1. Introduction

This report presents information from the 2001 National Household Survey on Drug Abuse (NHSDA) on rates of use, numbers of users, and other measures related to illicit drugs, alcohol, cigarettes, and other forms of tobacco. New measures related to mental health problems also are included. The NHSDA is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. This initial report on the 2001 data presents only national estimates. State-level estimates from the NHSDA, based on a complex small area estimation (SAE) method, will be presented in other reports to be released separately.

1.1 Summary of NHSDA

The NHSDA 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 their place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and data collection is carried out by RTI of Research Triangle Park, North Carolina. The project is planned and managed by SAMHSA's Office of Applied Studies (OAS). This section briefly describes the survey methodology. A more complete description is provided in Appendix A, which is contained in Volume II with other supplementary technical appendices.

The NHSDA collects information from residents of households, noninstitutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Persons excluded from the survey include homeless persons who do not use shelters, active military personnel, and residents of institutional group quarters, such as jails and hospitals. Appendix E describes surveys that cover populations outside the NHSDA sampling frame.

Beginning in 1999, the NHSDA interview has been carried out using a computer-assisted interviewing (CAI) methodology. The survey uses a combination of computer-assisted personal interviewing (CAPI) conducted by the interviewer and audio computer-assisted self-interviewing (ACASI). For the most part, questions previously administered by the interviewer are now administered by the interviewer using CAPI. Questions previously administered using answer sheets are now administered using ACASI. Use of ACASI is designed to provide the respondent with a highly private and confidential means of responding to questions and to increase the level of honest reporting of illicit drug use and other sensitive behaviors.

Consistent with the 2000 NHSDA, the 2001 NHSDA sample employed a 50-State design with an independent, multistage area probability sample for each of the 50 States 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 large enough to support direct State estimates. For the remaining 42 States and the District of Columbia, smaller, but adequate, samples were selected to support State estimates using SAE techniques. The design also oversampled youths and young adults, so that

each State's sample was approximately equally distributed among three major age groups: 12 to 17 years, 18 to 25 years, and 26 years or older. To enhance the precision of trend measurement, half of the first-stage sampling units (area segments) in the 2000 sample were also in the 2001 sample. However, all of the households included in the 2001 sample were new.

Nationally, 157,471 addresses were screened for the 2001 survey, and 68,929 persons were interviewed within the screened addresses. The survey was conducted from January through December 2001. Weighted response rates for household screening and for interviewing were 91.9 and 73.3 percent, respectively. See Appendix B in Volume II for more information on NHSDA response rates.

1.2 Format of Report and Explanation of Tables

The results from the 2001 NHSDA are given in three separate volumes. This report, Volume I, has separate chapters that summarize the findings on eight 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. A final chapter summarizes the results and discusses key findings in relation to other research and survey results. Supplementary technical appendices in Volume II describe the survey, provide technical details on the survey methodology, offer key NHSDA definitions, discuss other sources of data, list the references cited in the report, and present selected tabulations of estimates. In addition to the tables included in Volume II (Appendices G and H), a more extensive set of tables, including standard errors, has been prepared as Volume III and is available upon request. These tables are available through the Internet.

Tables and text present prevalence measures for the population in terms of both the number of substance users and the rate of substance use for illicit drugs, alcohol, and tobacco products. Tables show estimates of drug use prevalence in the lifetime (i.e., ever used), past year, and past month. The analysis focuses primarily on past month use, which is also referred to as "current use." Most tables present estimates for 2000 and 2001, with an indication of the statistical significance of changes.

Data are presented for major racial/ethnic groups in several categorizations, based on the level of detail the sample will allow. Because respondents were allowed to choose more than one racial group, a "more than one race" category is presented that includes persons who reported more than one category among the seven basic groups listed in the survey question (white, black/African American, American Indian or Alaska Native, Native Hawaiian, other Pacific Islander, Asian, other). It should be noted that the category "white" shown in this report includes only non-Hispanic whites, the category "black" includes only non-Hispanic blacks, and the category "Hispanic" includes Hispanics of any race. Also, more detailed categories were obtained in the survey for respondents who reported Asian race or Hispanic ethnicity.

Data are also presented for four U.S. geographic regions and nine geographic divisions within these regions. These regions and divisions 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.

Tables have been added to describe substance use based on population density. For this purpose, counties are grouped based on the "Rural-Urban Continuum Codes" developed by the U.S. Department of Agriculture (Butler & Beale, 1994). This variable differs from the "Population Density" measure presented in previous reports. Each county is either in a metropolitan statistical area (MSA) or outside an MSA, as defined by the Office of Management and Budget (OMB). For counties in New England, New England County Metropolitan Areas (NECMA) are used for defining codes. Large metropolitan areas have a population of 1 million or more. Small metropolitan areas have a population of fewer than 1 million. Nonmetropolitan areas are areas outside MSAs. For some tables, small metropolitan areas are further classified as having either fewer than or greater than 250,000 population. Counties in nonmetropolitan areas are 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 20,000 or more population 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.

Other than presenting results by age group and other basic demographic characteristics, no attempt is made in this report to control for potentially confounding factors that might help explain the observed differences. This point is particularly salient with respect to race/ethnicity, which tends to be highly associated with socioeconomic characteristics. The cross-sectional nature of the data limits the capability to infer causal relationships. Nevertheless, the data presented in this report are useful for indicating demographic subgroups with relatively high (or low) rates of substance use, regardless of what the underlying reasons for those differences might be.

1.3 Trend Measurement

The large sample size in the NHSDA allows the detection of small changes over time in the prevalence of substance use overall and within specific subgroups. Stated another way, the

small sampling errors sometimes result in statistical significance for small differences in prevalence rates from one year to the next. Although this makes the NHSDA a powerful tool for tracking trends, it also requires analysts to use caution when interpreting trend data. In particular, it is important to be aware of changes over time in the way the survey is conducted, the wording of survey questions, the way data are processed, and other factors that could impact the estimates produced by the survey.

Because of the importance of trend assessment, OAS and its contractor on the NHSDA project, RTI, have maintained consistency over time in the survey protocols as much as possible. However, changes in the data needs of policymakers and researchers often require questionnaire and sample changes. In addition, improvements in the methods used in the survey are sometimes implemented because of problems identified in the current methods or because better methods have been developed. Measurement of the impact of survey protocol changes on prevalence estimates is often possible, particularly if supplemental samples or questions are built in to the survey at the time of the change. However, this is not always feasible because of costs or because the effects of protocol changes were not anticipated. In this regard, some recent improvements in the survey design and management are worthy of mention. Most importantly, because of the major redesign of the sample and data collection method in 1999, estimates for 1999 and later (the primary focus of this report) are generally not comparable with estimates from 1998 and earlier NHSDAs. Second, during 2001 a new data collection quality control program and a small field experiment testing monetary incentives for respondents were implemented in the survey. The effect of these protocol changes on prevalence estimates was assessed and found to be small. Also in 2001, new questions on the use of Ecstasy were added to the survey, causing a small increase in the estimates for past month and past year hallucinogen use. Chapter 9 in this volume and Appendix C in Volume II discuss these issues in more detail.

1.4 Other NHSDA Reports

Additional methodological information on the NHSDA, including the questionnaire, is available electronically (http://www.DrugAbuseStatistics.samhsa.gov), as well as in OAS publications. Analytic reports focusing on specific issues or population groups also are produced by OAS. A few of the NHSDA reports in progress focus on the following topics:

- risk and protective factors for substance use,
- characteristics of adults using mental health services, and
- State estimates of substance use in 2000.

A complete listing of previously published reports from the NHSDA and other data sources is available from OAS. Most of these reports also are available through the Internet (http://www.DrugAbuseStatistics.samhsa.gov). In addition, OAS makes public use data files available to researchers through the Substance Abuse and Mental Health Data Archive (SAMHDA, 2002). Currently, files are available from the 1979 to 2000 NHSDAs at www.icpsr.umich.edu/samhda. The 2001 public use file will be available by the end of 2002.