Attachment B - NSDUH State Data User Survey
Final Report

NATIONAL SURVEY ON DRUG USE AND HEALTH

STATE DATA USER SURVEY RESULTS

Contract No. 283-2004-00022
RTI Project No. 0209009

Authors:

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Prepared for:

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Rockville, Maryland 20857

Prepared by:

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August 2008

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1. Introduction

The National Survey on Drug Use and Health (NSDUH), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and managed by the Office of Applied Studies (OAS) within SAMHSA, is a national survey of the U.S. civilian noninstitutionalized population aged 12 or older. The NSDUH is used to meet a critical objective of SAMHSA's mission: to maintain current data on the prevalence of substance use in the United States.

Since 1999, the NSDUH has employed a design that provides estimates at the State and substate levels for any NSDUH variable, subject to sample size and precision limitations. In addition, State estimates are produced using a small area estimate (SAE) procedure in which State-level NSDUH data are combined with local-area county and census block group/tract-level data from the State. These model-based estimates provide a more precise representation of substance use at the State level than can be produced based solely on the NSDUH survey data, given the small State sample sizes.

In an effort to gather information on State data needs, a 15-minute self-administered web-based questionnaire was developed by SAMHSA in collaboration with RTI International[1] and sent to each of the 50 States and the District of Columbia, which are collectively referred to as the "51 States" in this report. The questionnaire collected information on

- awareness of NSDUH data,
- use of NSDUH State and substate-level data (e.g., questionnaire topics used most frequently by the States and for what purposes),
- use of NSDUH micro data, and
- recommended changes to the NSDUH (e.g., proposed new topics and data products).

The information collected from the 2008 NSDUH State Data User Survey will be used to identify potential areas for changes in the NSDUH design and its data products to improve their utility for State users. This information will then be used in developing the 2012 NSDUH survey design.

This report summarizes the results of the 2008 NSDUH State Data User Survey. **Chapter 2** provides a description of the methodology used to conduct the survey. **Chapter 3** summarizes the findings. The **Appendices** include the web-based survey questionnaire, the initial e-mail requesting participation, the first reminder e-mail, the second reminder e-mail, and specific question-by-question findings.

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

2. Methods

This section of the report summarizes the main objective of the 2008 NSDUH State Data User Survey and the methodology used to administer the survey to the 51 States. The methodological components detailed in this report include the respondent universe, data-collection procedures, and methods used to maximize response rates.

2.1Main Objective of the 2008 NSDUH State Data User Survey

The main goal of the 2008 NSDUH State Data User Survey was to assess how States use the substance abuse and mental health data that are collected in the NSDUH and to solicit suggestions for changes to the survey that could increase its utility. To attain these goals, a self-administered web-based questionnaire was developed by SAMHSA in collaboration with RTI International and was maintained on a secure site by RTI (see Appendix A for the web questionnaire). The questionnaire asked whether or not the States used the NSDUH data; if so, in what ways; and if not, why not. Respondents were also asked to provide recommendations for additional topics or design changes that would make the NSDUH data more useful for their State. The results will be used to guide the redesign of the 2012 NSDUH survey.

2.2Respondent Universe

The survey aimed to collect data from contacts in all 51 States. Initial eligible respondents for the State Data User Survey were persons identified by SAMHSA's Center for Substance Abuse Treatment (CSAT). These 51 initial contacts represented the State agency responsible for the Substance Abuse Prevention and Treatment (SAPT) Block Grant Uniform application to SAMHSA and were therefore expected to be knowledgeable about State and substate substance use and treatment data needs and uses. Information contained in the SAPT Block Grant Uniform application is used by SAMHSA to 1) respond to requests for information on how the States intend to obligate Block Grant funds, 2) understand how the States spend funds allocated in previous years, and 3) examine the type of activities and services provided, demographics of those served, and assessments of the adequacy and effectiveness of these activities and services in meeting the needs of various populations. These 51 initial contacts (or their counterparts) were also involved in the identification of substate regions used in past NSDUH substate reports (e.g., see http://www.oas.samhsa.gov/substate2k8/toc.cfm). In most States, it was anticipated that a single point of contact (i.e., the initial contact) would be able to provide the information for the survey. It was also anticipated that in approximately one quarter to one third of the States, a second or third person (i.e., additional contacts) would also complete the questionnaire to provide additional details and present a complete picture of State data use and needs. Section 2.4 ("Methods to Maximize the Response Rate") provides details on the total number of initial and additional State contacts that responded to the survey.

2.3Data-collection Procedures

Data were collected through a self-administered web-based questionnaire on a secure site maintained by RTI International. The 51 State agency contact persons were notified about the survey via e-mail (see Appendix B) on May 19, 2008. The initial e-mail contained information on the survey topics, the anticipated time it would take to complete the questions, and a link to

the web-based questionnaire. The initial contact persons were asked to complete the questionnaire within 2 weeks. No monetary incentives were provided to the respondents.

State contacts who completed the questionnaire were provided the opportunity to recommend at least one additional person who knew how their State uses NSDUH data and could also complete the questionnaire. Upon receipt of the completed questionnaire from the initial contact, the additional contacts at this State were sent an e-mail requesting their participation in the survey.

2.4Methods to Maximize the Response Rate

A mix of methodologies was used to maximize the response rate for the State Data User Survey. Table 1 summarizes these procedures.

At the end of the first week of the data-collection period, initial State contacts who had not yet responded were sent a reminder e-mail (see Appendix C). At the end of the second week, RTI attempted to telephone the initial State contacts for whom responses had not yet been received, to remind them about the survey. If the initial State contacts were reached by telephone, they were given the option of completing the questionnaire over the telephone. To assure a high rate of participation, the initial State contacts received up to five follow-up call attempts. Initial State contacts who could not be reached by telephone and/or had not responded by the end of the third week were sent a second e-mail reminder (Appendix D) to solicit their participation. By the end of the fourth week, completed questionnaires had been received from all but two States. During the fifth week of the data-collection period, RTI attempted to communicate with the initial contacts at the remaining two States and to obtain completed data from any additional contacts who had not yet completed the questionnaire. Completed questionnaires still had not been received from these two States by the end of the fifth week. Therefore, the data-collection period remained open for a sixth week, at which time the questionnaire was completed by the remaining two States. On June 27, 2008, the data-collection period was closed.

Table 1. Data-collection Schedule for the 2008 NSDUH State Data User Survey

Task	Date (2008)
Web-based questionnaire was launched and e-mail requesting participation was sent to 51 initial State contacts.	May 19
First reminder e-mail was sent to initial State contacts who had not yet responded.	May 27
Up to five follow-up telephone calls were made to initial State contacts who had not yet responded.	June 2–June 6
Second reminder e-mail was sent to initial State contacts who had not yet responded.	June 9
Up to five follow-up telephone calls were made to initial State contacts and additional contacts who had not yet responded.	June 16–June 20
Data-collection period ended.	June 27

Completed questionnaires were obtained from all 51 States (100%) by the end of the data-collection period. At least one additional contact was provided for 31 States. Two additional contacts were provided for 7 of these States, resulting in a total of 38 additional contacts. The additional contacts were either provided through the web-based questionnaire or through e-mail or telephone correspondence with RTI staff. A total of 32 of the 38 additional contacts (84.21%) completed the State Data User Survey. Table 2 shows the number of additional contacts provided for each State and whether those contacts completed the questionnaire.

With questionnaires completed by 51 initial State contacts and 32 additional contacts, a total of 83 completed questionnaires were analyzed for this report in Chapters 3 ("Summary of Findings") and Appendix E ("Specific Question-by-question Findings"). Frequencies and percent distributions were developed for responses to the close-ended questions, and verbatim responses were reported by topic for the open-ended questions.

The results of the survey do not reflect all uses of NSDUH data or data needs for all States. While we attempted to identify and contact the appropriate State staff who use the NSDUH and have the most knowledge of State substance use and mental health data needs, we were not able to capture all data uses and data needs relevant to this report.

Table 2. Number of Additional Contacts Provided and Number that Completed the 2008 NSDUH State Data User Survey, by State		
STATE	**Number of Additional Contacts Provided**	**Number of Additional Contacts That Completed the Survey**
AK	0	Not applicable
AL	0	Not applicable
AR	1	1
AZ	0	Not applicable
CA	2	2
CO	1	1
CT	1	1
DC	0	Not applicable
DE	1	1
FL	2	2
GA	2	1
HI	1	0
IA	1	1
ID	2	2
IL	1	1
IN	1	1
KS	0	Not applicable
KY	1	0
LA	1	1
MA	0	Not applicable
MD	0	Not applicable
ME	1	1
MI	0	Not applicable
MN	1	1
MO	0	Not applicable
MS	1	0
MT	0	Not applicable
NC	0	Not applicable
ND	1	1
NE	1	1
NH	2	2
NJ	0	Not applicable
NM	1	1
NV	2	2
NY	1	1
OH	0	Not applicable
OK	0	Not applicable
OR	1	1
PA	2	2
RI	0	Not applicable
SC	0	Not applicable
SD	0	Not applicable
TN	0	Not applicable
TX	1	1
UT	1	1
VA	1	1
VT	1	0
WA	1	0
WI	0	Not applicable
WV	0	Not applicable
WY	1	1
TOTAL	**38**	**32**

Note: Numbers do not include the initial contact for each State.

3. Summary of Findings

In this section, we provide some general findings from the NSDUH State Data User Survey. The frequencies and percentages reported in this chapter are based on responses from contacts in the 51 States[2]. Appendix E ("Specific Question-by-question Findings") contains the complete detailed results from the questionnaires.

In the NSDUH, 8 of the 51 States are designated as large sample States as a sample of approximately 3600 cases are drawn from those States compared to a sample of approximately 900 cases from the remaining 43 States. These 8 States consist of California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas. Overall, it appears that the awareness, uses, and needs reported by respondents from the eight large States in the State Data User Survey are similar to those of the other 43 States. A summary of the awareness, data uses, and needs of the 51 States is provided in the following four subsections.

3.1 Awareness of NSDUH Data

Respondents in all 51 States were aware that SAMHSA publishes substance use and mental health data from the NSDUH at the State level. For most of the States (46; 90.2 percent) respondents reported being aware that SAMHSA also publishes NSDUH substate estimates. Respondents in five States (all small-sample States) reported that they were unaware that SAMHSA published NSDUH substate estimates. (See Tables 3 and 4)

Table 3. Awareness of State-level NSDUH Data

Q1: The first few questions are about your awareness of NSDUH data. Were you aware that SAMHSA publishes substance use and mental health data from the NSDUH at the State level?

	Total		Large-sample States		Small-sample States	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
Yes	51	100.0%	8	100.0%	43	100.0%
No	0	0%	0	0.0%	0	0.0%
TOTAL	**51**	**100%**	**8**	**100%**	**43**	**100%**

Table 4. Awareness of Substate-level NSDUH Data

Q2: Were you aware that SAMHSA publishes NSDUH substate estimates, providing substance use and mental health data for **specific areas within your State**?

	Total		Large-sample States		Small-sample States	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
Yes	46	90.2%	8	100.0%	38	88.4%
No	5	9.8%	0	0.0%	5	11.6%

[2] Data for States that had multiple respondents are summarized at the State level. Thus, findings reported in this chapter were applicable for at least one respondent at the State level.

TOTAL	**51**	**100%**	**8**	**100%**	**43**	**100%**

3.2 Use of NSDUH State- and Substate-Level Data

When asked whether their organizations used any State- or substate-level NSDUH data, respondents in 42 States (82.4 percent) reported using both State- and substate-level data, those in 7 (13.7 percent) reported using State-level data only, and those in 2 (3.9 percent) reported using neither. All 8 of the large-sample States reported using both State- and substate-level data. (See Table 5)

Table 5. Use of State or substate-level NSDUH Data

Q4: Does your organization use any State- or substate-level NSDUH data?						
	Total		**Large-sample States**		**Small-sample States**	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
State-level only	7	13.7%	0	0.0%	7	16.3%
Substate-level only	0	0.0%	0	0.0%	0	0.0%
Both	42	82.4%	8	100.0%	34	79.1%
Neither	2	3.9%	0	0.0%	2	4.6%
TOTAL	**51**	**100%**	**8**	**100%**	**43**	**100%**

Respondents who reported that their organization did not use NSDUH State- or substate-level data reported that they instead used data from State-based sources. These sources include State-developed data collections, State surveys that form part of the Behavioral Risk Factor Surveillance System or Youth Risk Behavior Surveillance System, or other national data collections. These sources are used rather than the NSDUH because of (1) specific reporting requirements (e.g., "TEDS data is required to be reported for the SAPTBG" in North Dakota), (2) small NSDUH sample sizes, (3) a focus on more specific areas of need and special populations than provided by the NSDUH, and (4) difficulty inputting and using NSDUH data due to technical problems with their own State data system.

Respondents who reported using the NSDUH data were asked "for what purposes" they used the data. The respondents could select from nine prespecified purposes that applied to their organizations and/or select "other." The most prevalent purposes selected were "informing the public" (44 States; 86.3 percent) and "reporting to State epidemiology work groups" (43 States; 84.3 percent). The least prevalent purposes selected were "funding allocation" (22 States; 43.1 percent) and "program evaluation" (17 States; 33.3 percent). (See Table 6) Specific examples of how the States use the NSDUH data for the purposes they selected are provided in Appendix E ("Specific Question-by-question Findings"), question 7_a. These responses are presented twice in Appendix E: once by State and once by topic.

Table 6. Purposes of State or substate-level NSDUH Data Use

Q7: For what purposes does your organization use the NSDUH data? Please select all that apply.						
	Total		**Large-sample States**		**Small-sample States**	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
Policy or Legislation	37	72.5%	6	75.0%	31	72.1%
Program development	33	64.7%	5	62.5%	28	65.1%
Program evaluation	17	33.3%	3	37.5%	14	32.6%
Funding allocation	22	43.1%	3	37.5%	19	44.2%
Briefing State officials	40	78.4%	6	75.0%	34	79.1%
Informing the public	44	86.3%	7	87.5%	37	86.0%
Comparison with other geographic areas	36	70.6%	7	87.5%	29	67.4%
Reporting requirements	39	76.5%	6	75.0%	33	76.7%
Reporting to State epidemiology work groups	43	84.3%	7	87.5%	36	83.7%
Other	10	19.6%	3	37.5%	7	16.3%
Not applicable	2	3.9%	0	0.0%	2	4.7%

Respondents in 10 States (19.6 percent) selected the "other" category when asked for what purposes their organization used the NSDUH data. The "other" responses reported for these States were similar to the nine prespecified purposes. For example, respondents in 5 States reported responding to legislator and media requests, which could be classified as "briefing state officials" and "informing the public," respectively. Respondents in 2 States reported comparing the analyses done in their State with national estimates (e.g., "Used to compare NJ's Household Survey findings with the national trends"), which might have been categorized as "comparison with other geographic areas." Appendix E ("Specific Question-by-question Findings"), question 7_b, contains of all of the verbatim responses for this question.

The specific estimates or topics used by most States that reported using the NSDUH data are the prevalence of tobacco, alcohol, and illicit drug use (including dependence on and abuse of) for various demographics such as age and gender. Respondents in a few States, including 3 of the large-sample States, also reported using NSDUH estimates corresponding to need for

treatment for both substance use and mental health. These responses can be found in Appendix E ("Specific Question-by question Findings"), question 8.

3.3 Use of NSDUH Micro Data

Respondents in most of the States, including 7 of the large-sample States, reported that it would be useful to have access to both the State- and substate-level NSDUH micro data. The remaining large-sample State responded that it would be useful to have access only to the State-level micro data. Of the remaining 7 States (all small-sample States), respondents in 6 reported that neither the State- nor substate-level NSDUH micro data would be useful to them and 1 was not sure. (See Table 7)

Table 7. Use of State or substate-level NSDUH micro data

Q11: Would your organization find it useful to have access to the State- and substate-level NSDUH micro data?

	Total		Large-sample States		Small-sample States	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
State-level only	1	2.0%	1	12.5%	0	0.0%
Substate-level only	0	0.0%	0	0.0%	0	0.0%
Both	43	84.3%	7	87.5%	36	83.7%
Neither	6	11.7%	0	0.0%	6	14.0%
Not Sure	1	2.0%	0	0.0%	1	2.3%
TOTAL	**51**	**100%**	**8**	**100%**	**43**	**100%**

When asked whether their organizations had the resources to analyze the NSDUH micro data, respondents in 31 States reported "Yes." Of the remaining 20 States, respondents in 10 reported "No" to having the resources to analyze the NSDUH micro data and those in 2 reported "Not Sure." Mixed answers (e.g., "Yes and No") were recorded for States with multiple respondents where one respondent may have reported one answer and another respondent reported a different answer. Table 8 shows the distribution of responses.

Table 8. Resources to analyze NSDUH micro data

Q12: Does your organization have the resources to analyze the NSDUH micro data?

	Total		Large-sample States		Small-sample States	
Response Categories	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**	**Response Frequencies**	**Response Percentages**
Yes	31	60.8%	6	75.0%	25	58.1%
No	10	19.6%	0	0.0%	10	23.3%
Not Sure	2	3.9%	0	0.0%	2	4.7%
Yes and No	6	11.7%	1	12.5%	5	11.6%
Yes and Not Sure	1	2.0%	0	0.0%	1	2.3%
No and Not Sure	1	2.0%	1	12.5%	0	0.0%

TOTAL	**51**	**100%**	**8**	**100%**	**43**	**100%**

3.4 Recommended Changes to the NSDUH

The NSDUH State Data User Survey included a few questions that provided State respondents with the opportunity to recommend various changes for the NSDUH. The first of these questions asked the respondents, "What additional survey estimates or topics could be added to the NSDUH to better meet the needs of your organization?" Respondents in 18 States (35.3 percent) reported that county-level or more specific substate regional data would be helpful. However, respondents in a few of the small-sample States countered by saying the NSDUH sample was too small to provide these types of estimates. This led to suggestions for larger sampling at the State or substate levels in some States. Respondents also reported various estimates that could be added to the NSDUH such as "IVDU (IV Drug Users) prevalence frequencies and percentages"; "alcohol and drug use co-occurring with mental health disorders"; various "needing treatment" estimates; and employment, industry, income, and poverty estimates. These responses can be found in Appendix E ("Specific Question-by question Findings"), question 9.

Many State respondents (29; 56.9 percent) also recommended changes that could be made to the NSDUH data products to better meet their needs. Some included suggestions for online data access such as simplifying the website so that it is easier to access, find relevant information, and download various reports or data. Others suggested including an interactive query on the website and sending e-mail updates to inform the States when there are new data or reports available. Providing estimates at the county level or for more specific substate regions was mentioned again here by respondents in some States. Respondents in 2 States reported the need for more timely data. Others commented on the usability of the data and reports made available to the States. For example, respondents in one State reported that "separating the maps from the tables would be helpful." Verbatim responses regarding the NSDUH data products are located in Appendix E ("Specific Question-by question Findings"), question 10.

Many of the recommendations reported by State respondents for the final two questions were similar to those for the questions referencing "survey estimates or topics" and "data products." [3] These recommendations included increasing the sample size for various States, providing county-level data, references to some additional estimates, and releasing data in a more timely fashion. One main theme that did arise from these final questions was the recommendation to organize a data users' conference composed of representatives from all States to discuss the NSDUH data and how they could be used or improved. See Appendix E ("Specific Question-by question Findings"), questions 13 and 14 for the verbatim responses to these questions.

One unanticipated result of this survey was that it is clear that improved communication with State data users might be useful. Responses illustrated an incomplete understanding by NSDUH data users regarding how the data are collected and what data are included in the survey. A number of suggestions were for new questionnaire items that are already on the

[3] The final two questions were as follows: (1) "Considering all aspects of the survey, what additional changes would you suggest to make the NSDUH data more useful for your State?" and (2) "What else would be useful for SAMHSA to consider while planning the NSDUH updates?"

NSDUH questionnaire and for estimates that are already published. A data users' conference may help with this issue.

Appendix A

Web-based Survey Questionnaire

INTRODUCTION

OMB No.: 0930-0290
Expiration Date: 3/31/11

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0290. Public reporting burden for this collection of information is estimated to average 0.25 hours per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857

Thank you for agreeing to participate in this survey. The information you provide will be very valuable to SAMHSA as we make plans to update the National Survey on Drug Use and Health (NSDUH). If you think there is someone else who can provide further information on your organization's data needs, please provide their contact information at the end of this survey.

CONTACT INFORMATION

Before we begin, please update the information we have for you and complete any missing fields below.

*****First Name
*****Last Name
Title
Organization
*Email
*Telephone

Please verify and correct this information as needed and click the Continue button.
*Required fields

Q1. The first few questions are about your awareness of NSDUH data.

Were you aware that SAMHSA publishes substance use and mental health data from the NSDUH at the State level?

1 Yes - - CONTINUE
2 No - - GO TO Q3

Q2. Were you aware that SAMHSA publishes NSDUH Substate estimates, providing substance use and mental health data for **specific areas within your State**?

1 Yes - - GO TO Q4
2 No - - GO TO Q4

Q3. [IF Q1=2] Who in your organization would most likely be knowledgeable about **sources** of substance use and mental health data that are used in your State?

1 I am most knowledgeable - - GO TO Q5
2 Someone else - - GO TO Q3_FNAME

Q3_FNAME	Please provide the person's contact information. *First Name
Q3_LNAME	*Last Name
Q3_TITLE	Title
Q3_ORGANIZATION	Organization
Q3_PHONE	*Phone Number
Q3_EMAIL	*Email Address

*Required Fields

GO TO CONC1

Q4 Does your organization use any State- or Substate-level NSDUH data?

1 State-level data only - - GO TO Q7
2 Substate-level data only - - GO TO Q7
3 Both State- and Substate-level data - - GO TO Q7
4 Neither - - GO TO Q5

Q5 [IF Q4=(4, NOT SURE, OR DECLINE TO ANSWER) OR Q3=1] What sources does your organization use for State- or Substate-level substance use and mental health data?

Q5_Source1
Q5_Source2
Q5_Source3
Q5_Source4
Q5_Source5

Q6 [IF Q5 NE BLANK, NOT SURE, OR DECLINE TO ANSWER] Why does your organization use this/these source(s) rather than the NSDUH?

IF Q1=2, GO TO CONC2, IF Q4=(4, NOT SURE, OR DECLINE TO ANSWER), GO TO Q9

Q7 [IF Q4= 1, 2, OR 3)] For what purposes does your organization use the NSDUH Data? Please select all that apply.

1 Policy or legislation
2 Program development
3 Program evaluation
4 Funding allocation
5 Briefing State officials
6 Informing the public
7 Comparison with other geographic areas
8 Reporting requirements (e.g., for National Outcome Measures/ Block Grant applications)
9 Reporting to State epidemiology work groups
10 Other - - ASK Q7_b

Q7_a You mentioned that your organization uses NSDUH data for {fill with response options 1 through 9 from Q7 if recorded by respondent}. Please provide specific examples of how your State uses NSDUH data for these purposes.

Q7_b [IF Q7=10] Please provide specific examples of how your State uses NSDUH data for other purposes.

Q8 What **specific** estimates or topics covered by the NSDUH does your organization use?

Q9 What additional survey estimates or topics could be added to the NSDUH to better meet the needs of your organization?

Q10 What changes could be made to the NSDUH **data products** to better meet the needs of your organization?

Q11 Would your organization find it useful to have access to the State- and Substate-level NSDUH micro data?

1 State-level data only
2 Substate-level data only
3 Both State- and Substate-level data
4 Neither

Q12 Does your organization have the resources to analyze the NSDUH micro data?

1 Yes
2 No

Q13 Considering all aspects of the survey, what additional changes would you suggest to make the NSDUH data more useful for your State?

Q14 What else would be useful for SAMHSA to consider while planning the NSDUH updates?

Q15 Is there anyone else in your organization that you recommend we contact to complete this survey?

1 Yes - - GO TO Q15_FNAME
2 No - - GO TO CONC2

Q15_FNAME	Please provide the person's contact information *First Name
Q15_LNAME	*Last Name
Q15_TITLE	Title
Q15_ORGANIZATION	Organization
Q15_PHONE	*Phone Number
Q15_EMAIL	***Email Address

*Required fields

GO TO CONC2

CONC1 Thank you for completing the NSDUH State Data User Survey, {fill with contact person's name}. Your responses are saved. The information you provided will be very valuable to SAMHSA as we make plans to update the National Survey on Drug Use and Health (NSDUH). Thanks for your time.

CONC2 Thank you for completing the NSDUH State Data User Survey, {fill with contact person's name}. Your responses are saved. The information you provided will be very valuable to SAMHSA as we make plans to update the National Survey on Drug Use and Health (NSDUH). Thanks for your feedback.

Appendix B

E-mail Requesting Participation

Hello XXX,

The Substance Abuse and Mental Health Services Administration (SAMHSA) is seeking your assistance with the National Survey on Drug Use and Health (NSDUH). The NSDUH is the primary source of statistical information on substance use and mental health in the U.S. population ages 12 and older. It is sponsored by SAMHSA and conducted by RTI International. In a continuing effort to provide the most current and relevant data, we are collecting information through a short web-based survey on how NSDUH stakeholders use the data. The survey will only take about 15 minutes of your time. The information you provide will be used to inform SAMHSA decisions regarding the design of future NSDUH surveys and the content of future State data reports.

As a State user of substance use and mental health data, your input into this process will be very useful. We would greatly appreciate your taking a few minutes to complete the online survey at https://nsduhweb.rti.org/statesurvey. You will need to enter the username and password found at the end of this email. The survey asks whether and how you use NSDUH data, what data are the most useful, reasons for non-use of the NSDUH data and what changes would be most useful to your organization. The input you provide will mainly be used by SAMHSA, but aggregate or state-level data may also be shared with other Federal agencies that are involved in the NSDUH design. If the report summarizing the survey results is provided to the Office of Management and Budget (OMB), it may be placed on a public website along with other materials submitted as part of the review process for future NSDUH surveys. Answers may be attributed to your state, but will not be attributed directly to you.

If you think there is someone else who can provide additional feedback on your organization's data needs, you will have an opportunity to provide this information in the survey. If you have any questions or would like to complete the survey over the phone, please contact Patty LeBaron at RTI International at plebaron@rti.org or 1-800-334-8571, extension 25204 between 8:15am and 5:00pm Central time. We look forward to receiving your responses by **May 30, 2008**.

https://nsduhweb.rti.org/statesurvey
USER NAME : XXXXX
PASSWORD : XXXX

Sincerely,

Peter Delany
Director, Office of Applied Studies, SAMHSA, DHHS

Anne Herron
Director, Division of State and Community Assistance, CSAT, SAMHSA, DHHS

This e-mail was sent by RTI International on behalf of Peter Delany and Anne Herron.

Appendix C

First Reminder E-mail

Hello XXX,

About a week ago, we sent you an email asking you to respond to a web-based survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the survey is to determine how states use data from the National Survey on Drug Use and Health (NSDUH), and how well the NSDUH meets States' data needs. We have not received your responses to date and your feedback is very important in helping us to plan future NSDUH updates. If someone else is more knowledgeable about your State's use of substance abuse and mental health data, you will have the opportunity to indicate this and provide this person's name and contact information in the survey.

The input you provide will mainly be used by SAMHSA, but aggregate or state-level data may also be shared with other Federal agencies that are involved in the NSDUH design. If the report summarizing the survey results is provided to the Office of Management and Budget (OMB), it may be placed on a public website along with other materials submitted as part of the review process for future NSDUH surveys. Answers may be attributed to your state, but will not be attributed directly to you.

We appreciate your participation in our efforts to identify how states use NSDUH data. The survey should not take more than 15 minutes, but your contributions will be valuable in helping us gain insight on this important topic. Please visit https://nsduhweb.rti.org/statesurvey and provide your responses by **May 30, 2008**. You will need to enter the username and password found at the end of this email. If you have any questions or would like to complete the survey over the phone, please contact Patty LeBaron at RTI International at plebaron@rti.org or 1-800-334-8571, extension 25204 between 8:15am and 5:00pm Central time.

https://nsduhweb.rti.org/statesurvey
USER NAME : XXXXXX
PASSWORD : XXXX

Sincerely,

Peter Delany
Director, Office of Applied Studies, SAMHSA, DHHS

Anne Herron
Director, Division of State and Community Assistance, CSAT, SAMHSA, DHHS

This e-mail was sent by RTI International on behalf of Peter Delany and Anne Herron.

Appendix D

Second Reminder E-mail

Hello XXX,

Several weeks ago, we sent you an email asking you to respond to a brief web-based survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the survey is to determine how well the National Survey on Drug Use and Health (NSDUH) data meets States' needs and how it could be improved to better serve those needs. This information will allow us to consider your State's data needs as we develop plans to update the NSDUH. We have not received your responses to date and your contributions are a very important part of this process.

If you are not the most knowledgeable person regarding your State's use of substance abuse and mental health data, please visit https://nsduhweb.rti.org/statesurvey and indicate this in the survey. You will also be given an opportunity to provide information for an alternate contact person. The input you provide will mainly be used by SAMHSA, but aggregate or state-level data may also be shared with other Federal agencies that are involved in the NSDUH design. If the report summarizing the survey results is provided to the Office of Management and Budget (OMB), it may be placed on a public website along with other materials submitted as part of the review process for future NSDUH surveys. Answers may be attributed to your state, but will not be attributed directly to you.

The survey only takes about 15 minutes. Please visit https://nsduhweb.rti.org/statesurvey and provide your responses no later than **June 13, 2008**. Your username and password for the survey are below. If you do not have an opportunity to respond by June 13, a member of our project staff may call you to ask some of the survey questions over the phone. This will ensure that every State is represented in this important process and we have a comprehensive picture of the NSDUH data uses. If you have any questions or would like to complete the survey over the phone, please contact Patty LeBaron at RTI International at plebaron@rti.org or 1-800-334-8571, extension 25204 8:15am and 5:00pm Central time. We appreciate your participation in this process.

https://nsduhweb.rti.org/statesurvey
USER NAME : XXXXXX
PASSWORD : XXXX

Sincerely,

Peter Delany
Director, Office of Applied Studies, SAMHSA, DHHS

Anne Herron
Director, Division of State and Community Assistance, CSAT, SAMHSA, DHHS

This e-mail was sent by RTI International on behalf of Peter Delany and Anne Herron.

Appendix E

Specific Question-by-question Findings

In this appendix we provide specific question-by-question findings from the NSDUH State Data User Survey and attribute the responses to specific States. The "Note(s)" at the top of each question box explains how the responses are reported for each question. The 8 large-sample States are bolded in each of the tables below.

QUESTION 1

**Note: The responses are reported at the State-level. i.e., for states with multiple respondents, if anyone selected "Yes" the final response at the State-level was recorded as "Yes."*

Q1: The first few questions are about your awareness of NSDUH data. Were you aware that SAMHSA publishes substance use and mental health data from the NSDUH at the State level?

Response Categories	Response Frequencies	Response Percentages	State Responses
Yes	51	100.0%	AK, AL, AR, AZ, **CA**, CO, CT, DC, DE, **FL**, GA, HI, IA, ID, **IL**, IN, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VA, VT, WA, WI, WV, WY
No	0	0.0%	Not applicable
TOTAL	**51**	**100%**	

QUESTION 2

**Note: The responses are reported at the State-level. i.e., for states with multiple respondents, if anyone* selected "Yes" the final response at the State-level was recorded as "Yes."

Q2: Were you aware that SAMHSA publishes NSDUH substate estimates, providing substance use and mental health data for **specific areas within your State**?

Response Categories	Response Frequencies	Response Percentages	State Responses
Yes	46	90.2%	AK, AR, **CA**, CO, CT, DC, DE, **FL**, GA, HI, IA, ID, **IL**, IN, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, ND, NE, NH, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VA, VT, WA, WI, WV
No	5	9.8%	AL, AZ, NJ, NM, WY
TOTAL	**51**	**100%**	

QUESTION 3

Q3: Who in your organization would most likely be knowledgeable about **sources** of substance use and mental health data that are used in your State?

Two respondents (one from ID and one from LA) were routed to this question because they reported "No" in Q1. The respondent from ID indicated that "Someone else" was most likely to be knowledgeable about the sources of substance use and mental health data that are used in that State and provided a new contact. The respondent from LA indicated that he/she was most knowledgeable and continued onto questions 5 and 6 before completing the survey.

QUESTION 4

**Note: The responses are reported at the State-level. i.e., for states with multiple respondents, the most inclusive category is reported. For example, if one respondent selected "Both State- and substate-level data" and another respondent from the same state selected "Neither," the final response at the State-level was recorded as "Both State- and substate-level data*."

Q4: Does your organization use any State- or substate-level NSDUH data?			
Response Categories	**Response Frequencies**	**Response Percentages**	**State Responses**
State-level data only	7	13.7%	AL, AZ, HI, NJ, OK, TN, UT
Substate-level data only	0	0.0%	Not applicable
Both State- and substate-level data	42	82.4%	AK, AR, **CA**, CO, CT, DE, **FL**, GA, IA, ID, **IL**, IN, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, NE, NH, NM[4], NV, **NY**, **OH**, OR, **PA**, RI, SC, SD, **TX**, VA, VT, WA, WI, WV, WY[5]
Neither	2	3.9%	DC, ND
TOTAL	**51**	**100%**	

QUESTION 5

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by State.*

Q5: What sources does your organization use for State- or substate-level substance use and mental health data?

DC (the one respondent was routed here after responding "Neither" in Q4)
APRA Client Information System (ACIS) (1)

ID (one of three respondents was routed here after responding "Neither" in Q4)
Idaho School Climate Survey (1)
YRBS (1)
BRFS (1)

IL (one of two respondents was routed here after responding "Neither" in Q4)
Illinois State Needs Assessment Studies funded by CSAT. (1)

LA (one of two respondents was routed here after responding "I am most knowledgeable" in Q3)
Louisiana Addictive Disorders Data System (LADDS) (1)
Quarterly Block Grant Set Aside Reports (internal data collection tool from Regions and Districts) (1)
Utilization Reports (web-based) monthly inpatient report including waiting list and beds data. (1)
Drug Abuse Patterns and Trends in Louisiana (Epidemiological Report) (1)
Special Reports requested from other agencies/individuals (1)

ND (the two respondents were routed here after responding "Neither" in Q4)

[4] This is a note regarding inconsistent data: Two respondents completed the survey for NM. In Q2, both respondents reported that they were *not* aware that SAMHSA published NSDUH substate estimates. However, in Q4, both respondents reported that their organization uses "Both State- and substate data."

[5] This is a note regarding inconsistent data: Two respondents completed the survey for WY. In Q2, both respondents reported that they were *not* aware that SAMHSA published NSDUH substate estimates. However, in Q4, one respondent reported that their organization uses "State-level data only" and the other respondent reported that their organization used "Both State- and substate data."

Proprietary software—electronic charting, data collection and billing system (1)
State developed applications (1)
TEDS (1)

Not applicable (46—AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, HI, IA, IN, KS, KY, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VA, VT, WA, WI, WV, WY)

QUESTION 6

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q6: Why does your organization use this/these source(s) rather than the NSDUH?

Reporting Requirements

I am not certain if OAD uses the NSDUH data. What ever information [initial LA respondent] included in her survey should be final response. The cited sources (LADDS) are data collection tools used for reporting outcome indicators to the Louisiana Legislature, as mandated by law. (1—LA)

Specific reporting requirements for block grant monies. (1—ND)

TEDS data is required to be reported for the SAPTBG. (1—ND)

Response Rate Issues

Because of the very low number of persons who take the NSDUH in Idaho, the data is not considered valid. We use State collected data which is more accurate. (1—ID)

Specific Areas of Need / Special Populations

Studies look at specific areas of need as identified by the state including special populations. (1—**IL**)

System Problems

Because of the implementation and subsequent enhancements to the ACIS, APRA has not been able to produce the most accurate data over the last few years. APRA has analyzed the system problems and have made plans to rectify the system issues. Once this has been done, APRA will utilize this information more. (1—DC)

Not applicable (46—AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, HI, IA, IN, KS, KY, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VA, VT, WA, WI, WV, WY)

QUESTION 7

**Note 1: The responses are reported at the State-level. i.e., for states with multiple respondents, the responses were combined and reported at the State-level. For example, if one respondent selected "Policy or legislation" and "Program development" and another respondent from the same state selected "Funding allocation," a response was recorded for that State in all three categories.*

**Note 2: States could indicate multiple purposes for which their organization uses the NSDUH data; thus, these response categories are not mutually exclusive.*

**Note 3: The total number written responses under each topic (response category) in question 7_a may not match the table below summarizing response to question 7 as not all respondents followed up with a detailed explanation of uses in question 7_a.*

Q7: For what purposes does your organization use the NSDUH Data?
Please select all that apply.

Response Categories	Response Frequencies	Response Percentages	State Responses
Policy or legislation	37	72.5%	AK, AL, AZ, **CA**, CO, CT, **FL**, GA, IA, ID, IN, KY, LA, MA, MD, ME, MN, MO, MT, NC, NE, NH, NV, **NY**, **OH**, OK, OR, **PA**, RI, SD, **TX**, VA, VT, WA, WI, WV, WY
Program development	33	64.7%	AK, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, IA, ID, KY, LA, MA, ME, MN, MS, MT, NC, NE, NH, NV, **NY**, **OH**, OR, **PA**, RI, SD, VA, VT, WI, WV, WY
Program evaluation	17	33.3%	AL, **CA**, CO, **FL**, ME, MN, MO, MS, MT, NC, NH, NV, SC, **TX**, VT, WI, WY
Funding allocation	22	43.1%	AK, AL, AR, CO, CT, **FL**, GA, IA, MA, MD, ME, MO, NE, NH, NV, OR, **PA**, SD, **TX**, VT, WI, WV
Briefing State officials	40	78.4%	AK, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, IA, IN, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, MT, NC, NE, NH, NJ, NV, **NY**, **OH**, OK, OR, **PA**, RI, SD, TN, VA, VT, WA, WI, WV, WY
Informing the public	44	86.3%	AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, IA, **IL**, KS, KY, LA, MA, MD, ME, MN, MO, MS, MT, NC, NE, NH, NJ, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VA, VT, WA, WI, WV, WY
Comparison with other geographic areas	36	70.6%	AR, AZ, **CA**, CT, DE, **FL**, GA, IA, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, NC, NE, NH, NJ, NM, NV, **NY**, **OH**, OR, **PA**, RI, TN, **TX**, UT, VA, VT, WI, WV, WY
Reporting requirements	39	76.5%	AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, HI, IA, IN, KY, LA, MD, ME, **MI**, MN, MO, MS, MT, NC, NE, NH, NM, NV, **NY**, OK, OR, **PA**, RI, SC, SD, TN, **TX**, UT, VT, WI, WV
Reporting to State epidemiology work groups	43	84.3%	AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, IA, ID, IN, KS, KY, LA, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, SD, **TX**, VT, WA, WI, WV, WY
Other (see question 7_b)	10	19.6%	**CA**, LA, NJ, NM, NV, **OH**, OR, **PA**, SD, WV
Not applicable	2	3.9%	DC, ND

QUESTION 7_a

Due to the amount of detail provided in the responses to this question, the results will be presented twice in this report; once by State and once by topic.

Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by State.

Q7_a: You mentioned that your organization uses NSDUH data for {fill with response options 1 through 9 from Q7 if recorded by respondent}. Please provide specific examples of how your State uses NSDUH data for these purposes.

AK

Data is used with state generated data in briefing documents, planning documents, and information for the general public. (1—AK)

AR

The Arkansas State Epidemiology Workgroup (SEW) is responsible for collecting and reporting data on: 1) the consumption of alcohol, tobacco, and other drugs and 2) the consequences associated with the use of these substances in the state of Arkansas. The SEW uses the data it collects to inform state prevention efforts, and it creates reports and publications (that hopefully increase public awareness of substance abuse in Arkansas). The NSDUH is extremely important because it provides the only general population estimates for illicit drug use in the state. (1—AR)

Program development - the director of prevention services reviews the data to get an idea of the need for prevention programming Funding allocation - In the event of a procurement competition where there are additional factors the NSDUH plays a part of who will receive the funding. It is one criteria but not the main one. State officials - we will recite what has been found by NSDUH. Comparison with other states while briefing state officials. Public - We might site information on flyers or on newsletters. Geographic - Conduct this in house. No specific examples. Reporting requirements - we opted for prepopulated nsduh data to be included in our applications. Epidemiology - NSDUH is primary source of data used for past 3 years. Used to determine prevalence rate. (1—AR)

AZ

Epidemiology report. Determining what substances to target for prevention, treatment and enforcement. Informing department heads and policy makers. It is also used for prevention NOMS. (1—AZ)

CA

We voluntarily report to the Governor's Prevention Advisory Committee on alcohol, tobacco, and other drug (ATOD) data. We produce a state level report, and in the midst of producing county-level reports on ATOD data. We refer to / use NSDUH data for these reports. As part of a SAMHSA/CSAP project--California's State Epidemiological Outcomes Workgroup (SEOW), we use NSDUH ATOD data on California residents. We ask for feedback about the data prepared for the SEOW, and for distribution to other audiences. (1—**CA**)

California uses NSDUH to inform analyses of ADP policies and proposed California legislation. NSDUH figures are used for trend analyses to assist in gap analysis, prioritizing department objectives, SAPT Block Grant application (e.g., Form 8). ADP's Office of Public Affairs often requests data that can be extracted from NSDUH and provided to the public. The California SEOW uses NSDUH data extensively to estimate AOD prevalence. (1—**CA**)

Outside contractor that provides technical assistance training to the Department of Alcohol and Drug programs. In the course of that work, do a lot of background briefing papers and whenever have to use household survey data. (1—**CA**)

CT
Program development: Specifically used state estimates to examine change over time for illicit drug use by young adults, 18-15. In particular the increase in non-medical use of prescription pain killers and developed practice models to address opiate addiction in this younger population. Briefing State officials: Have used NSDUH estimates to inform policymakers on the alcohol and other drugs (AOD) prevalence rate for youth in the State an access to treatment for adults. Used information from the NSDUH regarding access to painkillers to educate state officials as well as public as to the ready availability at home from family members (i.e., medicine cabinet). Informing the public: Used NSDUH findings to help inform the public on various health issues such as binge drinking by college-age adults, changes in perceived harm, access to prescription drugs, etc. Comparison with other geographic areas: In various ways, have used NSDUH data to compare the state with the regional and nation regarding AOD prevalence, treatment and access to care. This also relates to previous two items, as these presentations are to policymakers as well as local and regional stakeholders. Substate geographic areas are also compared, although substate comparisons are of less utility for planning, policymaking and program development. Reporting to Sate Epidemiology work groups: Under CSAP's Strategic Prevention Frameworks State Epidemiology Work group, NSDUH data is shared and explored with other state agency staff, university researchers, and others as treatment need and prevalence. NSDUH data are one set of information used in creating the SPF state profile of AOD problems. Also used for the National Outcome Measures prepopulated for reporting in the Substance Abuse Prevention and Treatment Block Grant. (1—CT)

Policy: To inform policies on underage drinking Program development: To target interventions Funding allocation: To target funding to state priorities Briefing state officials: One page information briefs Informing the public: Website and publications Comparison: Comparing CT to New England, US for Needs Assessment Reporting: NOMs. (1—CT)

DE
I used the state and sub-state data to complete forms 8 and 9 in my SAPTBG application. Without the NSDUH reports, my updates would never been completed and we would still be using old prevalence estimates for mental health and substance abuse. Our state epidemiological outcomes workgroup, named DDATA, utilizes this information frequently for completing the local and substate profiles. We publish datagrams that are at times based on this data for updating state officials. We use it for comparing trends with local, state, and national level for determining how we differ from the norm. It will also be used for program development in the prevention and treatment areas. (1—DE)

We use NSDUH data in the Substance Abuse Prevention and Treatment Block Grant application. (1—DE)

FL
Treatment needs in the substate planning areas are estimated using these data and reported in the annual SAPT block grant application. These data are also used in the annual planning documents for the state. , updating state officials and the public Data from this survey are also used for prevention activities, i.e., reports to state officials, the public and workgroups. (1—**FL**)

For most purposes, we use the Florida Youth Substance Abuse Survey data to track youth substance use, risk/protective factors, and other risk behaviors/attitudes. We use the NSDUH for young adult, adult, and older adult assessment and evaluation. (1—**FL**)

We use district level data in our annual SEW report to provide and compare estimates of drug consumption. (1—**FL**)

GA
We use the state data to make comparisons in groups and point out increases or decreases in certain drug use. We also point out increases in the number served to justify increased funding of state

dollars. The data is also used for presentations at conferences. We compare drug use and frequency in certain geographic areas to assist in RFP development and specialty programming. The data is sometimes used to brief state officials when relevant. (1—GA)

The data impacts the way legislators view the impact of policy. The data helps us to influence policy. The data helps this office decide what initiatives are important in our state. We brief other state officials with the acquired knowledge and build state collaborations (Community Integration Program is a classic example-- Partnership Dept of Corrections and Residential Treatment Facilities. We inform the public through various training, conferences, etc . . . (1—GA)

HI
Because our state is unable to conduct needs assessment studies on an annual basis, we rely upon pre-populated NSDUH data for completing our National Outcome Measures and Block Grant applications. (1—HI)

IA
We use the data mainly for the block grant and writing grants. The information is available and used as needed for our strategic and comprehensive prevention and treatment plans, which includes the other areas. (1—IA)

We are always looking for up to date data to show our legislators when appropriate, or when they request it. Current data is vital to grant writing, and to inform the public about current trends. (1—IA)

ID
Data is used for strategic planning outcomes reporting. (1—ID)

IL
We make available the national reports and any web links to members of the public that request them. If there are statewide trends that are of note they will be utilized in reports as appropriate. (1—**IL**)

IN
NSDUH data are only one source of information we may access as questions about substance usage arise. (1—IN)

SAPT Block Application on the Prevention NOMS. State epidemiology report data for local SPF/SIG projects Epidemiology reports inform SPF/SIG advisory council for policy discussions. (1—IN)

KS
When our agency prepares information or responds to requests from local officials we are able to use the information from our State and other States to support the need for treatment. We also use it for general information to the public. (1—KS)

KY
Policy and leg—use it when we draft leg or policy. We have to have the data to support changes we make. Driving force behind changes we make. Prog dev—Looking at prevalence and use What types of programs and how we might change programs. State official—the data are what we use when we talk about use and prevalence and changes we need to make and additional funding that we need. Use it to advocate, educate and inform. Informing pub—blips in newspaper, town hall meetings, communications office uses it. Comparison with geo—not only within but outside the state, looking at use and prevalence to see where we gain or lose ground. Reporting requirements—BGA is now prepopulated with NSDUH info. We use that. state Epidemiology—we have a state treatment and prevention work group and both utilize the data. (1—KY)

LA
Policy—Whenever there is legislation introduced that would impact client population we give info from a ntl level that would compare our state to other states. Look at specific drug trends. Program—

Part of natl outcome measures requires us to put into place systems to track measures. Train staff on measures. Briefing—In addition to #1 about informing legislators. Need to look at ntl data to share in press releases for our clients. Refer to data for instance reduction in tobacco use. Public—National info is published in state. When the press releases are sent out they go to new orgs in state. If we receive phone calls we provide additional information. Geographic—ntl outcome measures—we are developing a report card at the facility level which shows outcomes. Establish benchmarks and targets and facilities can see where they compare with similar program types. NOMs—we report these on the block grant. Epidemiology—we have used the info with the SRFSIG grant it was a requirement that the state convene a work group so we use the data from sources across state and at federal level. ID hotspots for funding to community coalitions to address problems seen through data. (1—LA)

MA

Often use estimates of dependence and abuse (state and substate) as indicators of population based (environmental strategies) prevention efforts. Use estimates of Dependence and Abuse as well as estimates of Need for justification of funding, and allocation of resources. Currently NSDUH provides states with the ONLY standard methodology to examine estimates and compare across states over time. Hopefully the substate estimates will become more stable over time with increased N`s. (1—MA)

MD

- Development of a funding allocation formula for MD`s 24 subdivisions.—Answering questions about how many users of (blank) are there in (blank)?—Validation of other needs assessment results. —Prevention NOMS.—Comparison of major subdivisions. (1—MD)

ME

NSDUH Data is one of the data sources used in the construction and presentation of our quarterly Community Epidemiology Surveillance Network publication. (1—ME)

MI

Information from the NSDUH survey is included in the Michigan Legislative and Annual Reports. Such reports contain data on all substate regions for comparison. NSDUH data for multiple years is used to look for trends and is compared to data from other sources. This information is shared with various State epidemiological work groups and is publicly available on our state web-site. (1—**MI**)

MN

We rely on NSDUH data to support information we furnish to our legislative liaisons, public presentations, in our work on program development as we look to close service gaps, and addressing needs in various parts of our state. We have a state epidemiological work group that includes NSDUH information in its compilation. (1—MN)

MO

The Missouri Division of Alcohol and Drug Abuse (ADA) compiles an annual Data book that captures data often requested by state legislators. NSDUH state estimates on number of individuals with "alcohol and illicit drug dependence or abuse" are compared with the number served by ADA in specialty treatment programs to provide the treatment penetration rate. NSDUH sub-state data were utilized by some of the Strategic Prevention Framework State Incentive Grant (SPF SIG) community coalitions as part of their baseline data collections. The coalitions will continue to track the NSDUH and local data as part of their project evaluation activities. During the past several years, ADA has utilized prevalence and social indicators data to determine the areas of the state that are most under-served, and to prioritize areas to allocate funding for treatment expansion. Based on analysis of past state-level NSDUH reports, ADA recently announced reductions in Missouri adolescent alcohol and marijuana use in the Department of Mental Health’s "DMH Cabinet Report" that is submitted bi-weekly to the Governor’s office. The May issue of the ADA News Bulletin featured trend data on alcohol use and binge drinking based on the last four NSDUH reports. Additional bulletins are

planned to summarize state trends for adolescent smoking and illicit drug use. The annual "Status Report on Missouri's Alcohol and Drug Abuse Problems" presents extensive national and Missouri NSDUH data, and provides analysis and comparisons of national, state, and sub-state prevalence estimates. The NSDUH is an important data source for the prevention NOMs. The NSDUH state estimates on dependence and abuse provide the basis for calculations of treatment need by sub-state region, age, gender, and race presented in the "SAPT Block Grant Application." NSDUH state and sub-state data have been provided to the SPF SIG State Epidemiology Workgroup and the funded SPF SIG community coalitions since the inception of the project. (1—MO)

MS
Data are utilized to develop programs in MS where there is the greatest need to prevent and treat drug use; statewide programs are evaluated utilizing NSDUH data to help indicate if programs are succeeding to combat the drug use problem; NSDUH data are utilized to inform the public in MS as to where MS ranks nationally and to show a comparison with other states; data are utilized in our SAPT Block Grant application for both prevention and treatment and state epidemiology profiles are conducted utilizing NSDUH data to compare MS to the rest of the nation. (1—MS)

MT
Policy or Legislation—used for need on both prevention and treatment Program development—used to look at changes in data and then other data looks at what is available—then develop Program evaluation—used in both prevention and treatment for 5 different funding sources Briefing State Officials—data used in county reports to county commissioners all the way up to the Governor's office Informing the public—data is used in county and state briefings for publication by providers Reporting requirements—self explanatory State Epidemiology group—uses the data for identifying priorities. (1—MT)

NC
The NC Institute of Medicine is using this data to determine the need for services and to make legislative proposals for additional funding and services. The Division uses the prevalence data to track treated prevalence rates in local areas and to encourage the growth of services to those populations in need. The SEW used the data as part of a State SA Profile to assess statewide needs and help prioritize SPF-SIG grant activities. (1—NC)

NE
Our state substance abuse prevention program has included these data into our state substance abuse epidemiological profile. The profile was made available to the public as well as prevention staff and key policy and decision makers within the state. The results were very important in our SPF SIG prioritization process, which led us to selecting three alcohol specific priorities for our SPF SIG grant. As part of our Epidemiology profile, we reported state level estimates from the NSDUH and made comparisons between Nebraska and the U.S. We did not include sub-state estimates in our Epidemiology profile report; however, we include them as part of our state SPF SIG strategic plan and will continue to ensure that our regional and local prevention experts have access to sub-state data. Regarding NOMS, our NE specific data are being used; however, we are not reporting those. SAMHSA is pre-populating those fields for us. (1—NE)

State allocates Block Grant resources to substate areas and includes "need" as part of the formula. State has issued press releases providing public information on depth of substance use/abuse in state especially underage drinking, binge drinking and driving while impaired. State allows substate entities to compare and contrast problems, and uses the materials of the survey to identify trends at the substate level. Epidemiological work group is utilizing elements of the NSDUH to look at setting priorities. (1—NE)

NH
Ad hoc reports detailing various demographics (age ranges and substances in particular) concerning

alcohol and other drug abuse are provided to legislative committees and state officials. NSDUH data combined with local data is used to fill out several tables in the Block Grant. Data are currently being used by the state's prevention epidemiology work group for SPF/SIG. (1—NH)

We develop reports and presentations for the NH Office of Alcohol and Drug Policy, NH legislators, the NH Department of Health and Human services and members of the public. We use NSDUH data to respond to SAPT Block Grant requirements and to support our funding decisions. (1—NH)

We organize and analyze our data for use by the NH Office on Alcohol and Drug Policy in developing the Alcohol and Other Drug Plan for the State. We organize and analyze our data for use by NH legislators in crafting legislation and rules for substance abuse prevention and treatment. We provide data to agency commissioners and directors for use in funding allocation decisions. We provide information on substance use incidence, prevalence and trends to the general public through various media presentations. Our data is used to report incidence, prevalence and trends to SAMHSA via our SAPT Block Grant application. (1—NH)

NJ
Used to respond to questions raised by state officials Used to respond to questions from news reporters Comparing NJ to other sections of the country Informing NJ`s SEOW workgroup (1—NJ)

NM
Pre-populated NOM's. (2—NM)

NV
Used for the preparation of PowerPoint presentations, prevention NOMS reporting for Block Grant (P Forms), and included in publications such as our Biennial Report. (1—NV)

1. To develop legislative factoids each legislative session. 2. To develop programs, such as the Governor's task force on Meth and Meth media campaigns. 3. Evaluate above programs in terms of efficacy. 4. funding allocations—not done 5. NSDUH data are used in the state Biennial Report and legislative factoids. 6. The media and SAPTA use NSDUH data for brochures and publications. 7. Data from other states are included in the biennial report and factoids to make the Nevada stats more meaningful. 8. NSDUH data is used for the NOMS review and to complete P Forms for Block Grant reporting. 9. NSDUH data is used by the EPI workgroups to target populations that need prevention and treatment interventions. (1—NV)

It is used for bench marking with national ranking. It is used for NOMs for prevention outcomes. We use the data for reporting to the legislature and the public. Our Epidemiology workgroup uses the data also. (1—NV)

NY
The commissioner is always forwarding NSDUH reports to our epidemiology staff asking for NY State-specific statistics, for further explanation or analysis, and/or for interpretation relative to specific policy or initiatives. We compare NSDUH findings with findings from other surveys or indicators, including OASAS school and household surveys. NSDUH data are incorporated into our SEOW State and Community Epidemiological Profiles and made available to county government and providers as part of our online County Planning System. (1—**NY**)

NSDUH New York State data are used along with other state data to help with ongoing monitoring of epidemiological and prevention performance measures and trends. This information, shared with state agencies and other stakeholders is used for the purposes of targeting problem areas and developing policy and programmatic responses consistent with addressing the National Outcome Measures (NOMs). Specifically, a State Epidemiological Profile was developed in 2007 which includes NSDUH indicators as baseline data against which progress and outcomes will be measured from future indicator estimates. Estimates from New York's epidemiological profile including those yielded from

NSDUH data are also provided to the OASAS Commissioner who may use this information to convene other state agencies and stakeholders. Other groups for which data are provided include local governments, prevention providers, and community organizations (eg. United Way). Findings from NSDUH will also be used by OASAS in the development of an easy access web-based dissemination project to provide state substance use trends to a broader audience than mentioned above. Finally, national NSDUH data are used as benchmarks for comparison with findings from New York surveys in developing New York State's treatment-need models. (1—**NY**)

OH

Data is used for the Department's strategic plan, responding to legislator data requests, grant application development, responding to public requests for data, helping to understand geographical differences throughout the state. County boards use the substate data for local planning. Data is also used in conjunction with SEOW and the Ohio Substance Abuse Monitoring Network (OSAM). NSDUH is THE source for substance use prevalence data in Ohio. (1—**OH**)

OR

We use the substate data to identify higher and lower risk regions of the state and we use the information provided for rank (7 groups) with the upper and lower limits to help describe the status of Oregon. We use the data in our block grant application and in our state epidemiological report. We use a lot of NSDUH data in our state epidemiological profile. We also use the data to estimate total cases of abuse/dependence for county epidemiological reports. (1—OR)

Policy or legislation—Target higher risk groups such as ages 18-25, also for age specific needs for youth, 12-17 Program develop.—Again this helps target estimated need and looks at how treatment is developed Funding Allocation—We use the treatment need from NSDUH (using a developed methodology) along with county census population to appropriate funding Briefing state officials—The epidemiology work-group and other policy makers, prevention specialists, even community organizers use the data to inform officials Reporting requirements—The upcoming block grant will be the first to use the NSDUH estimates where as previous years used statewide survey estimates from 1999 and then adjusted for the current census population Reporting to state epidemiology work-groups —It is integrated into the state and county reports that are shared. (1—OR)

PA

We use the NSDUH data for the Treatment Needs Assessment to provide estimates to the Single County Authorities (SCAs) who we fund to plan and manage the Prevention/Intervention/Treatment/Recovery Oriented System. The NSDUH is one of several data elements they use for determining TX needs. As for Prevention it was used for our State Profile for the SPF SIG and as a secondary funding indicator for the community level to determine high need. NSDUH is used by CSAP to populate the Prevention NOMs and as a State we really do not have any other choice. We do not support the NSDUH being used to show effectiveness of the Block Grant Dollars because it has no way of showing connection to the services we fund. The NSDUH questions that are used for the NOMs for prevention provided our State the ability to create a survey in our Performance Based Prevention System (PBPS) and had our prevention providers administer the youth and adult questions during the month of October and November to those that receive services we fund. We had approximately 14400 youth complete the surveys. We plan on doing this annually so we can begin to have some trend data. (Important to note this was not a scientific approach) We also send information to the field when we receive reports from OAS. This information is welcomed by the field. (1—**PA**)

1. Policy or Legislation: State level information on prevalence of substance use and dependence, mental health issues, the treatment gap and the other questions found in NSDUH all assist our policy-makers in their conversations with the legislature and the budget office. (1—**PA**)

2. Program Development. In Pennsylvania, the Drug and Alcohol service system supported with

SAPT funds is highly decentralized. Beyond this, the Pennsylvania Department of Health as a whole emphasizes community planning and decision-making for a broad range of public health efforts, with its State Health Improvement Plan (SHIP) process. As a result, dozens of local jurisdictions draw their own conclusions about specific services they need to develop, and use NSDUH data directly or as we re-package it for them, when we make it available on our Healthy People 2010 website. (1—**PA**)

4. Funding allocation. Our State Prevention Framework–State Incentive Grant (SPF-SIG) grants included a method by which applicants could document relative need by submitting data showing they propose to reach a population more highly impaired than the State Average reported by NSDUH. (1—**PA**)

5. Briefing State Officials. State officials are always interested in finding out how Pennsylvania compares with other states on NSDUH measures. They want to hear it from staff before they hear it in the political arena. (1—**PA**)

6. Informing the public. The Pennsylvania Department of Health maintains a web site which serves as a clearinghouse for state and local Pennsylvania data showing progress toward achieving the objectives of the Healthy People 2010 system. NSDUH data provides important indicators which document progress on indicators. These include Average Age of First Use of Alcohol, Marijuana and Tobacco, and prevalence of use or non-use (age 12-17) of alcohol or illicit drugs, use of marijuana, and use of inhalants. This year we will add Objective 26-10c (past 30 day illicit drug use, age 18+). (1—**PA**)

http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=175&Q=229393

7. Comparison with other geographic areas. Substate estimates for Pennsylvania have suggested regional differences in behavior and attitudes related to substance abuse, which have implications for program development. We are not sure how much they are used, but the analysis has been distributed. As mentioned above, comparisons of states are wanted by policy makers. (1—**PA**)

8. Reporting requirements. We use the estimates of past year alcohol or drug dependence or abuse from Table 78 to provide estimates of need for treatment for Pennsylvania and to develop estimates for our 49 Single County Authorities (SCAs), which are our substate planning areas used for SAPT Block Grant reporting. This information is used in SAPTBG Form 8 (Treatment Needs Assessment Summary Matrix, Column 3A). We provide the same data to our 49 Single County Authorities to use in their county level treatment needs assessments. The state level estimates available in Table 78 (based on 2 years of NSDUH data) are extremely important us, and we copy and save the entire table in Word format from the html version available on the OAS website [http://oas.samhsa.gov/2k6State/Pennsylvania.htm] so we can save it for documentation of our work. We recommend making more of an effort to increase awareness of the state estimates available in Table 78. SAMHSA also uses the NSDUH state estimates to “prepopulate” some of the Prevention Performance Measure “P” Forms in the SAPT Block Grant application. This is helpful to states such as Pennsylvania that would not otherwise be able to report on these measures, although we have some reservations about this that are discussed in our response to Q 14. (1—**PA**)

9. Reporting to State Epidemiology Work Groups. NSDUH estimates are included and used in the Pennsylvania State Epidemiological Profile developed for the SPF-SIG grant, and will be periodically updated, as new estimates are available. (1—**PA**)

10. Other: Grant applications. Many sub-state organizations use NSDUH estimates in their grant applications. NSDUH estimates are included in the Pennsylvania SPF SIG Strategic Plan. (1—**PA**)

Primarily for the block grant. Often times the data is prepopulated and we do not alter that. Informing the public—provide web type info. The black grant is published in itself and is available. Decision making—part of the compilation of data for the state Epidemiology work group to target priority areas

for prevention activities for strategic prevention framework state incentive grant. (1—**PA**)

RI
We used NSDUH substate regions and data in development of a plan for regional substance abuse prevention coalitions. The state and substate data are used by the State Epidemiology Workgroup to help determine state consumption and consequences priorities. NSDUH data are used for NOMs and the SAPT Block Grant. (1—RI)

SC
Program Eval- determining need Informing Public—Addressing data requests for prevalence rates Governors Accountability report Reporting Requirements—Block Grant Application Reporting to Epidemiology groups—SEOW (1—SC)

SD
Use data to identify specific drugs that need to be targeted in prevention and treatment -Once we are approved to move ahead, we use data to estimate level of service need -Use data to request funding for new initiatives -data is used to respond to questions from the Governor's Office and the press -Use data for completion of the block grant -data is used by the Epidemiology workgroup to update areas of highest risk in the State. (1—SD)

TN
Used data to provide information to state officials on the alcohol and drug use among adolescents and to compare Tennessee to other States. Data was used to prepopulate the Prevention Performance Measures for the FY 2008 Substance Abuse Prevention Treatment (SAPT) Block Grant. Data was used to assist with completing the Treatment Needs Assessment Matrix for the SAPT Block Grant. Use data to educate providers and public on the prevalence of substance abuse in the state. (1—TN)

TX
These data are used in the block grant. It has specific forms that require specific data. Fiscal info primarily. Some drug use and alcohol use info. Trends and patterns nationally. (1—**TX**)

1. The State uses the multiple-year NSDUH survey data (the state estimates) for treatment needs assessment among adults for block grant application, formula allocation and strategic planning. 2. NSDUH survey data is also used for Texas Epidemiology Work Group to help assess the prevention needs via Statewide Prevention Framework (SPF) grants. (1—**TX**)

UT
They NSDUH forms the pre-populated information for the prevention NOMS. We also use it for some comparisons between states for Mental Health Information. We will refer the public to the NSDUH site for information on adults that is not available from our own surveys. (1—UT)

Used to report pre-populated data on the P-Forms in the block grant application. (1—UT)

VA
Biannual report to the legislature; presentations to provider groups; annual interagency planning; monitoring trends; grant applications. (1—VA)

VT
Use of NSDUH Data is an integral part of our program operations. We regularly report the data to the public, use it in our program and financial planning, and to inform our work on designing new services or prevention approaches. We use it for NOMS and Block Grant reporting. People are used to seeing this information, and know it from year to year, as we discuss our program outcomes based upon the NSDUH data. (1—VT)

WA
Estimates of unmet need. Examining the relationship between those "in need of treatment" and those

who are chemically dependent. (1—WA)

WI
We use the various prevalence information to keep our Governor and State Council on Alcohol and Other Drug Abuse informed about substance abuse issues; just recently, we partnered with the University of Wisconsin to use the data in a policy and issues brief at the State Capitol; an internal group used the data as part of a needs assessment to identify conditions and locations having more or less substance abuse-related needs. (1—WI)

WV
Program development—review the substate planning areas, which ties into the funding that follows for high risk areas, high use and/or abuse areas. In program planning, specific types of programs, the focus of the program. Try to look for gender specific issues and/or trends. For Block Grant, the needs assessment component, unmet needs (gaps in treatment). For policy and legislative—will use for improvement package (submit data on the needs for treatment dollars). We provide and/or refer a lot of sister agencies to data online that's available for their grant writing. Use for grant writing purposes. (1—WV)

WY
The NSDUH data set is one of a few that surveys a sample of persons aged 18 and higher. In the state of Wyoming, we utilize this data to support policy movements, to inform officials of the latest trends in various drug and/or health-related arenas (based upon requests), and we also push it out to the public by using it in various publications that we release on a quarterly or yearly basis (e.g., newsletters, data reports, etc.). These data are also known to the state Epidemiology workgroups and are discussed on a fairly regular basis. (1—WY)

Anytime a request for data related to mental health or substance abuse issues arises, we always consult the NSDUH database to see if there are elements that can help us answer questions. These come from internal stakeholders, as well as external stakeholders (including the public, legislators, politicians, etc.). The NSDUH data set is one of the few that we are able to use for trending purposes when it comes to adult (18+) information, and thus we rely on it a great deal. (1—WY)

None / Not Sure / Decline to Answer (3—AL, CO and OK)

Not applicable (2—DC, ND)

***Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic**.*

Q7_a: You mentioned that your organization uses NSDUH data for {fill with response options 1 through 9 from Q7 if recorded by respondent}. Please provide specific examples of how your State uses NSDUH data for these purposes.

Specific Comments—Policy or Legislation
California uses NSDUH to inform analyses of ADP policies and proposed California legislation. (1-**CA**)

Policy: To inform policies on underage drinking (1—CT)

Policy and leg—use it when we draft leg or policy. We have to have the data to support changes we make. Driving force behind changes we make. (1—KY)

Policy—Whenever there is legislation introduced that would impact client population we give info from a ntl level that would compare our state to other states. Look at specific drug trends. (1—LA)

Policy or Legislation—used for need on both prevention and treatment (1—MT)

We organize and analyze our data for use by the NH Office on Alcohol and Drug Policy in developing

the Alcohol and Other Drug Plan for the State. We organize and analyze our data for use by NH legislators in crafting legislation and rules for substance abuse prevention and treatment. (1—NH)

To develop legislative factoids each legislative session. (1—NV)

Policy or legislation—Target higher risk groups such as ages 18-25, also for age specific needs for youth, 12-17 (1—OR)

Policy or Legislation: State level information on prevalence of substance use and dependence, mental health issues, the treatment gap and the other questions found in NSDUH all assist our policy-makers in their conversations with the legislature and the budget office. (1—**PA**)

For policy and legislative—will use for improvement package (submit data on the needs for treatment dollars). (1—WV)

Specific Comments—Program Development

Program development—the director of prevention services reviews the data to get an idea of the need for prevention programming. (1—AR)

Program development: Specifically used state estimates to examine change over time for illicit drug use by young adults, 18-15. In particular the increase in non-medical use of prescription pain killers and developed practice models to address opiate addiction in this younger population. (1—CT)

Program development: To target interventions (1—CT)

It will also be used for program development in the prevention and treatment areas. (1—DE)

Prog dev—Looking at prevalence and use What types of programs and how we might change programs. (1—KY)

Program—Part of natl outcome measures requires us to put into place systems to track measures. Train staff on measures. (1—LA)

Data are utilized to develop programs in MS where there is the greatest need to prevent and treat drug use; (1—MS)

Program development—used to look at changes in data and then other data looks at what is available —then develop (1—MT)

To develop programs, such as the Governor's task force on Meth and Meth media campaigns. Evaluate above programs in terms of efficacy. (1—NV)

Program develop.—Again this helps target estimated need and looks at how treatment is developed (1 —OR)

Program Development. In Pennsylvania, the Drug and Alcohol service system supported with SAPT funds is highly decentralized. Beyond this, the Pennsylvania Department of Health as a whole emphasizes community planning and decision-making for a broad range of public health efforts, with its State Health Improvement Plan (SHIP) process. As a result, dozens of local jurisdictions draw their own conclusions about specific services they need to develop, and use NSDUH data directly or as we re-package it for them, when we make it available on our Healthy People 2010 website. (1—**PA**)

We used NSDUH substate regions and data in development of a plan for regional substance abuse prevention coalitions. (1—RI)

Use data to identify specific drugs that need to be targeted in prevention and treatment -Once we are approved to move ahead, we use data to estimate level of service need (1—SD)

Program development—review the substate planning areas, which ties into the funding that follows for high risk areas, high use and/or abuse areas. In program planning, specific types of programs, the

focus of the program. Try to look for gender specific issues and/or trends. (1—WV)

Specific Comments—Program Evaluation
For most purposes, we use the Florida Youth Substance Abuse Survey data to track youth substance use, risk/protective factors, and other risk behaviors/attitudes. We use the NSDUH for young adult, adult, and older adult assessment and evaluation. (1—**FL**)

statewide programs are evaluated utilizing NSDUH data to help indicate if programs are succeeding to combat the drug use problem; (1—MS)

Program evaluation—used in both prevention and treatment for 5 different funding sources (1—MT)

Specific Comments—Funding Allocation
Funding allocation—In the event of a procurement competition where there are additional factors the NSDUH plays a part of who will receive the funding. It is one criteria but not the main one. (1—AR)

Funding allocation: To target funding to state priorities (1—CT)

Often use estimates of dependence and abuse (state and substate) as indicators of population based (environmental strategies) prevention efforts. Use estimates of Dependence and Abuse as well as estimates of Need for justification of funding, and allocation of resources. (1—MA)

Development of a funding allocation formula for MD`s 24 subdivisions.—Answering questions about how many users of (blank) are there in (blank)?—Validation of other needs assessment results.—Prevention NOMS.—Comparison of major subdivisions. (1—MD)

The NC Institute of Medicine is using this data to determine the need for services and to make legislative proposals for additional funding and services. The Division uses the prevalence data to track treated prevalence rates in local areas and to encourage the growth of services to those populations in need. The SEW used the data as part of a State SA Profile to assess statewide needs and help prioritize SPF-SIG grant activities. (1—NC)

We provide data to agency commissioners and directors for use in funding allocation decisions. (1—NH)

Funding Allocation—We use the treatment need from NSDUH (using a developed methodology) along with county census population to appropriate funding (1—OR)

Funding allocation. Our State Prevention Framework–State Incentive Grant (SPF-SIG) grants included a method by which applicants could document relative need by submitting data showing they propose to reach a population more highly impaired than the State Average reported by NSDUH. (1—**PA**)

Use data to request funding for new initiatives (1—SD)

Specific Comments—Briefing State Officials
State officials—we will recite what has been found by NSDUH. Comparison with other states while briefing state officials. (1—AR)

Outside contractor that provides technical assistance training to the Department of Alcohol and Drug programs. In the course of that work, do a lot of background briefing papers and whenever have to use household survey data. (1—**CA**)

Briefing State officials: Have used NSDUH estimates to inform policymakers on the alcohol and other drugs (AOD) prevalence rate for youth in the State an access to treatment for adults. Used information from the NSDUH regarding access to painkillers to educate state officials as well as public as to the ready availability at home from family members (i.e., medicine cabinet). (1—CT)

Briefing state officials: One page information briefs (1—CT)

We publish datagrams that are at times based on this data for updating state officials. (1—DE)

The data impacts the way legislators view the impact of policy. The data helps us to influence policy. The data helps this office decide what initiatives are important in our state. We brief other state officials with the acquired knowledge and build state collaborations (Community Integration Program is a classic example-- Partnership Dept of Corrections and Residential Treatment Facilities. We inform the public through various training, conferences, etc. . . . (1—GA)

When our agency prepares information or responds to requests from local officials we are able to use the information from our State and other States to support the need for treatment. We also use it for general information to the public. (1—KS)

State official—the data are what we use when we talk about use and prevalence and changes we need to make and additional funding that we need. Use it to advocate, educate and inform. (1—KY)

Briefing—In addition to #1 about informing legislators. Need to look at ntl data to share in press releases for our clients. Refer to data for instance reduction in tobacco use. (1—LA)

Briefing State Officials—data used in county reports to county commissioners all the way up to the Governor's office (1—MT)

Used to respond to questions raised by state officials (1—NJ)

NSDUH data are used in the state Biennial Report and legislative factoids. (1—NV)

Briefing state officials—The epidemiology work-group and other policy makers, prevention specialists, even community organizers use the data to inform officials (1—OR)

Briefing State Officials. State officials are always interested in finding out how Pennsylvania compares with other states on NSDUH measures. They want to hear it from staff before they hear it in the political arena. (1—**PA**)

data is used to respond to questions from the Governor's Office and the press (1—SD)

Used data to provide information to state officials on the alcohol and drug use among adolescents and to compare Tennessee to other States. (1—TN)

We use the various prevalence information to keep our Governor and State Council on Alcohol and Other Drug Abuse informed about substance abuse issues; just recently, we partnered with the University of Wisconsin to use the data in a policy and issues brief at the State Capitol; an internal group used the data as part of a needs assessment to identify conditions and locations having more or less substance abuse-related needs. (1—WI)

Anytime a request for data related to mental health or substance abuse issues arises, we always consult the NSDUH database to see if there are elements that can help us answer questions. These come from internal stakeholders, as well as external stakeholders (including the public, legislators, politicians, etc.). (1—WY)

Specific Comments—Informing the Public

Public—We might site information on flyers or on newsletters. (1—AR)

ADP's Office of Public Affairs often requests data that can be extracted from NSDUH and provided to the public. (1—**CA**)

Informing the public: Used NSDUH findings to help inform the public on various health issues such as binge drinking by college-age adults, changes in perceived harm, access to prescription drugs, etc. (1—CT)

Informing the public: Website and publications (1—CT)

We make available the national reports and any web links to members of the public that request them. If there are statewide trends that are of note they will be utilized in reports as appropriate. (1—**IL**)

Informing pub—blips in newspaper, town hall meetings, communications office uses it. (1—KY)

Public—National info is published in state. When the press releases are sent out they go to new orgs in state. If we receive phone calls we provide additional information. (1—LA)

NSDUH data are utilized to inform the public in MS as to where MS ranks nationally and to show a comparison with other states; (1—MS)

Informing the public—data is used in county and state briefings for publication by providers (1—MT)

We provide information on substance use incidence, prevalence and trends to the general public through various media presentations. (1—NH)

Used to respond to questions from news reporters (1—NJ)

The media and SAPTA use NSDUH data for brochures and publications. (1—NV)

Informing the public. The Pennsylvania Department of Health maintains a web site which serves as a clearinghouse for state and local Pennsylvania data showing progress toward achieving the objectives of the Healthy People 2010 system. NSDUH data provides important indicators which document progress on indicators. These include Average Age of First Use of Alcohol, Marijuana and Tobacco, and prevalence of use or non-use (age 12-17) of alcohol or illicit drugs, use of marijuana, and use of inhalants. This year we will add Objective 26-10c (past 30 day illicit drug use, age 18+). (1—**PA**)

http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=175&Q=229393

We will refer the public to the NSDUH site for information on adults that is not available from our own surveys. (1—UT)

Specific Comments—Comparison with Other Geographic Areas
Geographic—Conduct this in house. No specific examples. (1—AR)

Comparison with other geographic areas: In various ways, have used NSDUH data to compare the state with the regional and nation regarding AOD prevalence, treatment and access to care. This also relates to previous two items, as these presentations are to policymakers as well as local and regional stakeholders. Substate geographic areas are also compared, although substate comparisons are of less utility for planning, policymaking and program development. (1—CT)

Comparison: Comparing CT to New England, US for Needs Assessment Reporting: NOMs. (1—CT)

We use it for comparing trends with local, state, and national level for determining how we differ from the norm. (1—DE)

Comparison with geo—not only within but outside the state, looking at use and prevalence to see where we gain or lose ground. (1—KY)

Geographic—ntl outcome measures—we are developing a report card at the facility level which shows outcomes. Establish benchmarks and targets and facilities can see where they compare with similar program types. (1—LA)

Currently NSDUH provides states with the ONLY standard methodology to examine estimates and compare across states over time. Hopefully the substate estimates will become more stable over time with increased N`s. (1—MA)

Comparing NJ to other sections of the country (1—NJ)

Data from other states are included in the biennial report and factoids to make the Nevada stats more meaningful. (1—NV)

Comparison with other geographic areas. Substate estimates for Pennsylvania have suggested regional differences in behavior and attitudes related to substance abuse, which have implications for program development. We are not sure how much they are used, but the analysis has been distributed. As mentioned above, comparisons of states are wanted by policy makers. (1—**PA**)

We also use it for some comparisons between states for Mental Health Information. (1—UT)

The NSDUH data set is one of the few that we are able to use for trending purposes when it comes to adult (18+) information, and thus we rely on it a great deal. (1—WY)

Specific Comments—Reporting Requirements, (e.g., to State Epidemiology Work Groups, etc.)
The Arkansas State Epidemiology Workgroup (SEW) is responsible for collecting and reporting data on: 1) the consumption of alcohol, tobacco, and other drugs and 2) the consequences associated with the use of these substances in the state of Arkansas. The SEW uses the data it collects to inform state prevention efforts, and it creates reports and publications (that hopefully increase public awareness of substance abuse in Arkansas). The NSDUH is extremely important because it provides the only general population estimates for illicit drug use in the state. (1—AR)

Reporting requirements—we opted for prepopulated nsduh data to be included in our applications. Epidemiology—NSDUH is primary source of data used for past 3 years. Used to determine prevalence rate. (1—AR)

We voluntarily report to the Governor's Prevention Advisory Committee on alcohol, tobacco, and other drug (ATOD) data. We produce a state level report, and in the midst of producing county-level reports on ATOD data. We refer to / use NSDUH data for these reports. As part of a SAMHSA/CSAP project--California's State Epidemiological Outcomes Workgroup (SEOW), we use NSDUH ATOD data on California residents. We ask for feedback about the data prepared for the SEOW, and for distribution to other audiences. (1—**CA**)

NSDUH figures are used for trend analyses to assist in gap analysis, prioritizing department objectives, SAPT Block Grant application (e.g., Form 8). (1—**CA**)

The California SEOW uses NSDUH data extensively to estimate AOD prevalence. (1—**CA**)

Reporting to Sate Epidemiology work groups: Under CSAP's Strategic Prevention Frameworks State Epidemiology Work group, NSDUH data is shared and explored with other state agency staff, university researchers, and others as treatment need and prevalence. NSDUH data are one set of information used in creating the SPF state profile of AOD problems. Also used for the National Outcome Measures prepopulated for reporting in the Substance Abuse Prevention and Treatment Block Grant. (1—CT)

I used the state and sub-state data to complete forms 8 and 9 in my SAPTBG application. Without the NSDUH reports, my updates would never been completed and we would still be using old prevalence estimates for mental health and substance abuse. Our state epidemiological outcomes workgroup, named DDATA, utilizes this information frequently for completing the local and substate profiles. (1—DE)

We use NSDUH data in the Substance Abuse Prevention and Treatment Block Grant application. (1—DE)

We use district level data in our annual SEW report to provide and compare estimates of drug consumption. (1—**FL**)

Treatment needs in the substate planning areas are estimated using these data and reported in the annual SAPT block grant application. These data are also used in the annual planning documents for the state. , updating state officials and the public Data from this survey are also used for prevention

activities, i.e., reports to state officials, the public and workgroups. (1—**FL**)

Because our state is unable to conduct needs assessment studies on an annual basis, we rely upon pre-populated NSDUH data for completing our National Outcome Measures and Block Grant applications. (1—HI)

We use the data mainly for the block grant and writing grants. The information is available and used as needed for our strategic and comprehensive prevention and treatment plans, which includes the other areas. (1—IA)

Data is used for strategic planning outcomes reporting. (1—ID)

SAPT Block Application on the Prevention NOMS. State epidemiology report data for local SPF/SIG projects Epidemiology reports inform SPF/SIG advisory council for policy discussions. (1—IN)

Reporting requirements—BGA is now prepopulated with NSDUH info. We use that. state Epidemiology—we have a state treatment and prevention work group and both utilize the data. (1—KY)

NOMs—we report these on the block grant. Epidemiology—we have used the info with the SRFSIG grant it was a requirement that the state convene a work group so we use the data from sources across state and at federal level. ID hotspots for funding to community coalitions to address problems seen through data. (1—LA)

NSDUH Data is one of the data sources used in the construction and presentation of our quarterly Community Epidemiology Surveillance Network publication. (1—ME)

Information from the NSDUH survey is included in the Michigan Legislative and Annual Reports. Such reports contain data on all substate regions for comparison. NSDUH data for multiple years is used to look for trends and is compared to data from other sources. This information is shared with various State epidemiological work groups and is publicly available on our state web-site. (1—**MI**)

The Missouri Division of Alcohol and Drug Abuse (ADA) compiles an annual Data book that captures data often requested by state legislators. NSDUH state estimates on number of individuals with "alcohol and illicit drug dependence or abuse" are compared with the number served by ADA in specialty treatment programs to provide the treatment penetration rate. NSDUH sub-state data were utilized by some of the Strategic Prevention Framework State Incentive Grant (SPF SIG) community coalitions as part of their baseline data collections. The coalitions will continue to track the NSDUH and local data as part of their project evaluation activities. During the past several years, ADA has utilized prevalence and social indicators data to determine the areas of the state that are most under-served, and to prioritize areas to allocate funding for treatment expansion. Based on analysis of past state-level NSDUH reports, ADA recently announced reductions in Missouri adolescent alcohol and marijuana use in the Department of Mental Health’s "DMH Cabinet Report" that is submitted bi-weekly to the Governor’s office. The May issue of the ADA News Bulletin featured trend data on alcohol use and binge drinking based on the last four NSDUH reports. Additional bulletins are planned to summarize state trends for adolescent smoking and illicit drug use. The annual "Status Report on Missouri’s Alcohol and Drug Abuse Problems" presents extensive national and Missouri NSDUH data, and provides analysis and comparisons of national, state, and sub-state prevalence estimates. The NSDUH is an important data source for the prevention NOMs. The NSDUH state estimates on dependence and abuse provide the basis for calculations of treatment need by sub-state region, age, gender, and race presented in the "SAPT Block Grant Application." NSDUH state and sub-state data have been provided to the SPF SIG State Epidemiology Workgroup and the funded SPF SIG community coalitions since the inception of the project. (1—MO)

Data are utilized in our SAPT Block Grant application for both prevention and treatment and state epidemiology profiles are conducted utilizing NSDUH data to compare MS to the rest of the nation. (1

—MS)

Reporting requirements—self explanatory State Epidemiology group—uses the data for identifying priorities. (1—MT)

Our state substance abuse prevention program has included these data into our state substance abuse epidemiological profile. The profile was made available to the public as well as prevention staff and key policy and decision makers within the state. The results were very important in our SPF SIG prioritization process, which led us to selecting three alcohol specific priorities for our SPF SIG grant. As part of our Epidemiology profile, we reported state level estimates from the NSDUH and made comparisons between Nebraska and the U.S. We did not include sub-state estimates in our Epidemiology profile report; however, we include them as part of our state SPF SIG strategic plan and will continue to ensure that our regional and local prevention experts have access to sub-state data. Regarding NOMS, our NE specific data are being used; however, we are not reporting those. SAMHSA is pre-populating those fields for us. (1—NE)

State allocates Block Grant resources to substate areas and includes "need" as part of the formula. State has issued press releases providing public information on depth of substance use/abuse in state especially underage drinking, binge drinking and driving while impaired. State allows substate entities to compare and contrast problems, and uses the materials of the survey to identify trends at the substate level. Epidemiological work group is utilizing elements of the NSDUH to look at setting priorities. (1—NE)

We develop reports and presentations for the NH Office of Alcohol and Drug Policy, NH legislators, the NH Department of Health and Human services and members of the public. We use NSDUH data to respond to SAPT Block Grant requirements and to support our funding decisions. (1—NH)

Ad hoc reports detailing various demographics (age ranges and substances in particular) concerning alcohol and other drug abuse are provided to legislative committees and state officials. NSDUH data combined with local data is used to fill out several tables in the Block Grant. Data are currently being used by the state’s prevention epidemiology work group for SPF/SIG. (1—NH)

Our data is used to report incidence, prevalence and trends to SAMHSA via our SAPT Block Grant application. (1—NH)

Informing NJ`s SEOW workgroup (1—NJ)

Pre-populated NOM's. (2—NM)

Used for the preparation of PowerPoint presentations, prevention NOMS reporting for Block Grant (P Forms), and included in publications such as our Biennial Report. (1—NV)

NSDUH data is used for the NOMS review and to complete P Forms for Block Grant reporting. NSDUH data is used by the EPI workgroups to target populations that need prevention and treatment interventions. (1—NV)

The commissioner is always forwarding NSDUH reports to our epidemiology staff asking for NY State-specific statistics, for further explanation or analysis, and/or for interpretation relative to specific policy or initiatives. We compare NSDUH findings with findings from other surveys or indicators, including OASAS school and household surveys. NSDUH data are incorporated into our SEOW State and Community Epidemiological Profiles and made available to county government and providers as part of our online County Planning System. (1—**NY**)

NSDUH New York State data are used along with other state data to help with ongoing monitoring of epidemiological and prevention performance measures and trends. This information, shared with state agencies and other stakeholders is used for the purposes of targeting problem areas and developing policy and programmatic responses consistent with addressing the National Outcome Measures

(NOMs). Specifically, a State Epidemiological Profile was developed in 2007 which includes NSDUH indicators as baseline data against which progress and outcomes will be measured from future indicator estimates. Estimates from New York's epidemiological profile including those yielded from NSDUH data are also provided to the OASAS Commissioner who may use this information to convene other state agencies and stakeholders. Other groups for which data are provided include local governments, prevention providers, and community organizations (eg. United Way). Findings from NSDUH will also be used by OASAS in the development of an easy access web-based dissemination project to provide state substance use trends to a broader audience than mentioned above. Finally, national NSDUH data are used as benchmarks for comparison with findings from New York surveys in developing New York State's treatment-need models. (1—**NY**)

We use the substate data to identify higher and lower risk regions of the state and we use the information provided for rank (7 groups) with the upper and lower limits to help describe the status of Oregon. We use the data in our block grant application and in our state epidemiological report. We use a lot of NSDUH data in our state epidemiological profile. We also use the data to estimate total cases of abuse/dependence for county epidemiological reports. (1—OR)

Reporting requirements—The upcoming block grant will be the first to use the NSDUH estimates where as previous years used statewide survey estimates from 1999 and then adjusted for the current census population Reporting to state epidemiology work-groups—It is integrated into the state and county reports that are shared. (1—OR)

We use the NSDUH data for the Treatment Needs Assessment to provide estimates to the Single County Authorities (SCAs) who we fund to plan and manage the Prevention/Intervention/Treatment/Recovery Oriented System. The NSDUH is one of several data elements they use for determining TX needs. As for Prevention it was used for our State Profile for the SPF SIG and as a secondary funding indicator for the community level to determine high need. NSDUH is used by CSAP to populate the Prevention NOMs and as a State we really do not have any other choice. We do not support the NSDUH being used to show effectiveness of the Block Grant Dollars because it has no way of showing connection to the services we fund. The NSDUH questions that are used for the NOMs for prevention provided our State the ability to create a survey in our Performance Based Prevention System (PBPS) and had our prevention providers administer the youth and adult questions during the month of October and November to those that receive services we fund. We had approximately 14400 youth complete the surveys. We plan on doing this annually so we can begin to have some trend data. (Important to note this was not a scientific approach) We also send information to the field when we receive reports from OAS. This information is welcomed by the field. (1—**PA**)

Reporting requirements. We use the estimates of past year alcohol or drug dependence or abuse from Table 78 to provide estimates of need for treatment for Pennsylvania and to develop estimates for our 49 Single County Authorities (SCAs), which are our substate planning areas used for SAPT Block Grant reporting. This information is used in SAPTBG Form 8 (Treatment Needs Assessment Summary Matrix, Column 3A). We provide the same data to our 49 Single County Authorities to use in their county level treatment needs assessments. The state level estimates available in Table 78 (based on 2 years of NSDUH data) are extremely important us, and we copy and save the entire table in Word format from the html version available on the OAS website [http://oas.samhsa.gov/2k6State/Pennsylvania.htm] so we can save it for documentation of our work. We recommend making more of an effort to increase awareness of the state estimates available in Table 78. SAMHSA also uses the NSDUH state estimates to "prepopulate" some of the Prevention Performance Measure "P" Forms in the SAPT Block Grant application. This is helpful to states such as Pennsylvania that would not otherwise be able to report on these measures, although we have some reservations about this that are discussed in our response to Q 14. Reporting to State Epidemiology Work Groups. NSDUH estimates are included and used in the Pennsylvania State Epidemiological

Profile developed for the SPF-SIG grant, and will be periodically updated, as new estimates are available. (1—**PA**)

Other: Grant applications. Many sub-state organizations use NSDUH estimates in their grant applications. NSDUH estimates are included in the Pennsylvania SPF SIG Strategic Plan. (1—**PA**)

Primarily for the block grant. Often times the data is prepopulated and we do not alter that. Informing the public—provide web type info. The black grant is published in itself and is available. Decision making—part of the compilation of data for the state Epidemiology work group to target priority areas for prevention activities for strategic prevention framework state incentive grant. (1—**PA**)

The state and substate data are used by the State Epidemiology Workgroup to help determine state consumption and consequences priorities. NSDUH data are used for NOMs and the SAPT Block Grant. (1—RI)

Program Eval- determining need Informing Public—Addressing data requests for prevalence rates Governors Accountability report Reporting Requirements—Block Grant Application Reporting to Epidemiology groups—SEOW (1—SC)

Use data for completion of the block grant -data is used by the Epidemiology workgroup to update areas of highest risk in the State. (1—SD)

Data was used to prepopulate the Prevention Performance Measures for the FY 2008 Substance Abuse Prevention Treatment (SAPT) Block Grant. Data was used to assist with completing the Treatment Needs Assessment Matrix for the SAPT Block Grant. Use data to educate providers and public on the prevalence of substance abuse in the state. (1—TN)

These data are used in the block grant. It has specific forms that require specific data. Fiscal info primarily. Some drug use and alcohol use info. Trends and patterns nationally. (1—**TX**)

1. The State uses the multiple-year NSDUH survey data (the state estimates) for treatment needs assessment among adults for block grant application, formula allocation and strategic planning. 2. NSDUH survey data is also used for Texas Epidemiology Work Group to help assess the prevention needs via Statewide Prevention Framework (SPF) grants. (1—**TX**)

They NSDUH forms the pre-populated information for the prevention NOMS. (1—UT)

Used to report pre-populated data on the P-Forms in the block grant application. (1—UT)

Biannual report to the legislature; presentations to provider groups; annual interagency planning; monitoring trends; grant applications. (1—VA)

Use of NSDUH Data is an integral part of our program operations. We regularly report the data to the public, use it in our program and financial planning, and to inform our work on designing new services or prevention approaches. We use it for NOMS and Block Grant reporting. People are used to seeing this information, and know it from year to year, as we discuss our program outcomes based upon the NSDUH data. (1—VT)

Estimates of unmet need. Examining the relationship between those "in need of treatment" and those who are chemically dependent. (1—WA)

For Block Grant, the needs assessment component, unmet needs (gaps in treatment). We provide and/or refer a lot of sister agencies to data online that’s available for their grant writing. Use for grant writing purposes. (1—WV)

General Comments

Data is used with state generated data in briefing documents, planning documents, and information for the general public. (1—AK)

Epidemiology report. Determining what substances to target for prevention, treatment and enforcement. Informing department heads and policy makers. It is also used for prevention NOMS. (1—AZ)

We use the state data to make comparisons in groups and point out increases or decreases in certain drug use. We also point out increases in the number served to justify increased funding of state dollars. The data is also used for presentations at conferences. We compare drug use and frequency in certain geographic areas to assist in RFP development and specialty programming. The data is sometimes used to brief state officials when relevant. (1—GA)

We are always looking for up to date data to show our legislators when appropriate, or when they request it. Current data is vital to grant writing, and to inform the public about current trends. (1—IA)

NSDUH data are only one source of information we may access as questions about substance usage arise. (1—IN)

We rely on NSDUH data to support information we furnish to our legislative liaisons, public presentations, in our work on program development as we look to close service gaps, and addressing needs in various parts of our state. We have a state epidemiological work group that includes NSDUH information in its compilation. (1—MN)

It is used for bench marking with national ranking. It is used for NOMs for prevention outcomes. We use the data for reporting to the legislature and the public. Our Epidemiology workgroup uses the data also. (1—NV)

Data is used for the Department's strategic plan, responding to legislator data requests, grant application development, responding to public requests for data, helping to understand geographical differences throughout the state. County boards use the substate data for local planning. Data is also used in conjunction with SEOW and the Ohio Substance Abuse Monitoring Network (OSAM). NSDUH is THE source for substance use prevalence data in Ohio. (1—**OH**)

The NSDUH data set is one of a few that surveys a sample of persons aged 18 and higher. In the state of Wyoming, we utilize this data to support policy movements, to inform officials of the latest trends in various drug and/or health-related arenas (based upon requests), and we also push it out to the public by using it in various publications that we release on a quarterly or yearly basis (e.g., newsletters, data reports, etc.). These data are also known to the state Epidemiology workgroups and are discussed on a fairly regular basis. (1—WY)

None / Not Sure / Decline to Answer (3—AL, CO and OK)

Not applicable (2—DC, ND)

QUESTION 7_b

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q7_b: [IF Q7=OTHER] Please provide specific examples of how your State uses NSDUH data for other purposes.

Grant Writing

California is re-designing the needs assessment process to provide a timely reflective response to AOD needs in the state. NSDUH estimates of prevalence and unmet needs are key to these considerations. (1—**CA**)

California State Needs Assessment—that drives most of it. (1—**CA**)

Grant writing—people contact us for data and info that they can use as part of grant writing. We use it for other SAMHSA grants. Use it to address why you would need the funding for the grant. (1—LA)

Comparison of NM data, grant writing, SPF-SIG prevention activities (1—NM)

Other: Grant applications. Many sub-state organizations use NSDUH estimates in their grant applications. NSDUH estimates are included in the Pennsylvania SPF SIG Strategic Plan. (1—**PA**)

Legislator Requests

SAPTA produces information for the legislature about state rankings in terms of alcohol and drug abuse. All the data are taken from NSDUH tables. Information about demographics and geography is included by way of explaining the NSDUH data. For example, Nevada ranks number 1 in meth use nationwide. It is very close to Mexican distribution areas and Nevada's population has a disproportionately large number of male construction workers, miners and hotel/restaurant workers who use drugs and alcohol more than other groups. (1—NV)

We respond to a variety of constituent and legislator questions about prevalence. We have 50 county boards that act as middle managers and are responsible for county planning and they request prevalence data. We use it for strategic planning. (1—**OH**)

We use NSDUH data in presentations and fact sheets for providers, legislators, and state staff (including presentations to staff in other state agencies). We review NSDUH data in our AMH data users group. (1—OR)

Media Requests

The data is used for reports to the administration as well as responding to media requests. (1—**PA**)

Mostly responding to media questions. (1—SD)

Trend Analysis

Used to compare NJ`s Household Survey findings with the national trends. NJ uses the same survey questionnaire. (1—NJ)

Trend analysis within state compared to the national estimates. And substate areas to substate areas. (1—WV)

Other

We are using the state NSDUH prevalence #`s to then estimate overall state needs. We do not use the regional estimates because the counties are lumped together minus the exception of Multnomah. Since we cannot apply it consistently we use statewide rates and then apply it by adjusting for county specific census #`s. It is very helpful for both the 18-25 and the 12-17 age groups. It is known these are high need groups as well as groups with potentially to have the greatest impact on the system. We also use these estimates for current and future research to be shared and hopefully published. (1—OR)

Not applicable (41—AK, AL, AR, AZ, CO, CT, DC, DE, **FL**, GA, HI, IA, ID, **IL** ,IN, KS, KY, MA, MD, ME, **MI**, MN, MO, MS, MT, NC, ND, NE, NH, **NY**, OK, RI, SC, TN, **TX**, UT, VA, VT, WA, WI, WY)

QUESTION 8

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q8: What **specific** estimates or topics covered by the NSDUH does your organization use?

Prevalence of Tobacco, Alcohol, and Drug Use

Gender Differences in alcohol use and dependence Depression and the Initiation of drug use Serious Psychological Distress and Substance Use among veterans Inhalant use Nicotine dependence. (1—AK)

Some topics are those groups at high risk for substance use and abuse. (1—AL)

We generally use state and national level data on alcohol, tobacco, and other drug use. (1—AR)

Age of first use for marijuana and alcohol. Consumption / binge drinking in the past 30 days 12 to 17. (1—AR)

Rates of substance use. (1—AZ)

Binge Drinking Adults 18+ Past 30-Day use of Alcohol, Illicit Drugs, Cigarettes, and Marijuana (12-17, 18-25, 26+)--California and US (1—**CA**)

Alcohol and illicit drugs—all of it from both the different population sub aggregations. In the past have used mental health data, but typically wouldn't use. (1—**CA**)

Prevalence of use of specific substances and prevalence of use by specific populations statewide and by region. (1—CO)

Primarily estimates of alcohol and other drug use rates. Occasionally, upon request of legislators or stakeholders, we run special analyses to determine how substance use relates to other topics in the NSDUH. (1—**FL**)

Prevalence of all the major illicit drugs. (1—**FL**)

I specifically use the information on drug trends and admission rates. It is helpful to see state level changes. (1—GA)

Child & Adolescent SA. Co-occurring Disorders and SA. Trends in initiation of SA, and many more. (1—GA)

Type of substance used by age group. General "prevalence" by age group. (1—IN)

Statewide drug use estimates. Local level data are used to inform communities on what drugs they would focus on for strategic planning. (1—IN)

Look at prevalence for IV drug use. What don't we use? Age, gender, substate amounts, comparisons, drug types, adolescents, women, different populations. We use all of it. The data staff use it. When we are looking at grants. We used to do a state survey but stopped and just use the nsduh. (1—KY)

Dependence and Abuse; alcohol, illicit drugs, prescription drugs Need for Treatment. (1—MA)

30 day use of marijuana/pain killers/alcohol/illicit drugs/alcohol and/or illicit drugs.—past year use of cocaine.—dependence or abuse of alcohol or illicit drugs—unmet need for alcohol/drug treatment (would like an overlap estimate here). (1—MD)

Data collected on substance use patterns for alcohol and other drugs and its impact on health. (1—ME)

Specific estimates and/or topics include use in the past 30 days, perceptions of great risk, dependence on or abuse of illicit drugs in past year. These estimates are used for analyzed for all ages and for each age group. (1—**MI**)

Tobacco use, alcohol use, illicit drug use and prevention related data. (1—MN)

Alcohol, Tobacco and other drug consumption. (1—MN)

We use almost all of the 24 topics presented in the state tables. The most important are the past-month use of alcohol, binge alcohol, cigarettes, and marijuana; perceptions of great risk measures; and past-year alcohol and illicit drug dependence or abuse. (1—MO)

Any of the estimates that show increase or decrease in drug use. (1—MS)

We use all of the data for adults 18 and older—we have a good system for kids information—the data is better represented at our level for this kids. (1—MT)

Alcohol: prevalence estimates, any use, heavy use, binge drinking specific drugs: prevalence estimates, any use, 30-day use. (1—NC)

Patterns of drug use, risk and protective factors identified in school, community and familiar attachment by adult population. Adult attitudes toward youth use. (1—NE)

In particular; rates of abuse and dependence for various substances. (1—NH)

Incidence and prevalence of use of specific substances by sub-state areas, numbers and percentages of NH resident who meet DSM-IV-R diagnostic criteria for alcohol and/or other drug abuse and dependence, attitudes toward substance use. (1—NH)

We use substance abuse incidence, prevalence and trends both on a state level and substate levels. We use the numbers and percentages for people needing but not receiving treatment in New Hampshire. (1—NH)

NJ Division of Addiction Services (DAS) looks at the use of tobacco, alcohol and illicit drugs; substance abuse and dependence. (1—NJ)

Typically we report on any topics where the state differs significantly from national averages. State information about use, abuse and dependence (for all ATOD) is used for a variety of things too. (1—NV)

We use a lot of the information from the fact sheets that you generate past month use of alcohol, tobacco, marijuana and illicit drugs (including binge and heavy drinking) alcohol and drug abuse/dependence severe psychological distress Co-occurring disorders first time use For all of these we look at the age break outs and whenever available we look at the substate data. (1—OR)

Usage information Treatment Need information (specifically illicit drug/alcohol combined) To an extent psychological distress estimate. (1—OR)

Prevalence rates for drugs and alcohol. The substate estimates are also used for the treatment needs assessment. (1—**PA**)

We mention only those of which we are directly aware. Treatment need, 30 day use, dependence, and age of first use for tobacco, alcohol, marijuana, inhalants. (1—**PA**)

Incidence of marijuana use, alcohol use, other illicit drug use, binge drinking. Rates of dependence and abuse (alcohol and illicit drugs; needed but did not receive treatment (alcohol and illicit drugs); serious psychological distress. (1—RI)

Prevalence estimates, prevention, and treatment gap estimates. (1—SC)

Alcohol use among college students Underage alcohol use Youth prevention related measures Illicit

drug use among pregnant women. (1—TN)

Mainly the prevalence rates of alcohol and drug use/abuse and other related measures at the state (or sub-state) level. Demographic break-down for those rates is used too. (1—**TX**)

Adult I & P for substance abuse. (1—UT)

ALL BY STATE AND SUBSTATE REGION: Illicit drug dependence; illicit drug use other than marijuana; marijuana use; cocaine use; nonmedical use of pain relievers; tobacco product use; alcohol dependence; binge alcohol use among youth; percent of population needing but not receiving treatment. (1—VA)

Youth and adult use data, primarily. Treatment need estimates. (1—VT)

Need for treatment, substance abusing, and chemically dependent populations for both alcohol and illicit drugs. (1—WA)

1. Prevalence of use, abuse or dependence by state and substate area 2. Great risk smoking marijuana 3. Binge alcohol use 4. Great risk drinking five or more drinks 6. Serious psychological distress 7. Major depressive episode 8. Driving under the influence. (1—WI)

Binge drinking data, all the self reports on use (drug, alcohol, tobacco), perception of risk. Use actually all the NSDUH data for one reason or another. (1—WV)

We use all topics that are mental health or substance abuse related, and, to a lesser extent, any topics that are somehow correlated with mental health/substance abuse issues. (1—WY)

Any topics that relate to mental health or substance abuse issues. (1—WY)

Need for Treatment

The number of individuals needing treatment. (1—AL)

AOD prevalence and unmet treatment need frequencies and percentages. (1—**CA**)

State and local prevalence estimates of those in need of substance and mental health treatment are very often used in daily planning of program and policy. We use them to assist with prevention as well. We also share county data with our other stakeholder groups, such as community coalitions. (1—DE)

Treatment needs. (1—**FL**)

I also use the household survey to argue for more treatment services and funding needed. (1—GA)

Prevalence of Mental Health and SA Treatment. (1—GA)

Estimated number of people receiving treatment, needs estimate data. (1—LA)

in need of treatment who did not receive treatment; abuse/dependency estimates; (1—ME)

The number/percent of those needing but not receiving treatment in past year (alcohol and illicit drugs). These estimates are used for analyzed for all ages and for each age group. (1—**MI**)

We have tried to use the estimates for "needing but not receiving treatment" but have noticed discrepancies between those estimates, the estimates for past-year dependence or abuse, and the numbers served in our treatment programs. (1—MO)

And the number of NH residents needing but not receiving treatment. (1—NH)

Access to substance abuse treatment. (1—NJ)

Mental Health—serious emotional stress. (1—UT)

Needing but not receiving treatment. (1—WI)

National Outcome Measures
There are a number of brief reports that the agency has followed over time. These include veterans, older adults, depression, binge drinking, new initiates, trends in perceived harm, and many many others. For estimates, there is interest in of course those that track with the National Outcome Measures, but also AOD prevalence, treatment need, treatment access and barriers to treatment. We have begun to look at the measure for Serious Psychological Distress (SPD). (1—CT)

Other
ATOD consumption, perception of harm, Employment, Criminal Justice involvement, social connectedness, retention. (1—CT)

Abstinence from Drug/Alcohol Use; Increased/Retained Employment or Return to/Stay in School; Increased Social Support/Social Connectness. (1—HI)

The national survey does not always provide data that is specific enough for use in a state as geographically diverse as this—however—data is often available for the metro area that is helpful to that area—this included alcohol use rates among younger adults/adolescents. (1—**IL**)

Use of levels of care Census Populations. (1—KS)

To my knowledge, we are using nearly all available estimates. However, my work is specific to substance abuse prevention and can speak with more confidence to the use of alcohol and illicit drug use data. We included estimates for alcohol and drug use, dependence and abuse of these substances, and perceptions of risk in our epi profile. In addition, we included tobacco related measures; however, our state tobacco prevention program uses only BRFSS and YRBS for reporting tobacco prevalence. (1—NE)

30 day use; Age of First Use; Perception of Disapproval Attitude; Perceived Risk/Harm of Use; Perception of Workplace Policy; Alcohol related Car Crashes and Injuries; Family Communications Around Drug Use; Percentage of Youth seeing a prevention message. (1—NM)

Youth indicators, 12-17 year olds - 30 day use; Age of First Use; Perception of Disapproval Attitude; Perceived Risk/Harm of Use; Perception of Workplace Policy; Alcohol related Car Crashes and Injuries; Family Communications Around Drug Use; Percentage of Youth seeing a prevention message; All ages: Illicit and prescription drug use prevalence estimates, alcohol use indicators, mental health indicators, dependence and abuse estimates, mental health treatment and service utilization, needing but not receiving treatment, comorbidity (future use) (1—NM)

All of them! (1—NV)

We use all available state and sub-state-specific indicators, including mental health indicators. Areas of interest include: use and SUDs among veterans, drinking driving, prescription pain killers. We pay special attention to estimates of SUDs since we develop county-level estimates of SUDs to review proposals for new or expanded treatment and to allocate treatment resources. (1—**NY**)

Specific national and state-level NSDUH data used by our agency includes all substance use prevalence estimates as well as that of diagnostic DSM-IV disorders. Other relevant information used by this agency pertains to substance use patterns by demographic characteristics such as age, gender, and employment status, etc. (1—**NY**)

Any of the substance abuse info. All of it. Treatment gap info. Comparison to our OH substance abuse monitoring network. This is loosely modeled after NIDA`s epi work group. We have a qualitative approach and the data serves as a counterpoint to the qual data. (1—**OH**)

We use nearly all of them. There wasn't enough space to list all. (1—OK)

State level rates compared to surrounding states. (1—SD)

All that apply to P-form information. (1—UT)

Not Sure (2—IA, ID)

Not applicable (2—DC, ND)

QUESTION 9

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q9: What additional survey estimates or topics could be added to the NSDUH to better meet the needs of your organization?

County Level Data / Sample Size

If it would be possible to get county level data. The smallest cohort of reporting is a geographical region, but county level would be good. (1—AR)

County level data would be very helpful. (1—**CA**)

We would like to have those estimates [estimates of illicit drug use] at the county level. (1—**FL**)

Sub-state estimates. Currently, the sample is too small to provide sub-state (county) estimates. (1—HI)

We need data specific to Iowa, that is not combined with other states and/or multiple years. Iowa does a youth survey that closely resembles the NSDUH Survey, with slightly different age groups. It is currently done every 3 years, but Iowa hopes to change that to annual or every 2 years. We will be working on an adult needs assessment. (1—IA)

This state has great diversity in population density, with urban, suburban, rural and smaller cities. Having estimates for these areas that could be separated from the state total would be useful. (1—**IL**)

I just wish we could get more info about sub state areas. we need a deeper penetration about the number of people surveyed so we can make comparisons and know more about them. We gave up this info when we gave up the state survey. (1—KY)

Right now—no additional questions—but better or larger sampling would be most appreciated. (1—MT)

NC is focusing more attention on the needs of our Hispanic population and military personnel and their families. Oversampling or a larger sample size would make the NSDUH more useful for these purposes. Estimates of the prevalence of co-occurring MH and SA disorders would also be helpful. (1—NC)

We have two substate areas that are combined because of population size. This is not as useful for these two areas. The areas are somewhat unique in populations with one area having a very high mobile population. It would be better if the survey covered each substate area independently. Oversampling in these two areas would be extremely helpful. Both areas are rural/frontier with several "large rural" communities. (1—NE)

It would be helpful to NH if we could break use patterns down further using more sub-state areas. (1—NH)

It would be helpful to have the substate data broken down further by regions or by counties. Information on residents` experience with treatment would be helpful. (1—NH)

Consider adding a sampling stratum for older adults (e.g., age 60+) so that estimates could be

accurately made for older adults, along with age 12-17, 18-25 and 26-59. Add content related to ? recovery? experience. Add content related to gambling behavior and problems. Various members of the NY SEOW are especially interested in content related to fetal alcohol spectrum? disorder, mental health (co-occurring) disorders, domestic violence, eating disorders. (1—**NY**)

Substate data are broken down into regions in which several county boards are grouped together. We would love to have county specific prevalence data for everything that is provided now for substance abuse. Drug of choice and treatment gap. Recognize that this would take a larger sample size. (1—**OH**)

County level estimates! (1—SC)

If more samples at the state (or sub-state) level can be collected, that would be much better. (1—**TX**)

The NSDUH will not be able to be used for planning in our state, unless there was sampling to the 13 Local Health Districts or the County level. That would help us tremendously. (1—UT)

The NSDUH is relatively comprehensive as it is. I often hear that a county-level breakdown would be helpful to our stakeholders, so increased sample sizes in rural and frontier areas would be an excellent addition. (1—WY)

It would be helpful if estimates were available on a county-level (though we understand that without a certain sample size, this is not possible; therefore, it would be helpful in a frontier state like Wyoming to increase the sample of persons selected for the NSDUH survey). (1—WY)

Estimates

Alcohol and drug use coocurring with mental health disorders. (1—AK)

Alcohol, Cigarette, Illicit Drug use among Pregnant women, by trimester. (1—**CA**)

IVDU prevalence frequencies and percentages. Further disaggregration into gender, age, and race-ethnicity subgroups. (1—**CA**)

Measures of persons living in poverty. (1—CT)

There are certain subgroups that are difficult to determine treatment need for that appear in the SAPTBG form 8. The first reporting challenge is (4.)"Number of IVDU (IV Drug Users) (A.) Needing Treatment Services and (B.) That would seek treatment services". The second is "Number of Women in Need (A) Needing Treatment Services and (B) That would seek treatment services". We do not have any state data on these topics that is timely and relevant. At least a state level estimate would be helpful. (1—DE)

I personally would like to see more women`s and family specific data collected. I am not sure what is possible but the reunification of families is an important area not covered. And I also feel that measuring drug-free births of a priority admissions population would be helpful. (1—GA)

Current `hot topics` in Iowa are underage drinking and youth suicide. Anything that would update data is useful. (1—IA)

Prior treatment (type and time lines) and outcome of treatment received. (1—ID)

Data on adolescent treatment needs would be a great addition. Additional funding of current statewide data needs assessment--especially county level data. (1—**IL**)

Gender specific program information and how collected (number of children in treatment w/mother, children in custody, etc) (1—KS)

Unmet need for alcohol or drug treatment.—further delineation of the pain-killers category. (1—MD)

Add back in questions about disability that were in there in 2002-2003. (1—ME)

Would like to see additional data made available on a statewide basis to allow for trend analysis. New data items could be gender, data on those aged 55 and older, have respondents received treatment in the past and a question on use of prescription drugs (not just use of pain relievers). (1—**MI**)

We could really use an estimate of total number needing treatment. Currently we use the estimate "alcohol or illicit drug dependence or abuse", but we were told by the Office of Applied Studies that actual treatment need is probably about 10% higher than that number. It would help to understand the relationship between estimates for "dependence or abuse", "needing but not receiving", and numbers served, and whether traffic offender intervention programs should be included under need, unmet need. (1—MO)

It would be beneficial if there were drug use estimates regarding the elderly and additional information regarding the elderly. Also, additional information and estimates regarding pregnant and single parenting women. (1—MS)

To stay consistent with other surveys, I think it would be useful to change the binge drinking indicator to 4 or more drinks for women and keep it at 5 or more drinks for men. In addition, I think it would be useful to expand on the alcohol questions to ask about binge drinkers question similar to the BRFSS. (1—NE)

Treatment outcomes data, post discharge, relative to NOMS. (1—NH)

Answers to questions about effective treatment and self-help strategies would be helpful. (1—NH)

A section on obstacles to treatment affecting unmet treatment demand, e.g.,accessibility, childcare, transportation, affordability, hours, etc. Please contact us for a list of obstacles NJ will be testing for. A way to capture injuries related to alcohol or drug use. (1—NJ)

Prescription Drugs, Co-occurring and Veterans seem to be hot topics these days based on recent inquiries we get. Methamphetamine garnered much legislative attention during our last legislative session early in 2007. (1—NV)

Could NSDUH give employment/ industry information? Is that collected by the survey? Educational information? Educational level attained? (1—NV)

State patterns of use within specific demographic categories.—A measure for use by marital status.—Easy access to data for analyzing patterns of use/DSM diagnoses/demographics within all New York State counties. (1—**NY**)

Separate by 100%, 200%, 300%, 400% and 500% Poverty Level. Specific drugs, including meth and cocaine, not just any drug. (1—OK)

Information about employment and income. (1—OR)

Poverty levels of the household (and in intervals at 100, 100-199, 200-299, and 400+ FPL) above by region). Estimate of matched poverty levels within the region. Quality of life or life functioning meas Age groups by region for abuse/dependence, psychological distress Co-occurring rates (those reporting serious psychological distress and substance abuse/dependence rates) Demand indicator: the difference between those needing treatment and those seeking treatment and those receiving treatment. (1—OR)

As many State Drug and Alcohol Addiction Agencies are responsible for Gambling Addiction it would be very helpful to have some gambling questions added. In addition question(s) that would ask respondents if they know where in their community they could receive prevention services for Drug and alcohol and where they could go to receive treatment services. Questions on # of prevention services participated in (lifetime and with in the last 12 months. (1—**PA**)

We do not have adequate data on abuse/dependence on prescription opiates. We also lack state-

specific data by race/ethnicity. (1—WA)

1. Stigma questions such as, "Do you agree or disagree that people with an addiction can recover through treatment to lead happy, healthy and productive lives?". 2. Needing but not receiving treatment combined for alcohol and other drugs. (1—WI)

More instruction on best ways to interpret the data. More technical help with that. One thing they are really trying to figure out in their state is drug use/abuse addiction among pregnant women (how to use NSDUH data in a more technically appropriate way in relation to state epidemic) without the benefit of a statistics degree. (1—WV)

Data Comparability
Demographic profiling the age clustering (17 doesn't take you completely through high school). Recommend 12-18 to compare to MTF data (for example) and other national or state data. (1—**CA**)

Other
More sub state materials. (1—AZ)

Refinement of the SPD estimate which includes level of functioning would help the state more accurately determine those with a serious mental illness, our target population. Reporting out standardly for the 18 and older population (while keeping the 18-25 and 26+ groups). (1—CT)

If the State could facilitate the collection of the data it would be more accurate. One needs a phone to participate in the survey and many of the people we need information from do not have a phone. The State data collected is collected at schools throughout the state so we are able to collect more data on a wider range of Idahoans. (1—ID)

The State of Utah has its own data system that meets most of the division's needs. (1—UT)

None / Not Sure / Decline to Answer (14—AL, CO, DC, IN, LA, MA, MN, ND, NM, RI, SD, TN, VA, VT)

QUESTION 10

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q10: What changes could be made to the NSDUH **data products** to better meet the needs of your organization?

Suggestions for Online Data Access
The information can be retrieved from the website by anyone, so that is good for our organization. (1—AL)

I think it would be nice to get email updates about new data and report releases . . . so it would be nice to be able to sign up for a list serve or something. (1—AR)

Finding specific tables on the SAMHSA Web-site is a struggle.—Subject headings on the Web-site are unclear / duplicative. Recommend simplifying information to: Report Name/Contents (1—MD)

Website needs to be easier to access and find—you have to know the website to find what you are looking for—I teach a 1 day class just on accessing data. . . . (1—MT)

The NSDUH web pages and report links could be better organized. It is sometimes difficult to find specific state data from the many reports. (1—NH)

Monthly e-mails to each state with direct links to that specific state's organized data would eliminate searching through all of the NSDUH data for specific items. Possibly the NSDUH data could be

published in a format that is aligned with the requirements of the SAPT Block Grant application. It would be helpful to separate out the maps from the tables in the links. (1—NH)

I have been working with state rankings and have had to enter the rankings in Excel and then sort them to find out where Nevada ranks on all the different measures. Would it be possible to have the NSDUH state rankings on the web somewhere? (1—NV)

It is very helpful to have the Pennsylvania estimates accessible in a single document that is available online. It would be easier to use if it was available in a format other than html. That is where we found Tables 77 and 78. Perhaps this could be publicized even more. It is very time consuming to look for a single state's data in multiple sections of a report that is several hundred pages long. (1—**PA**)

Make it easier to download brief reports and to work with the data from our state. (1—VT)

A query section where you can go and ask for different components of it put together. That would be very helpful. This relates to previous response . . .what makes sense technically. (1—WV)

County Level Estimates

County level reporting; larger sample size at the county level for valid estimates. Further age, gender, and race-ethnicity breakdowns. (1—**CA**)

While you provide estimates of substate use, it would be useful to have a tool to match the characteristics of your substate definitions to our specific substate characteristics. For example, if we could go through screens that ask the characteristics of the substate regions for which we want to determine estimates, at the end it would tell us which data to use. (1—CT)

The uniqueness of the population of each of Hawaii's islands and the small sample surveyed make it impossible to report county-wide data. The demographics and substance use patterns differ from island to island. It would be helpful, if it were possible, for the NSDUH interviewers to sample respondents on each island. Note: Maui County is comprised on three islands: Maui, Lanai, and Molokai. (1—HI)

Provide for breakouts of data, suburban from the city, etc. have the estimates based upon the populations living in that area. (1—**IL**)

Having a comparison of like States-rural, frontier would be helpful, The general information is helpful but would like it broken down more so that it is easily accessed. (1—KS)

Larger sample sizes in Maine so that sub-state estimates could be obtained using one year of data (versus combining 2-3 years). (1—ME)

Include state and sub-state estimates for all Adults? 18+. Include age-gender-specific estimates for state and substate areas. Include all NOMs indicators in state and sub-state-level reports (e.g., Table 65-66 for NY). (We did not include certain NOMs NSDUH indicators in our most recent State Epidemiology Profile because the statistics made available thought CSAP appeared to be inconsistent with published NSDUH data and there was no readily available citation for the NOMs data provided through CSAP.) Pooling of data 2 years at a time is confusing because the years overlap. The pooled data points are not independent measure?any given point shares half its data with the previous data point and the other half with the next data point. This gives the appearance that there is more data than there is. The overlapping pooling has the effect of smoothing the time series. Provide state and sub-state aggregate indicator data in some type of database (e.g., Excel) so that data does not have to be re-entered. It would be relatively easy then to transfer data into databases we use to generate analyses and graphic reports at the state and substate levels. (1—**NY**)

One of things we would love to do would be able to analyze the OH data ourselves. We can do that with the national data but not broken down by state. Don't think there is much we can do to play with

OH data. (1—**OH**)

LARGER sample size, raw data to do our own analysis (1—OK)

Provide raw unadjusted dataset for our state (in STATA/SAS/DBF format). Provide the rate adjustment info. If the sample size was appropriate, report on county level so communities/counties can take charge of their information and we can better report to counties. Provide an online survey system we could also use to reach a different or specified population. Include co-occurring rates, need vs demand vs tx need met, poverty level estimates, resources and source/amount used to pay for service. (1—OR)

Short reports by state and short substate reports for each state. (1—RI)

Increase sampling in the state. Make it easier to run ad hoc reports on state and sub-state levels, instead of having to search through reports. (1—UT)

The survey is not stratified across treatment districts and does not include enough participants to be used in the state for any other purpose than has been identified in this survey. We would require at least 5000 participants stratified across all 13 treatment districts. (1—UT)

Estimates
Do the additional reports breaking out by demographic profiles. (1—**CA**)

Again, more women's and children specifics and a tab with my state name with everything in one place. (1—GA)

Health indicators regarding drug use should be specified. (1—IN)

Details table already provided are very helpful. (1—MA)

First, reporting state data by gender is very important. Second, the website is one of the most unorganized and confusing website I have every used. I have spent hours trying to find what I am looking for at times. I think it would be great to reorganize it and add an interactive query component similar to the CDC's BRFSS website. (1—NE)

Timeliness
Quicker processing & release of the data. (1—**FL**)

Substate data available more quickly (1—OR)

Usability
The brief reports are great. I do have some problems reading the state estimates and regional/national comparisons, so I copy and paste into my own Excel spreadsheet and align (for each measure) the national, regional and state estimates. (1—CT)

The general public does not always know where to look or how to interpret the data. (1—IA)

As stated previously, we need to communicate the number needing treatment and the level of services (from brief interventions to full-array treatment) needed. A training on how to integrate NSDUH data with other state data might be very helpful. We would also like any data that could be collected to generate state estimates of economic cost of substance abuse. (1—MO)

Separating the maps from the tables would be helpful—they now appear on the same document/link. More direct links to specific data for each state would be helpful. (1—NH)

Other
Interactive mapping capacity and the ability to download these files if you have the GIS application. Being able to download the data for local customization would be great. (1—DE)

A rolling average across the reported variable from the 1999 to 2006 on 3 year increments. This will

help to "smooth" out difference in the surveys as they grow. (1—NE)

Perhaps development of state-specific result books similar to that provided nationally. (1—**NY**)

For tables 77 and 78, add the dimension of Gender. Gender within substance within age within State. If it is necessary to use an additional year to get enough sample, it is worth it, because prevalence and treatment need both vary substantially by gender, and the programmatic response needs to be gender-specific to some extent. (1—**PA**)

Some federal Healthy People 2010 objectives are developed in such a way that it is clear that the expectation is that the state estimates will come from NSDUH. Develop a standard report which produces those estimates for each state. Pennsylvania writes a letter to the Office of Applied Statistics to request those estimates each year. Why not do them for everyone? (1—**PA**)

None / Not Sure / Decline to Answer (22—AK, AZ, CO, DC, ID, KY, LA, **MI**, MN, MS, NC, ND, NJ, NM, SC, SD, TN, **TX**, VA, WA, WI, WY)

QUESTION 11

**Note: The responses are reported at the State-level. i.e., for states with multiple respondents, the most inclusive category is reported. For example, if one respondent selected "Both State- and substate-level data" and another respondent from the same state selected "Neither," the final response at the State-level was recorded as "Both State- and substate-level data."*

Q11: Would your organization find it useful to have access to the State- and substate-level NSDUH micro data?

Response Categories	Response Frequencies	Response Percentages	State Responses
State-level data only	1	2.0%	**MI**
Substate-level data only	0	0.0%	Not applicable
Both State- and substate-level data	43	84.3%	AK, AL, AR, AZ, **CA**, CO, CT, DE, **FL**, GA, HI, IA, ID, **IL**, IN, KS, KY, LA, MA, ME, MN, MO, MT, NC, ND, NE, NH, NJ, NV, **NY**, **OH**, OK, OR, **PA**, RI, SC, **TX**, UT, VA, VT, WA, WI, WY
Neither	6	11.7%	DC, MD, MS, SD, TN, WV
Not Sure	1	2.0%	NM
TOTAL	**51**	**100%**	

QUESTION 12

**Note: The responses are reported at the State-level. The response categories "Yes and No," "Yes and Not Sure," and "No and Not Sure" were added to the table to record states with multiple respondents providing different answers.*

Q12: Does your organization have the resources to analyze the NSDUH micro data?			
Response Categories	**Response Frequencies**	**Response Percentages**	**State Responses**
Yes	31	60.8%	AK, AL, AR, AZ, **CA**, CT, DE, **FL**, ID, KS, KY, MA, ME, **MI**, MN, MO, MT, NC, ND, NE, NJ, NV, **NY**, **OH**, OK, SC, **TX**, VA, WA, WI, WY
No	10	19.6%	DC, HI, LA, MD, MS, RI, SD, TN, VT, WV
Not Sure	2	3.9%	IA, NM
Yes and No	6	11.7%	GA, IN, NH, OR, **PA**, UT
Yes and Not Sure	1	2.0%	CO
No and Not Sure	1	2.0%	**IL**
TOTAL	**51**	**100%**	

QUESTION 13

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q13: Considering all aspects of the survey, what additional changes would you suggest to make the NSDUH data more useful for your State?

Sample Size

Have a sample size large enough to cover the various substate areas. Identify the substate areas in partnership with the states (states may have vastly different priorities that those at the national level). Base estimates on populations living in identified areas. Alcohol and drug use and addiction are large problems throughout each state—surveys need to recognize this and not let the larger cities "overwhelm" the findings. (1—**IL**)

Increase survey resources to improve N`s. (1—MA)

Bigger sampling sizes to allow for smaller regions to be reported. . . . currently we have 5 health planning regions—we could use the data best at our judicial regions—which is 22 (1—MT)

NC is growing extremely fast and is expected to continue to do so in the next decade. A larger sample size would make the survey much more useful for planning and analysis. Perhaps moving to a three-tiered grouping of sample sizes could make this feasible. Coordinating the NCDUH with the BRFSS, both in terms of the questions and reports, would be helpful, as we move toward coordination of behavioral health and physical health services. (1—NC)

Oversample American Indian populations (1—NM)

Large sample size is our primary concern (1—OK)

Increase the sample size to allow for sampling at the levels which we must report by statute. (1—UT)

As previously stated, I believe an increased sample size/data collection attempt in rural and/or frontier states would allow for more widespread use of the NSDUH data set. We rely heavily on the NSDUH

survey to inform stakeholders about adult use/abuse patterns in the state, and if we were able to break down the information at the local level it would be greatly helpful. (1—WY)

As stated previously, an increased sampling of Frontier states would be useful, as the NSDUH survey is one of the few (or only) adult surveys that ask questions about mental health and/or substance use and abuse on a yearly basis. We rely on this survey but it would be most helpful if we could break it down at the county level as well. (1—WY)

Estimates

Maybe if we could add questions specific to the drugs and substances used here in AR. Some of the categories are not what we are looking for / some of the categories are collapsed. (1—AR)

Adult attitudes toward substance use. (1—AZ)

For prevention planning, risk and protective factor items would be useful. (1—HI)

Does not match up with Iowa Youth Survey which is census grades 6,8, and 11. Is such a small sampling, we do not get good useful data. (1—IA)

In general the information related to alcohol and substance use/abuse is useful because it has become the standard for estimates. The addition of mental health indicators two or three years ago is problematic as it can be misleading and therefore misused. This data does not seem to bear any relationship to the standards for estimates of mental illness established in the 1980s. (1—IN)

Make it so that users can analyze data by different age groupings. (1—**MI**)

Additional questions to survey participants that yield data about the progression of the disease of addiction as well as use patterns would be helpful. Questions about treatment options, experiences, and the reasons behind treatment success or failure would be helpful. (1—NH)

Have more specific information about prescription drug use—what types of prescription drugs do you use? Where do you get them (from the web, off the street, doctor shopping, etc . . .) (1—NV)

Substate Estimates

As mentioned before, estimates at state and substate level on the IV drug use in need of treatment and seeking treatment, females in need of treatment and seeking treatment. Ability to interact via the web to customize maps. (1—DE)

As mentioned it would be useful to have reliable estimates at the county level for all the major illicit drugs on a regular basis (every 2 years if possible). (1—**FL**)

If they provided the breakdown of the substate areas. (1—LA)

Besides state and sub-state estimates of treatment need (by age group if possible), it would be helpful to have sub-state estimates for all 24 data measures currently provided at the state level. We could also benefit from having access to the sub-state data and learning how to use it to generate smaller area estimates. (1—MO)

Fund a parallel state oversample through a local university of minority populations and "rural/frontier" areas, especially the two western regions that are currently combined in analysis. Native American urban and Native American rural (reservation) special survey would be helpful. (1—NE)

If there was a way to actually have county level estimates it would greatly assist with needs assessment. Having the age breakdowns match the state estimates for population would also be helpful. (1—**PA**)

Providing county level data. (1—SC)

Presentation

Incorporating the data on our website for public information. (1—AL)

No further recommendations unless some colorful bar charts could be developed to enhance the presentation of the data . . . (1—GA)

Timeliness
More timely release of information; larger sample in Maine. (1—ME)

Data to be submitted in a more timely manner. (1—MS)

The data are very useful, but are not very timely. It would be useful to get estimates released more quickly, possibly through an interactive website, with hard copy reports to follow. (1—NE)

Usability
Again, allow the state to facilitate the collection of this data or let us use state collected data to populate the fields. (1—ID)

Not anything other than more state level participation and getting access to the data. Those would be the most beneficial. (1—KY)

Data needs to be better organized and treatment outcomes data would be useful. Similar answer to what I provided in an earlier question. (1—NH)

A listserve with prompted update e-mails to tell us when any changes to the data have been published would be helpful. A list serve for state input/feedback would be helpful. (1—NH)

Since NSDUH is cited in peer-review journals, it would be wise to have permanent weblinks so persons can access links over time (NSDUH links to reports etc. sometimes disappear). (1—NM)

Provide states either the state data directly or the ability to analyze the data online for their state. Provide states access to data for sub-state regions within their state. (1—**NY**)

Make it easier to use the data at the state level. (1—VT)

Have a technical consultant available to address previous responses. (1—WV)

Other
Some states make specific data requests for variables that are not routinely reported. It would be helpful if reports were automatically generated for states annually, if the same variables are requested on a yearly basis (1—NM)

Longer term trend analysis could be helpful at the state level. Now we can compare 2 year periods to last 2 years but longer term would be helpful. (1—**OH**)

Be sure CDC definitions (BRFSS) are aligned with yours. Gender specific reports that examine how male and female use are similar/different. Data on use pre-,post- and during pregnancy. Patterns of use and treatment over the life cycle (to get a better sense of how much of a role treatment plays). Information about health status and disease incidence that could be analyzed at the national level. (1—OR)

I had included comments in previous questions: Co-occurring estimates Need vs demand vs met need County level estimates by age group Sources and amount from each source used to pay for treatment Months without use, abuse or dependence if received past treatment Poverty levels up to 400% above FPL Flag for if they have health insurance and if they know their insurance covers addiction tx. (1—OR)

Periodically, a state profile/report can be produced based on multiple-year NSDUH data—especially for those 8 over-sampled states, such as Texas. The report may cover those 22-23 core measures with in-depth analyses by sub-state, demographic, or other variables. (1—**TX**)

We need more discussion of the relationship between "need for tx" and "chemically dependent". Publicly funded tx is only available for those who are chemically dependent, but we have no estimates have the percentage of those who are dependent who do not receive Tx. The need for tx category, as currently defined, is not particularly helpful to us. (1—WA)

None / Not Sure / Decline to Answer (15—AK, **CA**, CO, CT, DC, KS, MD, MN, ND, NJ, RI, SD, TN, VA, WI)

QUESTION 14

**Note: The counts for each comment are indicated in parentheses. Responses from all respondents administered this question are included. Responses are arranged by topic.*

Q14: What else would be useful for SAMHSA to consider while planning the NSDUH updates?

Sample Size

Larger sample so we can get Iowa exclusive data. (1—IA)

I really question whether data is effective and really truly needed to be collected every year—I think a two year cycle would be much easier to handle—it would allow for a better sampling in the states to better represent the needs and because if the expansion of size to allow for better micro data is going to be made available—you could divide the states in half and perform the survey in half the states in even numbered years and half the states in odd numbered years. . . . (1—MT)

Sample size increase. (1—**TX**)

Estimates

Trends over years and data pertaining to all ethnic groups. Data specific to older adults. (1—AZ)

Would like a break-out of alcohol, marijuana, cocaine, heroin and other opiates, although we recognize the difficulty of obtaining hard drug use information from surveys. Multi substance use—Measures of use/abuse of both alcohol and drugs. (1—MD)

State Specificity

Nothing that comes to mind. If some kind of a state summary (we have graphs and tables) but some state profile might be useful. SAMHSA could develop these with a combo of data sources that SAMHSA has available to help paint a state picture. TEDS and list of treatment programs would be data sources as well as NSDUH. (1—**OH**)

State-specific reports would be great. (1—RI)

More specificity (1—UT)

Timeliness

Making the surveys available every year. (1—AL)

By the time we receive the information, information may have drastically changed. Our State sometimes has a lot of change in a 2 year time frame. (1—KS)

The data always seems old. I know it takes a long time to get an analysis out, but faster reporting would be good. (1—UT)

Usability of Data

I suggest that SAMHSA develop a network of state contacts who would be trained to utilize NSDUH data. Training could include how specific measures are related to survey items; how to generate state, sub-state, and small-area estimates; how to integrate NSDUH data with other data sets; and how to develop, support, and share data with sub-state epidemiology workgroups. (1—MO)

SAMHSA should bring together a group of representatives of all states and stakeholders for a few days to form a workgroup for interactive discussion and questions that would inform the planning process. (1—NH)

It would be helpful to bring representatives from each state together to discuss the data and improvements in person. Possibly, a NSDUH data workgroup comprised of representatives from all stakeholders would better identify data needs and gaps. (1—NH)

Review with our Data Team and our EPI Workgroup. (1—NV)

It might be useful to provide some type of tutorial on NSDUH data. We love the data, but it is dry. It might help increase use if potential users and even current users had an introduction to certain topics. Think as if you were a teacher or bureau head and you wanted you students/staff to have a beginning knowledge of the survey instrument, method, analysis potential or using online analysis capability. You probably already have something like this, but I'm not up-to-date. (1—**NY**)

National meeting to discuss results, future surveys, etc. (1—OK)

Talk/ask such as this method to ask for additional feedback and modifications on the NSDUH survey. We like the survey and are making use of the survey. (1—OR)

There may already be a workgroup with States that meet on a quarterly basis to discuss NSDUH, but if not maybe OAS will consider developing this workgroup. (1—**PA**)

The information you are collecting in this survey. Reinforce the fact of user friendliness and being able to really use it in a whole variety of ways (as previously mentioned). (1—WV)

Other

Maybe a work group of state representatives on it to get together and discuss possible enhancements to the survey. (1—AR)

Continue surveys on an annual basis. (1—**CA**)

Organizing data by NOMS (1—CT)

If there is a means to project future treatment estimates into the next decade would be beneficial for long term program and policy. (1—DE)

State and local input in the planning phase (1—**FL**)

Make only minor changes that won't affect the ability to track data over time—avoid the problems that happened when the NHSDA was changed to NSDUH. (1—**FL**)

Usefulness of NSDUH for planning purposes. (1—HI)

Work with state representatives, particularly those who worked in the state level needs assessment/household survey projects formerly funded by SAMHSA/CSAT. (1—**IL**)

I believe that SAMHSA should consider how the NOMs may be influenced by the NSDUH, and include health indicators as well as social indicators. (1—IN)

The NSDUH has much valuable information in it. SAMHSA`s releases of special topics are interesting tid bits and assist the state to continue public awareness of substance abuse problems. Matching risk and protective indicators would strengthen the surveys speak to local communities. (1—NE)

A new definition of binge drinking. In Nevada (and Wisconsin) drinking 5 drinks at a time is not considered unusual. The casinos love it if you drink 5 drinks or more while gambling!!!!! (1—NV)

SAMHSA's decision to use NSDUH estimates to prepopulate items in the SAPT block grant application which request National Outcome Measures (NOMS), has caused a great deal of anxiety

and difficulty. It is not the NSDUH items which are the problem. They are fine for measures of need, and this is the way we use them. But the concept that those items are measures for outcomes is very problematic. Prevention programs do not have enough control over what happens in a state so that changes in state estimates can be assumed to be outcomes of the federal prevention expenditures. The prepopulating of the Prevention Performance Measure "P Forms" is presented as a first step toward some other step. Program managers know they are supposed to require use of the NOMS, but how the federal government will use required NOMS estimates is just not known and causes concern and inappropriate measurements in an attempt to ward off sanctions anticipated for not using them. (1—**PA**)

None / Not Sure / Decline to Answer (24—AK, CO, DC, GA, ID, KY, LA, MA, ME, **MI**, MN, MS, NC, ND, NJ, NM, SC, SD, TN, VA, VT, WA, WI, WY)

QUESTION 15

Q15: Is there anyone else in your organization that you recommend we contact to complete this survey?

This question was added at the end of the survey to give respondents the opportunity to recommend an additional person who knows how their State uses NSDUH data and could also complete the survey. Please reference Chapter 2.4 (Methods to Maximize Response Rates) for a complete summary on additional contacts.