10 empty cells (5 for each illicit and licit) to avoid double counting.

All State estimates, along with the national estimates, were included in model fitting because it would be of interest to see how the GVF model-predicted SEs compare for large and small States. The possible influence of unstable State estimates on estimated model parameters was avoided by using the suppression rule for low precision estimates. It may be comforting to note that the model parameter estimates with or without the use of State estimates were found to be similar. The CVs (based on the design effects used to calculate the medians in Tables 6.1, 6.2, and 6.3) were used as part of the input data for model fitting. In the interest of obtaining unique

predicted SE, values of p < 0.5 in the input data were converted to 1-*p* when the model was fit. The estimated regression coefficients for the models (5) and (7) are shown below.

	Illicit		Licit	
Beta Coeff	**Model 5**	**Model 7**	**Model 5**	**Model 7**
b_0	0.3594	-1.2136	0.0102	-1.8598
b_1	-0.8995	-0.5083	-1.2814	-1.4725
b_2	1.0827	1.2487	1.0392	1.1175
b_3	-0.9198	-0.7615	-0.8946	-0.7380

A prediction equation for the approximate SE is obtained from Equation (5) as follows:

$$SE_i(p)_{appx} = \left\{ e^{(b_{0i}/2)} * p^{(2+b_{1i})/2} * (1-p)^{(b_{2i}/2)} * n^{(b_{3i}/2)} \right\},$$

where

$b_{0i}, b_{1i}, b_{2i}, b_{3i}$ = estimates of regression coefficients for the intercept, $\ln(p)$, $\ln(1-p)$, and $\ln(n)$, respectively, in Equation (5).

The index-*i* indicates whether the SE approximation is for a licit drug or illicit drug prevalence estimate.

After solving for the regression coefficients, the above approximation reduces to the following two prediction equations:

$$SE(p_{illicit})_{appx} = [e^{0.3594} * p^{1.1005} * (1-p)^{1.0827} * n^{-0.9198}]^{1/2} \quad \textbf{(8)}$$

and

$$SE(p_{licit})_{appx} = [e^{0.0102} * p^{0.7186} * (1-p)^{1.0392} * n^{-0.8946}]^{1/2} . \quad \textbf{(9)}$$

The corresponding formulas for model (7) can be similarly obtained. Tables 7.1 and 7.2 present generalized SEs for various percentages (from 1 to 99%) and sample sizes (from 100 to 71,764) for the 2000 NHSDA, predicted using Equation (5). The model based on equation (7) was not used since the model based on Equation (5) was found to perform better as explained in

the following paragraph. The entries in the tables marked (*) signify that the corresponding estimates would be suppressed using the rule for low precision given in Section 3.

Tables 7.3 and 7.4 give an example of the results of the SE estimates using SRS formulas, SRS, SUDAAN, the mean and median design effects using Equation (4) and Tables 6.2 for illicit and 6.3 for licit, and the two GVF models. In this example, the estimates used are the percentage of persons with any illicit drug use in the past year and the percentage using cigarettes in the past year. Results are given for the total, by age, and by race/ethnicity. Observe that in these examples median- and model-based SEs are both overestimating and underestimating the design-based SEs obtained from SUDAAN. Overall among the two models (based on Equations 5, and 7), model (5) seems to perform reasonably well. Note that GVF results for small States confirm that the direct estimates may be quite unstable because of high SE, and alternative methods based on small area estimation techniques for point and interval estimation should be used (see Section 6.1).

The GVF model (5) was developed using estimates with DEFF >1 that did not meet the suppression criterion. As a further model diagnostic, it was found that for the illicit drug use estimates with DEFF $\leq$1, the predicted DEFF using this model was almost always greater than 1; only one out of 5346 estimates had predicted DEFF $\leq$1. This may be deemed reasonable because estimates with DEFF $\leq$1 are expected to be associated with low prevalence outcomes that exhibit low clustering effects due to sample being not large enough. For illicit drug use estimates with DEFF >1, all the predicted DEFF out of a total of 15399 estimates were >1 as expected. Next, for the sake of illustration, the model (5) was also fit using all the illicit drug use estimates (a total of 20745) with both DEFF $\leq$ or > 1, and it was found that for estimates with DEFF $\leq$1, over 42% of the predicted DEFF were >1, while for estimates with DEFF >1, about 7% of the predicted DEFF were $\leq$1. This inconsistency is clearly undesirable and lends support to the use of estimates with DEFF >1 in GVF modeling. The results are somewhat similar in the case of licit drugs. For estimates (a total of 552) with DEFF $\leq$1, and for estimates (a total of 4982) with DEFF >1, the proposed model gave rise to all the predicted DEFF >1. However, when the model (5) was fit using all the licit drug use estimates (a total of 5534), for estimates with DEFF $\leq$1, over 95 % predicted DEFF were >1, while for estimates with DEFF >1, all but one had predicted DEFF >1.

More diagnostics for the proposed model (5) were obtained by checking how often the predicted or GVF model based RSE of estimates meet low precision criterion. It was found that for estimates meeting suppression criterion with SUDAAN based RSE, 63% of the predicted RSE continue to meet the suppression criterion, i.e., are classified as having low precision. Among the estimates not meeting the suppression criterion but with DEFF $\leq$1, over 77 % of predicted RSE do not meet the suppression criterion, and among those with DEFF >1, over 99 % of predicted

RSE do not meet the suppression criterion. These results indicate that the proposed GVF model behaves reasonably well in view of the fact that the model based predicted DEFF tends to be >1.

In summary, the user may obtain SE estimates for the 2000 NHSDA for drug recency outcomes from the following recommended order of sources:

1. commercially available variance estimation software packages, such as SUDAAN; otherwise,

2. published SEs from reports using data from the 2000 NHSDA (available at http://www.drugabusestatistics.samhsa.gov/ or upon request from the OAS at SAMHSA); otherwise,

3. median domain design effects appearing in Tables 6.1, 6.2, and 6.3 and application of Equation (4) for drug recency of use; otherwise,

4. model-based prediction for national and the eight large State estimates for drug recency of use, using Equation (5).

Table 7.1 Generalized Standard Errors for Estimated Percentages of Illicit Drug Use Estimates

Sample Size for Base of Percentage, *n*	Estimated Percent (Proportion *p*, Multiplied by 100)								
	1, 99	**2, 98**	**3, 97**	**5, 95**	**10, 90**	**20, 80**	**30, 70**	**40, 60**	**50, 50**
100	1.14*	1.65*	2.06*	2.69*	3.83*	5.26*	6.12*	6.59*	6.75*
300	0.69*	1.00*	1.24*	1.62	2.31	3.17	3.69	3.98	4.08
500	0.54*	0.79*	0.98	1.28	1.83	2.51	2.92	3.15	3.22
700	0.46*	0.68	0.84	1.10	1.57	2.15	2.50	2.69	2.76
900	0.41*	0.60	0.75	0.98	1.39	1.92	2.23	2.40	2.46
1,000	0.39*	0.57	0.71	0.93	1.33	1.82	2.12	2.29	2.34
1,250	0.36	0.52	0.64	0.84	1.20	1.65	1.91	2.06	2.11
1,500	0.33	0.48	0.59	0.78	1.10	1.51	1.76	1.90	1.94
2,000	0.29	0.42	0.52	0.68	0.97	1.33	1.54	1.66	1.70
2,500	0.26	0.38	0.47	0.61	0.87	1.20	1.39	1.50	1.54
5,000	0.19	0.27	0.34	0.45	0.63	0.87	1.01	1.09	1.12
7,500	0.16	0.23	0.28	0.37	0.53	0.72	0.84	0.91	0.93
10,000	0.14	0.20	0.25	0.32	0.46	0.63	0.74	0.79	0.81
20,000	0.10	0.14	0.18	0.24	0.33	0.46	0.54	0.58	0.59
30,000	0.08	0.12	0.15	0.20	0.28	0.38	0.44	0.48	0.49
40,000	0.07	0.11	0.13	0.17	0.24	0.33	0.39	0.42	0.43
50,000	0.07	0.09	0.12	0.15	0.22	0.30	0.35	0.38	0.39
71,764[1]	0.06	0.08	0.10	0.13	0.19	0.26	0.30	0.32	0.33

Note: Obtained using the model given in Equation (5) for illicit drug recency of use.

[1] The total sample size for the 2000 NHSDA is 71,764.
* The corresponding estimates would get suppressed using the rule in Section 3.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 7.2 Generalized Standard Errors for Estimated Percentages of Licit Drug Use Estimates

Sample Size for Base of Percentage, *n*	Estimated Percent (Proportion *p*, Multiplied by 100)								
	1, 99	**2, 98**	**3, 97**	**5, 95**	**10, 90**	**20, 80**	**30, 70**	**40, 60**	**50, 50**
100	2.44*	3.11*	3.58*	4.25*	5.30	6.40	6.91	7.07*	6.97*
300	1.49	1.90	2.19	2.60	3.24	3.92	4.23	4.33	4.26
500	1.19	1.51	1.74	2.07	2.58	3.12	3.36	3.44	3.39
700	1.02	1.30	1.50	1.78	2.22	2.68	2.89	2.96	2.92
900	0.91	1.16	1.34	1.59	1.99	2.40	2.59	2.65	2.61
1,000	0.87	1.11	1.28	1.52	1.89	2.29	2.47	2.52	2.49
1,250	0.79	1.00	1.16	1.37	1.71	2.07	2.23	2.28	2.25
1,500	0.73	0.93	1.07	1.27	1.58	1.91	2.06	2.11	2.08
2,000	0.64	0.81	0.94	1.11	1.39	1.68	1.81	1.85	1.82
2,500	0.58	0.74	0.85	1.01	1.26	1.52	1.64	1.68	1.65
5,000	0.42	0.54	0.62	0.74	0.92	1.11	1.20	1.23	1.21
7,500	0.35	0.45	0.52	0.62	0.77	0.93	1.00	1.03	1.01
10,000	0.31	0.40	0.46	0.54	0.68	0.82	0.88	0.90	0.89
20,000	0.23	0.29	0.33	0.40	0.50	0.60	0.65	0.66	0.65
30,000	0.19	0.24	0.28	0.33	0.41	0.50	0.54	0.55	0.54
40,000	0.17	0.21	0.25	0.29	0.36	0.44	0.47	0.48	0.48
50,000	0.15	0.19	0.22	0.26	0.33	0.40	0.43	0.44	0.43
71,764[1]	0.13	0.16	0.19	0.22	0.28	0.34	0.36	0.37	0.37

Note: Obtained using the model given by Equation (5) for licit drug recency of use.

[1] The total sample size for the 2000 NHSDA is 71,764.
* The corresponding estimates would get suppressed using the rule in Section 3.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 7.3 Comparison of Simple Random Sample, Design-Based (SUDAAN), Medians, Means, and Generalized Variance Functions GVF for Estimating the Standard Errors for Percentages Using Any Illicit Drug in the Past Year, by Age and Race/Ethnicity

Characteristics	Standard Error Estimates							
	Sample Size	Prevalence Percentage	SRS	Design Based[1]	Median[2]	Mean[3]	GVF[4]	GVF[5]
Total	71,764	10.99	0.12	0.20	0.18	0.18	0.20	0.21
Age in Years								
12-17	25,717	18.65	0.24	0.31	0.31	0.30	0.40	0.42
18-25	22,613	27.90	0.30	0.46	0.40	0.40	0.50	0.52
26+	23,434	7.07	0.17	0.23	0.22	0.22	0.27	0.27
Race/Ethnicity								
White	49,890	11.24	0.14	0.25	0.22	0.21	0.24	0.25
Black	8,720	11.12	0.34	0.53	0.50	0.51	0.53	0.52
Hispanic	9,393	10.12	0.31	0.51	0.43	0.46	0.49	0.48
Other	3,761	8.47	0.45	0.81	0.72	0.67	0.68	0.66
States								
California	5,022	13.11	0.48	0.87	0.75	0.77	0.73	0.72
Florida	3,478	11.03	0.53	0.85	0.70	0.68	0.80	0.78
Illinois	3,660	11.21	0.52	0.82	0.72	0.67	0.79	0.76
Michigan	3,576	12.12	0.55	0.71	0.49	0.54	0.83	0.80
New York	3,589	10.39	0.51	0.70	0.64	0.65	0.77	0.74
Ohio	3,678	9.47	0.48	0.62	0.44	0.47	0.72	0.70
Pennsylvania	3,997	9.73	0.47	0.82	0.75	0.70	0.71	0.69
Texas	4,020	8.00	0.43	0.60	0.41	0.44	0.64	0.62
Remainder of States[6]	927	11.33	1.01	1.44	1.05	1.18	1.45	1.37

[1] Calculated using SUDAAN—with replacement variance.
[2] Calculated using Equation (4) and the domain-specific median design effects of Table 6.2.
[3] Calculated using Equation (4) and domain-specific mean design effects.
[4] Calculated as predicted SEs from the GVF function based on $\ln(CV^2(p))$ (Equation 5).
[5] Calculated as predicted SEs from the GVF function based on $\ln[CV^2(p)-(1-p)/np]$ (Equation 7).
[6] Calculated as median of the 43 State estimates.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Table 7.4 Comparison of Simple Random Sample, Design-Based (SUDAAN), Medians, Means, and Generalized Variance Functions (GVF) for Estimating the Standard Errors for Percentages Using Cigarettes in the Past Year, by Age and Race/Ethnicity

Characteristics	Standard Error Estimates							
	Sample Size	Percentage	SRS	Design Based[1]	Median[2]	Mean[3]	GVF[4]	GVF[5]
Total	71,764	29.12	0.17	0.34	0.33	0.33	0.31	0.43
Age in Years								
12-17	25,717	20.84	0.25	0.34	0.34	0.33	0.44	0.44
18-25	22,613	45.83	0.33	0.49	0.50	0.49	0.61	0.63
26+	23,434	27.41	0.29	0.43	0.41	0.41	0.51	0.52
Race/Ethnicity								
White	49,890	30.23	0.21	0.40	0.38	0.38	0.38	0.40
Black	8,,720	26.81	0.47	0.90	0.92	0.92	0.78	0.77
Hispanic	9393	26.07	0.45	1.00	0.91	0.91	0.75	0.74
Other	3,761	23.89	0.70	1.47	1.47	1.53	1.09	1.05
States								
California	5,022	27.20	0.63	1.47	1.15	1.26	1.01	0.98
Florida	3,478	29.21	0.77	1.24	1.36	1.36	1.22	1.18
Illinois	3,660	31.49	0.77	1.40	1.30	1.29	1.23	1.19
Michigan	3,576	28.74	0.76	1.11	1.11	1.14	1.20	1.16
New York	3,589	26.97	0.74	1.02	1.08	1.12	1.17	1.13
Ohio	3,678	32.31	0.77	1.12	1.14	1.20	1.23	1.20
Pennsylvania	3,997	28.47	0.71	1.28	1.09	1.09	1.14	1.10
Texas	4,020	27.10	0.70	1.43	1.27	1.29	1.11	1.08
Remainder of States[6]	927	29.42	1.49	2.32	2.28	2.38	2.20	2.08

[1] Calculated using SUDAAN—with replacement variance.
[2] Calculated using Equation (4) and the domain-specific median design effects of Table 6.3.
[3] Calculated using Equation (4) and domain-specific mean design effects.
[4] Calculated as predicted SEs from the GVF function based on ln ($CV^2(p)$) (Equation 5).
[5] Calculated as predicted SEs from the GVF function based on ln [$CV^2(p)$-(1-p)/np] (Equation 7).
[6] Calculated as median of the 43 State estimates.

Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

8. Conclusion

The 2000 NHSDA met its precision goals for 16 of the 17 target domains defined by five age groups (12 to 17, 18 to 25, 26 to 34, 35 or older, and combined age, i.e., 12 or older) crossed by four race/Hispanicity groups (Hispanic, black, white, and combined race/Hispanicity). However, three domains corresponding to combined age group for Hispanic, black, and white were excluded because the corresponding target SEs were not specified.

Only for blacks aged 26 to 34 years old, the RSE was somewhat off. Reasons for not meeting the precision are partly due to smaller sample size and partly due to larger design effect relative to the value projected in the sample design plan.

This report compared mean and median design effects for each age and race/ethnicity domain. The differences were generally small. Median design effects can be used to approximate SE estimates for drug recency use when published estimates or computer software are not available. The report also presented the generalized variance function model as a general method for approximating SE estimates.

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