

2013 National Survey on Drug Use and Health

SUPPORTING STATEMENT

A. JUSTIFICATION

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), sponsor of the National Survey on Drug Use and Health (NSDUH), submits a revision for approval from the Office of Management and Budget to conduct the 2013 NSDUH. The conduct of the NSDUH is paramount in meeting a critical objective of SAMHSA's mission, i.e., to maintain current data on the incidence and prevalence of substance use and mental health problems in the United States. The NSDUH has been conducted on a periodic basis from 1971-1988, and annually since 1990. The 2013 surveys will represent the thirty-third in the series (OMB No. 0930-0110).

The NSDUH is authorized by Section 505 of the Public Health Service Act (42 USC 290aa4 – Data Collection). Section 505 specifically authorizes annual data collection for monitoring the incidence and prevalence of illicit substance use and mental health problems, as well as the abuse of licit substances in the United States population.

The NSDUH provides current data on the U.S. population – aged 12 or older – as well as each state. Eight States are designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) with target sample sizes of 3,600. For the remaining 42 States and the District of Columbia, the target sample size was 900. This approach ensures there is sufficient sample in every State to support small area estimation (SAE) while at the same time maintaining efficiency for national estimates.

Information collected through the NSDUH has multiple applications, including: (1) the study of the epidemiology of substance abuse and mental health; (2) monitoring substance abuse and mental health trends and patterns; (3) identifying licit and illicit substances being abused (including those causing/contributing to medical, psychological, or social problems requiring emergency medical care or rehabilitation); (4) the study of the use of health care resources for treatment of substance abuse and mental health problems; and (5) assisting federal, state and local agencies in the allocation of resources, and the proper design and implementation of substance abuse prevention, treatment, and rehabilitation programs.

The NSDUH instrument is administered by computer-assisted interviewing (CAI) using a laptop computer. The household screening and respondent selection procedures will be administered using a hand-held computer. The length and content of the screening questions and the overall screening process will remain essentially the same in 2013 as in 2012. The 2013 instrument has been updated to include new questions on military service, medical marijuana, physician substance use screening, and respondent characteristics.

The sample design for 2013 NSDUH will be the same as it was for the 2012 sample in that it will be large enough to facilitate the reporting of drug use incidence and prevalence estimates for each of the 50 States, and the District of Columbia.

In December 2006, a meeting of expert consultants was convened by SAMHSA's Center for Mental Health Services (CMHS) and Office of Applied Studies (OAS) to solicit recommendations for mental health surveillance data collection and analysis strategies. The panel recommended conducting methodological studies to calibrate NSDUH mental health and impairment screening tools with a 'gold standard' clinical psychiatric interview to create a statistically sound methodology that may be used to estimate the prevalence of serious mental illness (SMI) among adults (age 18+).

Based on these recommendations, a mental health surveillance study (MHSS) was conducted as an embedded split-sample follow-up study within the 2008 NSDUH. Analysis of data from the first 2 quarters of 2008 (approximately 750 adults) determined one impairment scale that, combined with a psychological distress score (K6), best predicted SMI as determined from the clinical interview. This single impairment scale, a modified version of the World Health Organization-Disability Assessment Scale (WHO-DAS) (Rehm et al, 1999), was administered in the 2009-2012 NSDUHs and will continue to be included in the 2013 NSDUH.

The Structured Clinical Interview for DSM-IV- TR Axis I Disorders Non-patient Edition (SCID-I/NP, 2/2007 revision) (First, M; Spitzer, R; Gibbon, M; & Williams, J; 2002) was tailored for the study and used as the follow-up interview. Data from the 2008 clinical interviews were combined with the main interview short scale data (K6 and WHODAS) to develop a predictive model that was applied to the full main sample to estimate SMI. To maximize trend validity, this model has been applied to 2009-2011 data. With the completion of 1500 clinical interviews in 2012, SAMHSA will have accumulated a large enough sample (4,500) to update and improve the models. Therefore, the MHSS clinical interviewing will be discontinued in 2013.

2. Purpose and Use of Information

The purpose of the survey is to collect and report current data on substance use incidence and prevalence, and mental health statistics for the total U.S. population as well as each State. The sample is sufficient to support small area estimates in each state and the District of Columbia while maintaining efficiency for national estimates.

NSDUH data are used by SAMHSA, the National Institute on Drug Abuse (NIDA), the Centers for Disease Control and Prevention, the Office of National Drug Control Policy (ONDCP), and other Federal agencies interested in the incidence and prevalence of substance use. The data are used to design prevention programs, respond to inquiries on the extent of substance use, estimate treatment need, study the social and economic impact of substance abuse, identify the correlates of substance use, and evaluate the overall impact that Federal and State programs have on drug demand. The NSDUH will provide a useful indicator of individual States' overall success at reducing youth substance use. In conjunction with other data sources, the NSDUH data will provide a means for assessing and improving outcomes of prevention and treatment services. It will help SAMHSA identify areas where serious substance abuse problems exist and provide assistance to States to help them develop and adopt targeted responses for those problems. Also, many special requests for survey information emanate from the White House, Congress, and various State and local government agencies. The questionnaire asks for the minimum information necessary to meet the needs of Federal policy makers and the substance abuse research, prevention, and treatment communities.

The Department of Health and Human Services (DHHS) continues to affirm the need for annual NSDUH surveys as essential to the President's annual Drug Control Strategy and Federal objectives related to substance use. Since the NSDUH is the nation's only source of reliable national substance use data on the U.S. population, this survey will ensure that SAMHSA and other Federal, State, and local agencies will have timely data available for release by late summer of the year following data collection. The ability to respond effectively and efficiently to the continually changing dynamics of the drug culture is critical to sound prevention and treatment strategies. Data from the NSDUH are also used for measurement of program performance and improvement including Quality Outcome Measures, GRPA and other requirements.

Because mental health issues are correlates of substance abuse, SAMHSA continues to include questions on mental health and utilization of mental health services in the NSDUH. Questions on mental health, in conjunction with questions on substance use, treatment for substance use, and mental health services, greatly enhance the ability to characterize and understand the co-occurrence and treatment of mental illness and substance use problems in the U.S.

To look specifically at depression, the 2004 NSDUH introduced two depression modules – one for adults and one for youths. The data collected focuses on lifetime and past year prevalence of major depressive episodes, past year treatment for it, and its severity and impact on functioning. These data are used to obtain the prevalence and need for treatment of depression in the U.S., and will allow further research into the interaction between depression and drug use. These modules were included in the 2005-2012 NSDUHs, and will be included in the 2013 instrument as well. A detailed discussion of the 2013 questionnaire is presented in section B.2.

3. Use of Information Technology

The NSDUH study has been administered via computer-assisted interviewing (CAI) since 1999. The interview is administered using audio computer-assisted self-interviewing (ACASI) for the more sensitive questions, representing most of the interview; the remainder of the interview is administered using computer-assisted personal interviewing (CAPI).

The CAPI/ACASI technology affords a number of advantages in the collection of survey data. First, this methodology permits the instrument designer to incorporate more complex routings into the questionnaire compared to a paper-and-pencil instrument. The computer can be programmed to implement complex skip patterns and fill specific wordings based on answers previously provided by the respondent. Errors made by interviewers (and respondents) due to faulty implementation of skip instructions are virtually eliminated. A second feature relates to the consistency of data. The computer can be programmed to identify inconsistent responses and attempt to resolve them through respondent prompts. This reduces the need for most manual and machine editing, thus saving both time and money. In addition, it is likely that respondent-resolved inconsistencies will result in data that are more accurate than when inconsistencies are resolved using editing rules. Also, the ACASI technology permits nonreaders to complete the interview in total privacy.

CAPI/ACASI technology permits greater expediency with respect to data processing and analysis, e.g. a number of back-end processing steps, including editing, coding, and data

entry become part of the data collection process. Data are transmitted electronically rather than by mail. These efficiencies save time due to the speed of data transmission, as well as receipt in a format suitable for analysis. Tasks formerly completed by clerical staff are accomplished by the CAPI/ACASI program. In addition, the cost of printing paper questionnaires and associated mailing is eliminated.

There is evidence that the ACASI methodology is especially useful for surveys of sensitive topics. Providing the respondent with a methodology that improves privacy and confidentiality makes reporting of potentially embarrassing, stigmatizing, and illegal behaviors (e.g., drug use, mental health issues) less threatening and enhances response validity and response rates.

The NSDUH will continue to use iPAQ hand-held computers to conduct household screening interviews. The primary advantage of this computer-assisted methodology is improved accuracy in selecting the correct household member for an interview. The computer automatically selects the correct household member based on the demographic variables entered, thus substantially reducing the probability for human error.

4. Efforts to Identify Duplication

The NSDUH is the only survey of substance use in the United States with a sample size capable of producing high quality national and separate state incidence and prevalence estimates, especially by detailed demographic variables. No other survey provides the level of detail on substance use and abuse as provided by the NSDUH. No duplication of effort has been identified.

Several other surveys and data systems collect data on substance use, abuse, and dependence. However, it is important to understand the methodological differences between the different surveys and the impact that these differences could have on estimates of substance use prevalence.

The Monitoring the Future (MTF) study is a national survey, sponsored by the National Institute on Drug Abuse (NIDA) that tracks substance use trends and related attitudes among America's adolescents. It is a school-based survey of 8th, 10th, and 12th graders that includes an ongoing panel study from each graduating class conducted by mail. Since the NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older, the two studies clearly have different populations of interest. In addition, the MTF does not survey dropouts, a group that NSDUH has shown to have higher rates of illicit drug use (Gfroerer et al., 1997).

Research has shown that the mode of a survey can have considerable effects on the results, especially with items that are prone to social desirability bias (Groves, 1989). The MTF conducts self-administered surveys in a school setting and by mail. The NSDUH is conducted in the household using a computer-assisted instrument. When the NSDUH is subset to the same student population covered by the MTF, comparisons between the MTF and NSDUH estimates generally have shown NSDUH substance use prevalence levels to be lower than MTF estimates, with differences tending to be more pronounced for 8th graders. The lower prevalences in the NSDUH may be due to more underreporting in the household setting as compared with the MTF school setting.

The Youth Risk Behavior Survey (YRBS) is a component of the Centers for Disease Control and Prevention's (CDC's) Youth Risk Behavior Surveillance System (YRBSS), which biennially measures the prevalence of six priority health risk behavior categories: (a) behaviors that contribute to unintentional and intentional injuries; (b) tobacco use; (c) alcohol and other drug use; (d) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs); (e) unhealthy dietary behaviors; and (f) physical inactivity. The YRBSS includes national, State, territorial, and local school-based surveys of high school students in grades 9 through 12. The students are given a self-administered questionnaire during a regular class period. Although the YRBS includes measures on tobacco, alcohol, and illicit drugs, it is not a comprehensive substance use survey. It only includes a few basic questions on these topics. Like the MTF, this study is targeted at a different population and collects data in a different setting than the NSDUH. As a result, the prevalence estimates of illicit drug use are generally much higher from the YRBS.

In 2000, a series of papers comparing different aspects of the NHSDA, MTF, and the YRBS was commissioned by the U.S. Department of Health and Human Services (DHHS). Under contract with the Office of the Assistant Secretary for Planning and Evaluation, Westat, Inc., identified and funded several experts in survey methods to prepare these papers. The papers were published in the *Journal of Drug Issues* (Hennessy & Ginsberg, 2001). The major findings of this study indicate that differences in survey methodology may affect comparisons of prevalence estimates among youths. The study also found that all three surveys were well designed and managed, but they each have different purposes.

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual, State-based telephone survey of the civilian, noninstitutionalized adult population aged 18 or older and is sponsored by the Centers for Disease Control and Prevention (CDC). Since 2002, BRFSS has collected data from all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam using a computer-assisted telephone interviewing (CATI) design. BRFSS collects information on access to health care, health status indicators, health risk behaviors (including cigarette and alcohol use), and the use of clinical preventive services. More than 350,000 adults are interviewed each year. National data are calculated using a median score across States.

NSDUH has shown consistently higher rates of binge drinking than BRFSS. The use of audio computer-assisted self-interviewing (ACASI) in NSDUH, which is considered to be more anonymous and yields higher reporting of sensitive behaviors, was offered as an explanation for the lower rates in BRFSS (Miller et al., 2004).

Sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Epidemiologic Survey on Alcohol and Alcohol Related Conditions (NESARC) is another study that contains comprehensive assessments of drug use, abuse, and dependence, as well as associated mental disorders. While the NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older, the NESARC was designed to make inferences for persons aged 18 or older and is conducted in waves (2001/2002 and 2004/2005). The NESARC is designed to be a longitudinal survey, whereas the NSDUH provides annual cross-sectional data. Another methodological difference is that sensitive questions in the NSDUH are self-administered while the NESARC is wholly interviewer-administered. Methodological variables, including factors related to privacy and anonymity, and differences in diagnostic instrumentation result in different prevalence estimates. In particular, NSDUH produces substantially higher rates of

use of illicit drugs (Gruca et al., 2007).

5. Involvement of Small Entities

This survey does not involve small businesses or other such entities.

6. Consequences If Information Collected Less Frequently

The existence of substance abuse patterns and behaviors is a rapidly evolving and changing phenomenon, which calls for timely measurement and analysis of the data. It is imperative to continue the Survey on an annual basis for three reasons:

- 1) the statutory mandate for annual data collection on the national incidence and prevalence of substance abuse,
- 2) the continued demand within SAMHSA, ONDCP and other federal agencies for data on the nature and size of the nation's substance abuse problem, and
- 3) the requirement for current data for each of the 50 States and the District of Columbia, to evaluate the effectiveness of programs designed to reduce the use of illicit substances.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with 5 CFR 1320.5 (d)(2).

8. Consultation Outside the Agency

A Federal Register notice, published on April 12, 2012 (Vol. 77, page 21985), solicited one comment on the 2013 NSDUH (see Attachment T for the comment and SAMHSA's response).

It is DHHS policy that all national surveys are reviewed by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The review for the 2013 NSDUH was conducted in April 2012. The DHHS Data Council has been kept informed about the status and plans for the 2013 NSDUH.

Appendix A of the Supporting Statement contains a listing of current consultants on the main NSDUH questionnaire.

There are no unresolved issues resulting from these consultations.

9. Payment to Respondents

On October 18, 2001, the use of a \$30.00 incentive was approved by OMB for use in the 2002 NSDUH survey. The 2002 NSDUH experienced an increase in the weighted overall response rate (screening * interviewing) from 67% to 71%. Prior OMB approval was provided for the continued use of the \$30.00 incentive for the 2003-2012 NSDUH surveys. The weighted overall response rates for 2003-2011 appear in the table below. The 2013 NSDUH calls for the same incentive plan, whereby a \$30.00 incentive will be given to

respondents upon completion of the interview. The incentive is mentioned in the following respondent materials: Lead Letter (Attachment D), Appointment Card (Attachment E), Study Description (Attachment G), Introduction and Informed Consents (Attachment F), Screening Questions (Attachments H), Question and Answer Brochure (Attachment I), Unable to Contact Letters (Attachment P), Call-Me Letters (Attachment P), Refusal Letters (Attachment Q) and Interview Incentive Receipt (Attachment N).

Year	Overall Response Rate %
2001	67
2002	71
2003	71
2004	70
2005	70
2006	68
2007	67
2008	67
2009	67
2010	66
2011	65

NSDUH screening and overall response rates have generally decreased while the interview response rate has remained relatively steady over the past several years. Please see the chart below.

Year	Screening	Interview	Overall
2006	90.23%	74.21%	66.96%
2007	89.07%	73.87%	65.80%
2008	88.62%	74.24%	65.79%
2009	88.40%	75.56%	66.79%
2010	88.42%	74.57%	65.94%
2011	86.98%	74.38%	64.69%

Providing the incentive prior to the interview is a method that has been shown to be successful in increasing response rates. However, this idea was considered for application in NSDUH and rejected. Since the screening respondent is often not the same person who completes the NSDUH interview, it would not be appropriate to offer the interview incentive at the end of the screening. Frequently, the interview respondent is not immediately available at the time of the screening and there would be no assurances that the \$30 would eventually reach that respondent if it was left with another household member. According to the Census Bureau, increasing numbers of households are composed of unrelated individuals, so in many cases, the incentive would not even be left with a relative

(http://www.census.gov/newsroom/releases/archives/families_households/cb12-111.html). Providing the incentive to the screening respondent would also introduce an inconsistent procedure into an otherwise highly standardized interview, since the respondent would sometimes receive the incentive directly from the interviewer and sometimes from another person in the household (if at all). Additionally, providing the incentive at the end of the interview has likely served to minimize the number of breakoffs in the NSDUH.

10. **Assurance of Confidentiality**

Concern for the confidentiality and protection of respondents' rights has always played a central part in the implementation of the National Survey on Drug Use and Health and will continue to be given the utmost emphasis.

Interviewers are thoroughly educated in methods for maximizing a respondent's understanding of the government's commitment to confidentiality. Furthermore, interviewers make every attempt to secure an interview setting in the respondent's home that is as private as possible, particularly when the respondent is a youth. (Attachment A: notice of approval of Federal-Wide Assurance, submitted by RTI to the Office for Human Research Protections (OHRP), DHHS in compliance with the requirements for the protection of human subjects (45 CFR 46)).

The interview incorporates several procedures to ensure that respondents' rights will be protected. The interviewer introduces himself/herself and the session with a consent statement. This statement will appear in the Showcard Booklet (Attachment K) and will be read out loud to each interview respondent. As part of the process for obtaining informed consent, respondents are given a Study Description (Attachment G), which includes information on the Confidential Information Protection and Statistical Efficiency Act of 2002 (included as Title V in the E-Government Act of 2002, P.L. 107-347) and the protection that it affords. Specifically, the Study Description states that respondents' answers will only be used by authorized personnel for statistical purposes and cannot be used for any other purpose.

The questionnaire uses techniques to afford privacy for the respondent during the interview process. The audio computer-assisted self-interviewing (ACASI) portion of the instrument will maximize privacy and confidentiality by giving control of the sensitive questionnaire sections directly to the respondent. The ACASI methodology allows the respondent to listen to questions through a headset and/or to read the questions on the computer screen, then key his or her own responses into the computer via the keyboard.

Hard copy materials generated during the course of the interview are marked for identification by the interviewer according to specific instructions. Name, address, or other easily traceable marks are never noted on the hard copy materials, except on the Quality Control Form (Attachment C) at the end of the interview (with the respondent's permission); even then, the name is not recorded for interview respondents. Furthermore, the respondent places the Quality Control Form in an envelope and seals it after recording the information. The respondent is told of these procedures in advance. The Quality Control Form is mailed directly to the Contractor's main office in North Carolina.

With the CAI methodology, all sensitive data are entered privately by the respondent, and

completed interview data are electronically transmitted to the Contractor's offices on a regular basis via secure encrypted data transmission. Interviewers are unable to review or to edit questionnaire data as the completed interview files are locked. Also, once the respondent has completed the ACASI portion of the interview, the ACASI section is locked, so that the interviewer is unable to back up into this area and review the respondent's most sensitive data. On the data file, respondents are identified only by a link number assigned to screening files and questionnaires/interviews. Although the link number is associated with a location number and a dwelling unit number, this location information is deleted by the Contractor before the delivery of data to SAMHSA. The dwelling unit address information, which is maintained in a separate file for Contractor use in sampling, fielding, and weighting cases, is purged at the completion of data processing.

After delivery and acceptance of the final survey data files, all Quality Control Forms are destroyed, thus eliminating any means of identifying addresses of sample dwelling units. The permanent sampling records show only the general location in which interviews were conducted; there is no record of specific dwelling units contacted.

There will be no Privacy Act System of Records established for this effort.

11. Questions of a Sensitive Nature

As mentioned in section A.1 above, SAMHSA is required to report annually on the incidence and prevalence of substance abuse and mental health problems due to Section 505 of the Public Health Service Act. Many safeguards, including the mode of questionnaire administration, have been incorporated into the NSDUH study design in order to improve the collection of data on sensitive issues/information. As a part of the interview process and upon introduction, the interviewer informs the respondent why the information is necessary, indicates who sponsors the Survey, requests consent to conduct an interview, and explains the procedures which assure confidentiality. For respondents between the ages of 12 and 17, verbal consent is obtained from both the parent and the youth. (See Attachment K, Showcard Booklet, for verbal consent text.) However, every attempt is made to ensure that the actual interview is conducted without parental observation or intervention.

Answers to sensitive questions, including all substance use questions and mental health questions, are obtained by closed interview design. In the ACASI administration, the respondent enters his/her answers directly into the computer. The interviewer does not see the answers. Data from the electronic interviews are transmitted regularly to the Contractor via secured data transmission. All CAI data are telecommunicated to the Contractor's office, and are identified with a respondent number, which is a code associated with the sample dwelling unit. There is no system of records which identifies respondents. The questionnaire data are processed immediately upon receipt at the Contractor's facilities and all links between a questionnaire and the respondent's address are destroyed after all data processing activities are completed.

No signed consent forms are used; however, verbal consent is obtained as explained above. The listing of selected dwelling unit locations and addresses are kept under locked and secured conditions and destroyed after all data processing activities are completed.

12. Estimates of Annualized Hour Burden

The total sample size for the 2013 National Survey is approximately 67,500 persons per year. This sample size is required to ensure reliable state-level estimates for each of the 50 states, as well as estimates on the many sub-populations included in NSDUH specifications, e.g., Blacks, Hispanics, youth, etc. It is necessary to screen approximately 145,474 households to obtain the requisite survey sample size. The total number of responses is 228,499. Most of the new questions will be administered to only a subset of respondents. Questions in the health module apply to all respondents aged 12 and older, but skip patterns will limit the number of new questions each respondent receives. The level of burden that results from these new questions is negligible.

The experience with the first half of 2012 indicated that the average interview time remained approximately 60 minutes.

Based on the questionnaire having approximately the same length, it is estimated that the average amount of time required to administer the 2013 CAI questionnaire will also be approximately 60 minutes, including 2 minutes for the Quality Control Form. Administration of the screening questions will take an average of 5 minutes per dwelling unit.

Screening verification and interview verification contacts both take an average of 4 minutes and are administered only to a subsample of the cases. An approximate fifteen percent random sample of each interviewer's work (i.e., completed interviews) will be verified. In addition to the verification of completed interviews, certain completed screening codes (vacant, not primary residence, not a dwelling unit, DU contains ONLY military personnel, respondents living at residence for less than half of the quarter, and no one selected for interview) will be verified. Previous experience indicates that approximately 60% of all screenings will result in one of these six screening codes. An approximate five percent random sample of all such screening codes will be selected for verification follow up.

The hourly wage of \$14.45 was calculated based on weighted data from the 2010 NSDUH respondents' personal annual income.

The data collection field period for the 2013 NSDUH is 12 months long, spanning the period from January through December of the year. The respondent burden for the 2013 NSDUH is shown in the following table:

Estimated Burden for 2013 NSDUH

<i>Instrument</i>	<i>No. of Respondents</i>	<i>Responses per respondent</i>	<i>Hours per response</i>	<i>Total burden hours</i>	<i>Hourly Wage rate</i>	<i>Annualized costs</i>
Household Screening	145,474	1	0.083	12,074	\$14.45	\$174,469
Interview	67,500	1	1.000	67,500	\$14.45	\$975,375

Screening Verification	5,400	1	0.067	362	\$14.45	\$5,231
Interview Verification	10,125	1	0.067	678	\$14.45	\$9,797
TOTAL:	145,474			80,614		\$1,164,872

13. Estimates of Annualized Cost Burden to Respondents

There are no capital, startup, operational, or maintenance costs to respondents.

14. Estimates of Annualized Cost to the Government

Total costs associated with the 2013 National Survey on Drug Use and Health are estimated to be \$56,434,251 over a 47-month contract performance period. Of the total costs, \$51,112,059 are for contract costs, e.g., sampling, data collection, processing, reports, etc., and approximately \$5,322,192 represents SAMHSA costs to manage/administrate the survey. The annualized cost is approximately \$14,408,745. This represents a total decrease in costs from the 2012 survey request of approximately \$8,344,721. The main reasons for the decrease in costs are the elimination of the Mental Health Surveillance Study. In addition, the prior request was for clearance of two years of data collection. This package only requests clearance for one survey year.

15. Changes in Burden

Currently there are 85,991 total burden hours in the 2012 OMB inventory. The 2013 NSDUH is requesting 80,614 burden hours. The decrease of 5,377 burden hours is due to the cancellation of clinical follow-up interviews.

16. Time Schedule, Publication and Analysis Plans

Plans for the 2013 Survey data involve four major types of products: an early report that presents results from the 2012 NSDUH (available at the annual DHHS press release of NSDUH data); two state specific reports; five analytic reports; and a public use data file. Descriptions of major publications, as well as delivery dates for major publications, follow.

NATIONAL FINDINGS FROM THE 2013 NSDUH (September, 2013 and 2014) - These reports will present highlights and detailed findings from each data collection year. It consists of a series of exhibits, both graphic and tabular, presenting recent trends of substance use by recency of use and numerous demographic characteristics. Essentially, this report examines substance use incidence and prevalence in 2013, trends since 2002, demographic correlates of substance use, substance use patterns, and public perceptions of the harmfulness of illicit substance use as well as opportunities to use drugs. Final weighted and edited data are used to construct the tables.

STATE FINDINGS REPORT (Early, 2015) - A state data report (approximately 200 pages)

will present substance use incidence and prevalence estimates for each of the 50 states and the District of Columbia. It will also document the methodology in detail.

NATIONAL MENTAL HEALTH FINDINGS REPORT (November, 2013) – This report will produce detailed mental health findings from the 2013 data collection year. It consists of tables and narrative highlights summarizing prevalence by mental health measure, trend analysis of drug use for selected mental health measures, and socio-demographic tables by mental health measures.

ANALYTIC REPORTS - Additional data analyses and special analytical papers will be produced and released as part of the SAMHSA, CBHSQ Analytic Series or A report series. Additional topics and dates of completion for these reports are currently undetermined. Supplemental tables involving population projections for specified licit and illicit substances also will be produced and made available to those requesting such information.

2013 NSDUH PROJECT SCHEDULE

<u>ACTIVITY</u>	<u>TIME FRAME</u>
Design and select area frame sample	December 2011 to March 2012
Prepare field Segment Kits	January 2012 to May 2012
Recruit/train field staff to list Sample Dwelling Units (SDUs)	March 2012 to May 2012
Field listing and subsequent keying of SDUs	April 2012 to January 2013
Recruit remaining field staff and generate all required materials/assignments for distribution	August 2012 to January 2013
Finalize programming of NSDUH interview	August 2012 to October 2012
Prepare for and conduct field staff training	May 2012 to January 2013
Conduct NSDUH interviews	January 2013 to December 2013
Data processing and file preparation	January 2014 to March 2015
Trend Tables and Special Tabulations:	
-- Shells	March 2014
-- Annual Tables	June 2014
Raw Data Files	May 2014
Preliminary Weighted Data Files	May 2014
Final analytic data file and documentation	September 2014
Sampling Error Report	July 2014

National Findings	September 2014
State Small Area Estimation Analytical Report	August 2014 to March 2015
Public Use Data File	December 2014
Methodological Resource Book	March 2015

17. Display of Expiration Date

The OMB expiration date will be displayed on all data collection instruments.

18. Exceptions to Certification Statement

The certifications are included in this submission.