

# 2017 National Survey on Drug Use and Health

## SUPPORTING STATEMENT

### A. JUSTIFICATION

#### 1. Circumstances of Information Collection

##### **Overview**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting OMB approval for a revision to the National Survey on Drug Use and Health (NSDUH). The survey is sponsored by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and approved under OMB No. 0930-0110. The data collection is a national survey of the U.S. civilian, non-institutionalized population aged 12 or older. This survey is paramount in meeting a critical objective of SAMHSA's mission—to maintain current data on the incidence and prevalence of substance use and mental health problems in the United States. NSDUH has been conducted on a periodic basis from 1971 to 1988, and annually since 1990. The 2017 NSDUH will represent the thirty-seventh in the series.

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 U.S. population.

Information collected through NSDUH has multiple applications, including (1) advancing 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) advancing 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.

For the sample design, the 2017 NSDUH will continue to use the same design implemented since the 2014 survey, which provides data at both the national level and the State level. The survey's sample design will yield 4,560 completed interviews in California; 3,300 completed interviews each in Texas, New York, and Florida; 2,400 completed interviews each in Illinois, Pennsylvania, Ohio, and Michigan; 1,500 completed interviews each in Georgia, North Carolina, New Jersey, and Virginia; 967 completed interviews in Hawaii; and 960 completed interviews in each of the remaining 37 States and the District of Columbia. This approach will ensure a sufficient sample in every State to support either small area estimation (SAE) or direct estimation methods while at the same time maintaining efficiency for national estimates.

The 2017 sample design will also include the same age group allocation implemented since the 2014 survey. To accurately estimate drug use and related mental health

measures among the aging drug use population, the 2017 NSDUH sample will be allocated to age groups as follows: 25 percent 12 to 17, 25 percent 18 to 25, and 50 percent 26 or older. More details on the sample design can be found in Section B.1 and in Attachment A (Sample Design).

While CBHSQ must periodically update other aspects of the NSDUH to reflect changing substance use and mental health issues and to continue producing current data, for the 2017 NSDUH only the following minor changes from 2016 are included : 1) updated questions so respondents who report no use of alcohol are not asked about misuse of prescription drugs with alcohol; and 2) included other minor wording changes to improve the flow of the interview, increase respondent comprehension or to be consistent with text in other questions.

For further reference, a detailed summary of all specific NSDUH questionnaire changes for 2017, as compared with the 2016 NSDUH, is included on page i of Attachment B, CAI Questionnaire.

## **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 civilian, non-institutionalized population aged 12 or older in the U.S. as well as for each State. The sample is sufficient to support SAEs 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 (CDC), ONDCP, FDA, other Federal agencies, Congress, and various State and local government agencies interested in the incidence and prevalence of substance use and mental health statistics. The NSDUH questionnaire asks the minimum information necessary to meet the needs of Federal policymakers and the substance abuse research, prevention, and treatment communities. In conjunction with other data sources, NSDUH 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;
- evaluate the overall impact that Federal and State programs have on drug demand and reducing youth substance use;
- assess and improve outcomes of prevention and treatment services;
- measure program performance and improvement, including Quality Outcome Measures, Government Relations and Public Affairs (GRPA), and other requirements; and

- identify areas where serious substance abuse problems exist and provide assistance to States to help them develop and adopt targeted responses for those problems.

The Department of Health and Human Services (HHS) continues to affirm the need for annual NSDUHs as essential to the President’s annual Drug Control Strategy and Federal objectives related to substance use. Because NSDUH is the nation’s primary 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 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.

Because mental health issues are correlates of substance abuse, CBHSQ continues to include questions on mental health and utilization of mental health services in 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 United States.

To look specifically at depression, the 2004 NSDUH introduced two depression modules—one for adults and one for youth. The data collected focus 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 2005-2016 NSDUHs, and will be included in the 2017 instrument as well. A detailed discussion of the 2017 questionnaire is presented in Section B.2.

#### Changes

While NSDUH must be updated periodically to reflect changing substance use and mental health issues and to continue producing current data, for the 2017 NSDUH only the following minor changes are planned : 1) updated questions so respondents who report no use of alcohol are not asked about misuse of prescription drugs with alcohol; and 2) included other minor wording changes to improve the flow of the interview, increase respondent comprehension or to be consistent with text in other questions.

### **3. Use of Information Technology**

NSDUH data will be collected in a face-to-face interview setting in respondents’ homes using laptop computers. Interviews will be administered using ACASI for sensitive questions, which represent most of the interview. The remainder of the interview will be administered by the FIs using computer-assisted personal interviewing (CAPI). This mode has been used on NSDUH since 1999, while continually enhancing and expanding the interviewing program to take advantage of improvements in technology.

The CAPI/ACASI technology affords a number of advantages in the collection of NSDUH data. First, this methodology permits the instrument designer to incorporate into the questionnaire routings that might be overly complex or not possible using a paper-

and-pencil instrument. The computer can be programmed to implement complex skip patterns and fill specific words based on the respondent's previous answers. Field Interviewer (FI) and respondent errors caused by faulty implementation of skip instructions are virtually eliminated. Second, this methodology increases the consistency of the data. The computer can be programmed to identify inconsistent responses and attempt to resolve them through respondent prompts. This approach 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. Third, in addition to time and money saved by minimizing edits needed to resolve discrepancies, the ACASI technology reduces social desirability bias.

CAPI/ACASI technology permits greater expediency with respect to data processing and analysis (e.g., a number of back-end processing steps, including coding and data entry). 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. Finally, as noted above, the ACASI technology permits respondents, including nonreaders, to complete sensitive portions of the interview in total privacy. Providing the respondent with methodology that improves privacy and confidentiality makes reporting of potentially embarrassing, stigmatizing, or illegal behaviors (e.g., drug use, mental health issues) less threatening and enhances response validity and response rates.

For 2017, questions administered via ACASI in the NSDUH interview will continue to be read aloud to respondents using Text-to-Speech (TTS) software offered by Microsoft, Speech Platform, which features a dynamic implementation mode that uses the TTS engine to read question text in real time and eliminates the use of pre-recorded audio files altogether. Following the integration of the Speech Platform software into the questionnaires used in 2015 and 2016, there were no reported problems with the pronunciation of any words or phrases produced by the TTS voices in English or Spanish.

NSDUH will continue to use hand-held computers to conduct household screening interviews in 2017. The primary advantage of this computer-assisted methodology is accuracy in selecting the correct household member or members for an interview. The computer automatically selects the correct household member or members based on the demographic variables entered, thus substantially reducing the probability for human error. The hand-held computers also provide the benefits of complex case management tools and quick, secure electronic transfer of data.

A 7-inch touch screen Android tablet computer, used on NSDUH since 2015, will be used again for household screenings in 2017. This device will be used for screening, interview respondent selection, answering FI observation questions, and case management. The light-weight, ultra-book laptops, also used on NSDUH since 2015, will be used for 2017. These have the advantage of being easy for FIs to transport in the field while providing ample processing power for the necessary computer programs. Because these laptops have solid state drives, they are more durable and reliable than previous generations of NSDUH data collection laptops.

#### 4. **Efforts to Identify Duplication**

CBHSQ is in contact with major Federal health survey managers and is aware of no other surveys that provide the level of detail on substance use and abuse as provided by NSDUH. NSDUH is the only survey of substance use in the U.S. with a sample size capable of producing high-quality national and separate State incidence and prevalence estimates, especially by detailed demographic variables. No duplication of effort has been identified.

While several other surveys and data systems collect information on substance use, abuse, and dependence, there are important methodological differences between these surveys and NSDUH, which have implications on estimates of substance use prevalence. For example, the Monitoring the Future (MTF) study is a NIDA-sponsored national survey that tracks substance use trends and related attitudes among adolescents in the U.S. 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. Because NSDUH is an annual survey of the civilian, noninstitutionalized population of the U.S. aged 12 or older, the two studies 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, Wright, & Kopstein, 1997).

It is also important to note that MTF conducts self-administered surveys in a school setting and by mail. 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). NSDUH is conducted in the household using a computer-assisted instrument. Among the same student population covered by the MTF, NSDUH substance use prevalence estimates are generally lower than MTF estimates, with differences tending to be more pronounced for 8th graders. The lower prevalences in NSDUH may be due to more underreporting in the household setting as compared to the MTF school setting, or more overreporting in the school setting as compared to the NSDUH household setting,

The Youth Risk Behavior Survey (YRBS) is another study that collects data on substance use within the U.S. YRBS is a component of the 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; (e) unhealthy dietary behaviors; and (f) physical inactivity. The YRBS 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 includes only 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 NSDUH. Possibly as a result of these differences, the prevalence estimates of illicit drug use from the YRBS are generally much higher than those from the NSDUH.

Our assessment of the differences between NSDUH, MTF, and YRBS is supported by a series of papers published in the *Journal of Drug Issues* (Hennessy & Ginsberg, 2001) by an independent set of survey methods experts commissioned by HHS under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The experts suggest that differences in survey methodology among these studies may affect comparisons of prevalence estimates among youth. The assessment also found that all three surveys were well-designed and managed, but they each have different purposes.

Another study that collects data on health related behaviors is the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual, State-based telephone survey of the civilian, noninstitutionalized adult population aged 18 or older and is sponsored by the 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 ACASI in NSDUH, which is considered to improve privacy and confidentiality and yields higher reporting of sensitive behaviors, was offered as an explanation for the lower rates in BRFSS (Miller et al., 2004). In addition to these differences, it is important to note that BRFSS does not interview anyone under the age of 18 whereas NSDUH interviews respondents aged 12 or older.

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 assessments of drug use, abuse, and dependence, as well as associated mental disorders. While NSDUH is an annual survey of the civilian, noninstitutionalized population of the U.S. aged 12 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). Also, the NESARC was designed to be a longitudinal survey, whereas NSDUH provides annual cross-sectional data. Another methodological difference between the two surveys is that sensitive questions in NSDUH are self-administered via ACASI whereas the NESARC is all interviewer-administered. There is evidence to suggest that methodological features, 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 than NESARC (Gruca et al., 2007).

**5. Involvement of Small Entities**

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

**6. Consequences If Information Is Collected Less Frequently**

The existence of substance abuse patterns and behaviors is a rapidly evolving and changing phenomenon that 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 was published on March 25, 2016 (81FR16190). No public comments were received.

It is HHS policy that ASPE reviews all national surveys. The review for the 2017 NSDUH was conducted in May 2016. The HHS Data Council was kept informed about the status and plans for the 2017 NSDUH.

Appendix A of this 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**

Adult respondents (aged 18 or older) and youth respondents (aged 12 to 17) are given \$30.00 in cash upon completion of the full interview. On October 18, 2001, the use of a \$30.00 incentive was approved by OMB for use in the 2002 NSDUH. The 2002 NSDUH experienced an increase in the weighted overall response rate (screening \* interviewing) from 67 percent to 71 percent. Prior OMB approval was provided for the continued use of the \$30.00 incentive for the 2003-2016 NSDUHs. The weighted overall response rates for 2001-2015 appear in Table 1. The 2017 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 C); Question & Answer Brochure (Attachment D); Tablet Screening Video Scripts (Attachment E); Contact Cards (Attachment F); Study Description (Attachment G); Introduction and Informed Consent Scripts (Attachment H); Screening Questions (Attachment I); Unable-to-Contact, Controlled Access, and Call-Me Letters (Attachment J); Refusal Letters (Attachment K); and Interview Incentive Receipt (Attachment L).

Since implementation in 2002, the \$30.00 incentive used in NSDUH has contributed to the annual overall survey response rates. However, NSDUH screening, interview, and overall response rates have generally declined since 2006 (Table 2).

**Table 1. Overall NSDUH Weighted Response Rates, by Year**

<b>Year</b>	<b>Overall Weighted Response Rate</b>
2001	67%
2002	71%
2003	70%
2004	70%
2005	70%
2006	67%
2007	66%
2008	66%
2009	67%
2010	66%
2011	65%
2012	63%
2013	60%
2014	58%
2015	55%

**Table 2. Screening, Interview, and Overall NSDUH Weighted Response Rates, by Year**

<b>Year</b>	<b>Screening</b>	<b>Interview</b>	<b>Overall</b>
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%
2012	86.07%	73.04%	62.87%
2013	83.93%	71.69%	60.18%
2014	81.94%	71.20%	58.34%
2015	79.69%*	69.25%*	55.19%*

**10. Assurance of Confidentiality**

Concern for the confidentiality and protection of respondents' rights has always played a central part in the implementation of NSDUH and will continue to be given the utmost emphasis.

FIs are thoroughly educated in methods for maximizing a respondent's understanding of the government's commitment to confidentiality. Furthermore, FIs 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. The Contractor's Institutional Review Board (IRB) was granted a Federalwide Assurance (Attachment M) by the Office for Human Research Protections (OHRP) and HHS in compliance with the requirements for the protection of human subjects (45 CFR 46). The Contractor's IRB will approve the protocols and consent forms for the 2017 NSDUH prior to any respondent contact. The IRB's primary concern is protecting respondents' rights, one of which is maintaining the confidentiality of respondent information. By obtaining IRB approval for NSDUH procedures and materials, CBHSQ is assured that respondent confidentiality will be maintained.

Several procedures ensure that respondents' rights are protected. First, the FI introduces himself or herself and the study using the Introduction and Informed Consent Scripts (Attachment H), reading the scripted text aloud to each interview respondent. This statement will appear in the Showcard Booklet (Attachment N) and is read aloud 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 (CIPSEA, included as Title V in the E-Government Act of 2002, P.L. 107-347) and the protection that it affords. This statute prohibits disclosure or release, for non-statistical purposes, of information collected under a pledge of confidentiality. Specifically, the Study Description states that respondents' answers will be used only by authorized personnel for statistical purposes and cannot be used for any other purpose. If a respondent is aged 12 to 17, except in rare instances where a 17-year-old lives independently from his or her parent or guardian (in which case the 17-year-old provides his or her own consent), when the youth is selected for the interview, the FI can read the parental introductory script (Attachment O) to the parent or guardian requesting permission to speak with the youth about NSDUH. After that introduction, parental consent for the interview is obtained from the selected respondent's parent or guardian, youth assent is requested and at least one parent, guardian or another adult must remain present in the home throughout the interview.

Under CIPSEA, data may not be released to unauthorized persons. CIPSEA safeguards the confidentiality of individually-identifiable information acquired under a pledge of confidentiality by controlling access to, and uses made of, such information. CIPSEA includes fines and penalties for any knowing and willful disclosure of individually identifiable information by an officer, employee, or agent of SAMHSA. Willful and knowing disclosure of protected data to unauthorized persons is a felony punishable by up to five years imprisonment and up to a \$250,000 fine.

As CIPSEA agents, all Contractor staff complete an annual CIPSEA training and sign a notarized Confidentiality Agreement (Attachment P). FIs and Field Supervisors (FSs), who work for a subcontractor to the Contractor, will also complete CIPSEA and project training on ensuring respondent confidentiality and will have signed a notarized Data Collection Agreement (Attachment P) certifying they will keep all respondent information confidential.

After obtaining informed consent, FIs make every attempt to secure an interview setting in the respondent's home that is as private as possible. In addition, the interview process, by design, includes techniques to afford privacy for the respondent. The ACASI portion

of the questionnaire maximizes 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, and then key his or her own responses into the computer via the keyboard. At the end of the ACASI portion, the respondent's answers are locked so that no one can see the responses until after the data are transmitted, processed, and aggregated by the Contractor.

To further ensure confidentiality, the respondent's name, address, or other identifying information are never noted. The one exception is the Quality Control Form (Attachment Q), which the respondent is asked to voluntarily complete at the end of the interview. The FI explains the procedures in advance, asking the respondent to record his or her phone number and current address on the Quality Control Form and then place the form in an envelope and seal the envelope. The Quality Control Forms are mailed directly to the Contractor's office in North Carolina and used only for verification purposes.

Each day they work, FIs electronically transmit all completed screening and interview data to the Contractor's servers via secure encrypted data transmission. On the data files, respondents are distinguished only by a unique number assigned to screenings and interviews. Although the unique number is associated with a location number and a dwelling unit number, the Contractor deletes this location information before the delivery of data to CBHSQ. 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 records of sample dwelling unit (SDU) addresses. The permanent sampling records show only the general location in which interviews were conducted; there is no record of specific dwelling units contacted.

This data collection is subject to the Privacy Act of 1974.<sup>1</sup> Furthermore, the most recent Privacy Impact Assessment (PIA), updated by SAMHSA in March 2016, would covers the 2017 NSDUH (since this is processed annually).

## **11. Questions of a Sensitive Nature**

Many of the NSDUH interview questions concern topics that are likely to be of a sensitive nature to many respondents. Many safeguards, including the ACASI mode of questionnaire administration, improve the privacy of data collected on sensitive issues. As a part of the interview introduction, the FI informs the respondent why the information is necessary, indicates who sponsors the study, requests consent to conduct an interview, and explains the procedures that ensure confidentiality. As noted in section A.10, for respondents between the ages of 12 and 17—except in rare instances where a 17-year-old lives independently without a parent or guardian and provides his or her own consent—verbal consent is obtained from both the parent or guardian and then the youth. (See Attachment H, Introduction and Informed Consent Scripts, for verbal consent text.) Once parental consent is obtained, every attempt is made to ensure that the actual interview is conducted without parental observation or intervention, though at least one

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<sup>1</sup> The SAMHSA System of Record Notice covering NSDUH is 09-30-0036 and 09-30-0049. See <http://samhsa.gov/privacy/pia> for more information.

parent, guardian or another adult must remain present elsewhere in the home throughout the interview.

Answers to sensitive questions, including all substance use, mental health, and sexual orientation and attraction questions (adults only), are obtained by closed interview design. In the ACASI portion of the interview, the respondent enters his or her answers directly into the computer. The FI does not see these answers.

As explained in section A.10, all NSDUH data collected using Computer Assisted Interviewing (CAI) are transmitted regularly to the Contractor via secure encrypted data transmission and distinguished only with a unique number, which is a code associated with the SDU. The questionnaire data are processed immediately upon receipt at the Contractor's facilities, and all associations between a questionnaire and the respondent's address are destroyed after all data processing activities are completed. The listings of SDU addresses are kept under secured conditions and destroyed after all data processing activities are completed.

## **12. Estimates of Annualized Hour Burden**

For the 2017 NSDUH, the sample has been designed to yield approximately 67,500 completed interviews. It will be necessary to sample approximately 200,092 households and complete approximately 131,983 screenings to obtain the requisite number of interviews. This sample size is required to ensure reliable State-level estimates for each of the 50 States and the District of Columbia, as well as estimates by various sub-groupings such as race, Hispanicity, and age.

Based on experience with the 2016 screening process, administration of the screening questions is expected to take an average of five minutes per SDU.

Initial timing data indicate the NSDUH questionnaire used in 2016 took about 60 minutes to administer, on average. Since there are only a few changes to the 2017 questionnaire, it is estimated that the average amount of time required to administer the 2017 CAI Questionnaire (Attachment B) will also be approximately 60 minutes, including two minutes for the Quality Control Form (Attachment Q).

Screening and interview verification contacts each take an average of four minutes and are administered only to a subsample of the cases. An approximate 15 percent random sample of each FI's completed interviews will be verified. In addition, the following completed screening codes that do not result in a respondent being selected for an interview will be verified:

- vacant;
- not a primary residence;
- not a dwelling unit;
- contain only military personnel;
- include only residents who will live in the household for less than half of the quarter; and
- no one was selected for interview.

Previous experience indicates that approximately 60 percent of all screenings will result in one of those six screening codes. An approximate five percent random sample of all such screening codes will be selected for verification follow-up.

The data collection field period for the 2017 NSDUH is 12 months, spanning the period from January through December 2017. The annualized estimated respondent burden for the 2017 NSDUH is shown in Table 3. The hourly wage of \$15.50 was calculated based on weighted data from the 2014 NSDUH and respondents' reported personal annual income.

**Table 3. Annualized Estimated Respondent Burden for 2017 NSDUH**

Instrument	No. of respondents	Responses per respondent	Total number of responses	Hours per response	Total burden hours	Hourly wage rate	Total hour cost
Household Screening	131,983	1	131,983	30.083	10,955	\$15.50	\$169,803
Interview	67,507	1	67,507	71.000	67,507	\$15.50	\$1,046,359
Screening Verification	3,755	1	3,755	50.067	252	\$15.50	\$3,906
Interview Verification	10,126	1	10,126	60.067	678	\$15.50	\$10,509
Total	131,983		213,371	71	79,392		\$1,230,577

**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 2017 NSDUH are estimated to be \$57,075,837 over a 48-month contract performance period. Of the total costs, \$50,752,896 are for contract costs (e.g., sampling, data collection, processing, reports), and approximately \$6,322,941 represents CBHSQ costs to manage/administrate the survey. The annualized cost is approximately \$14,268,959.

**15. Changes in Burden**

Currently, there are 78,826 total burden hours in the OMB inventory. SAMHSA is requesting 79,392 burden hours. This adjustment of an increase of 566 burden hours are due to a decline in response rates, which results in the need to contact additional dwelling units to yield the targeted number of completed interviews.

**16. Time Schedule, Publication and Analysis Plans**

Plans for the 2017 survey data involve six major types of data products: (a) First Findings Reports (available at the annual HHS press release of NSDUH data or soon thereafter); (b) State findings; (c) analytic reports; (d) Public Use Data File (PUF); (e) Restricted Use Data File (R-DAS); and (f) Data Portal Data File System. Descriptions of major products, as well as approximate delivery dates follow. Table 4 includes a schedule for the 2017 NSDUH.

### **(a) Overall Reports**

**First Findings Reports (September 2018).** Prior to 2014, RTI produced one or two major national reports annually from the most current NSDUH data: a national findings report that focused on issues related to substance use, and (since the 2009 NSDUH) a mental health findings report that focused on mental health issues. Since 2014, RTI has worked with SAMHSA to produce a series of shorter reports that are focused on specific topics at the national level and a web-only methodological summary. Topical national reports have covered behavioral health trends among people aged 12 or older, suicidal thoughts and behavior among adults aged 18 or older, receipt of services for behavioral health problems, and risk and protective factors and initiation of substance use.

### **(b) State Findings**

**State Findings (December 2018).** Data from the combined 2016 and 2017 NSDUHs will be used to provide state estimates (for the 50 States and the District of Columbia) for select substance use and mental health outcomes. These estimates will be produced using SAE methodology. Along with the 2016-2017 SAEs, significant tests of change between the 2015-2016 and the 2016-2017 SAEs will be included.

### **(c) Analytic Reports**

**Analytic Reports.** Additional data analyses and special analytical papers will be produced and released as part of the 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.

### **(d) Public Use Data File (PUF)**

**Public Use Data File (October 2018).** This data file is created from the Master file, and the variables delivered on the Analytic Data File serve as the base for the PUF. Each analytic variable is reviewed for potential disclosure risk, and each one is retained, deleted, or receives further treatment for the PUF. Recoded and logically imputed variables created for the National Findings report produced each year are also included to complete the PUF. The data treatment process has been enhanced over several years to ensure the data remain confidential.

### **(e) Data File for the Restricted-Use Data Analysis System**

**Restricted-Use Data Files (Ongoing).** The R-DAS is a combination of various Analytic Data File variables that are continuous across study years. There are currently six pair-year data files, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011 and 2012-2013. Similarly, there are three 4-year files, 2002-2005, 2006-2009 and 2010-2013, one 10-year file, 2002-2011 and one 12-year file, 2002-2013 which is under current development. There is no treatment to the variables and the files are delivered to the Substance Abuse and Mental Health Data Archive (SAMHDA) and SAMHSA. A set of variables are excluded from any R-DAS data file due to disclosure issues. Further, any variables that can determine a specific study year are also excluded.

**(f) Data File for the Data Portal Data File System**

**Data Portal Data Files (Ongoing).** The Data Portal is managed by SAMHDA. RTI provides Analytic Data Files and Codebooks to SAMHDA for use in their system. The system provides a list of ‘base’ variables that are included for SAMHSA agents that apply for data. The Base variables are variables that exist on the PUF in their Analytic form, i.e. no additional treatment. In addition to the Base Variables, all other Analytic variables are eligible for agents but they must apply for them, and SAMHSA determines whether they may be added to the agent’s data file.

**Table 4. Project Schedule for the 2017 NSDUH**

<b>Activity</b>	<b>Time Frame</b>
Design and select area frame sample	January 2016 to March 2016
Prepare field Segment Kits	February 2016 to May 2016
Prepare for and conduct field staff training	February 2016 to January 2017
Recruit/train field staff to list SDUs	March 2016 to May 2016
Conduct field listing and subsequent keying of SDUs	April 2016 to January 2017
Program the screening and interview instruments	August 2016 to October 2016
Recruit remaining field staff and generate all required materials/assignments for distribution	August 2016 to January 2017
Conduct screenings and interviews	January 2017 to December 2017
Conduct full-year data processing and file preparation	January 2018 to March 2019
Prepare Trend Tables and Special Tabulations: <ul style="list-style-type: none"> <li>• Finalize Shells</li> <li>• Finalize Annual Tables</li> </ul>	March 2018 June 2018
Prepare Raw Data Files	May 2018
Release Preliminary Weighted Data Files	May 2018
Finalize Sampling Error Report	July 2018
Prepare State Findings	August 2018 to March 2019
Release Final Analytic Data File and documentation	September 2018
Publish First Findings Reports	September 2018
Publish Mental Health Findings	November 2018
Release Public Use Data File	October 2018
Publish Methodological Resource Book	March 2019

**17. Display of Expiration Date**

The OMB expiration date will be displayed.

**18. Exceptions to Certification Statement**

The certifications are included in this submission and fully comply with 5 CFR 1320.9.