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Comparing and Evaluating Substance Use Treatment Utilization Estimates from the National Survey on Drug Use and Health and Other Data Sources

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This report presents an evaluation of the coverage, overlap, biases, strengths, and weaknesses of three sources of data on the receipt of specialty substance use treatment: the National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Treatment Services (N-SSATS), and the Treatment Episode Data Set (TEDS). NSDUH is an annual survey of a representative sample of persons aged 12 or older at their places of residence. N-SSATS is an annual census of all known drug and alcohol abuse treatment facilities in the United States. TEDS is a compilation of data detailing the demographic and substance use characteristics of admissions to and discharges from substance use treatment. Methodological differences among these data sources that may contribute to differences in estimates are described. Specialty substance use treatment measures compared include numbers and characteristics of persons treated in a given year, single-day treatment counts, numbers of admissions in a given year, and estimates of the numbers of persons who needed substance use treatment but did not receive it.

NSDUH estimates of persons treated in a given year were significantly higher than the estimate from TEDS. Single-day treatment counts from NSDUH

were similar to those from N-SSATS, and both were significantly higher than those from TEDS. N-SSATS counts of annual admissions were significantly higher than counts derived from TEDS data. The consistently lower counts in TEDS appear to be due to coverage differences in the three data systems. TEDS is mainly limited to those persons whose treatment was publicly funded, whereas N-SSATS includes a census of all facilities regardless of funding, and NSDUH includes persons who are treated in both privately and publicly funded facilities.

Precise agreement among the data sources is not expected, and this lack of agreement does not reduce the importance of NSDUH, N-SSATS, and TEDS in contributing to our understanding of specialty substance use treatment in the United States. The analyses presented in this report provide a strong basis for improving the interpretation of results from these three studies. This will facilitate developing clear guidance for future analyses to better answer some basic questions about substance use treatment, such as how many persons receive treatment in a year, how large is the gap between treatment received and treatment needed, and how have the numbers of persons receiving and needing treatment changed over time.

1. Introduction

This report presents an evaluation of the coverage, overlap, biases, strengths, and weaknesses of three sources of data on the receipt of substance use treatment. These data sources are managed by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality (CBHSQ). Substance use treatment includes treatment for alcohol, illicit drugs, or both alcohol and illicit drugs. The three data sources include the following:

- National Survey on Drug Use and Health (NSDUH),
- Treatment Episode Data Set (TEDS), and
- National Survey of Substance Abuse Treatment Services (N-SSATS).

The overall objective of the analyses presented in this report is to improve the understanding of the information on substance use treatment from these three data sources and to inform future reporting of results and uses of the data. NSDUH, TEDS, and N-SSATS differ in their intended goals and in their methods of data collection. A clear understanding of the differences between these three data systems, as well as their strengths and limitations, is necessary in order to maximize the usefulness of the systems and ensure the accurate interpretation of findings related to the number of persons who receive substance use treatment. The specific goals of this study are to

- enhance the utility of the treatment data from NSDUH, TEDS, and N-SSATS by identifying differences in methods and measures that may affect estimates to aid in the interpretation of data from these three data sets;
- provide detailed comparisons between these data sets on various measures related to the receipt of substance use treatment; and
- evaluate methods of assessing the percentages of persons who needed but did not receive substance use treatment at the national and State levels.

Most comparisons of the three data sets in this report are based on consideration of treatment in specialty substance use treatment facilities. Multiple measures of treatment receipt are examined, including treatment within the past year, treatment for the first time within a given year, single-day counts of the number of persons in treatment, and admissions to treatment in a 12-month period.

1.1. Background

Substance use disorder (alcohol or drug dependence or abuse) is a serious public health threat in the United States and is associated with psychosocial and legal problems, such as mental and physical health conditions, lower educational attainment, underemployment or unemployment, involvement with the criminal justice system, victimization by and perpetration of violence, and homelessness (Chermack, Fuller, & Blow, 2000; Hser, Hoffman, Grella, & Anglin, 2001; Kubiak, Arfken, Swartz, & Koch, 2006; Mansell et al., 2006; Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003; Stein, Dixon, & Nyamathi, 2008; CBHSQ, 2012). Substance use treatment has been shown to be effective in reducing substance use and can produce positive psychosocial and physical outcomes for persons who receive it (O'Brien & McLellan, 1996). In general, persons with substance dependence who receive treatment have been found to experience less disability related to substance use in their lifetime than untreated persons (Hasin, Stinson, Ogburn, & Grant, 2007). Given the public health implications of substance use treatment, obtaining accurate counts of the number of persons who need and receive substance use treatment is critical.

1.2. Overview of Data Sources

1.2.1 NSDUH

NSDUH, formerly called the National Household Survey on Drug Abuse (NHSDA), is the Federal Government's primary source of information on the nature and extent of substance use and abuse in the United States. Conducted since 1971, the survey collects data by administering questionnaires to a representative sample of persons aged 12 or older at

their places of residence. The survey is sponsored by SAMHSA and is planned and managed by CBHSQ. Data collection is currently conducted under contract with RTI International, Research Triangle Park, North Carolina.¹ Approximately 67,500 persons are surveyed each year through face-to-face interviews. Data from the survey are used extensively by policymakers and researchers to measure the prevalence and correlates of licit and illicit substance use; to identify and monitor trends in substance use, treatment need, and treatment; and to analyze differences in substance use patterns by population subgroups. NSDUH also collects data on mental disorders and mental health treatment. This section briefly describes the survey methodology; Appendix A provides a more complete description. Reports on results from NSDUH data are available on the SAMHSA Web site (<http://www.samhsa.gov/data/NSDUH.aspx>).

NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals.

From 1971 through 1998, the survey used paper-and-pencil data collection. Since 1999, the NSDUH interview has been carried out in English or Spanish using computer-assisted interviewing (CAI). Most of the questions are administered with audio computer-assisted self-interviewing (ACASI). ACASI is designed to provide the respondent with a highly private and confidential mode for responding to questions in order to increase the level of honest responses to questions about illicit drug use and other sensitive behaviors. Less sensitive items are administered by interviewers using computer-assisted personal interviewing (CAPI).

This review uses NSDUH data collected in the 6-year period from 2005 through 2010. Multiple years of data were used in order to provide a sufficient sample size to produce estimates for demographic subgroups. During those years, NSDUH employed a State-based design with an independent, multistage area probability sample within each State and the District of Columbia. The 8

States with the largest populations (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas, which together account for about half of the total U.S. population aged 12 or older) were designated as “large sample States” and had an annual sample size of about 3,600 respondents each. For the remaining 42 States and the District of Columbia, the annual sample size was about 900 respondents per State. The design oversampled adolescents aged 12 to 17 and young adults aged 18 to 25.

A 5-minute screening procedure using a handheld computer involves listing all household members along with their basic demographic data. Depending on the composition of the household, zero to two persons in each household are selected for an interview. The household screening response rates for the survey years 2005 to 2010 ranged from 88.8 percent in 2010 to 91.3 percent in 2005. Interview response rates for persons aged 12 to 17 ranged from 84.8 percent in 2007 to 87.1 percent in 2005; interview response rates for persons aged 18 to 25 ranged from 79.8 percent in 2007 to 83.1 percent in 2005; and interview response rates of persons aged 26 or older ranged from 71.4 percent in 2005 to 73.5 percent in 2007. Appendix B of the 2012 NSDUH report on national findings discusses how NSDUH response rates are calculated (see CBHSQ, 2013).

Because of the change in interviewing mode in 1999, the estimates from the pre-1999 surveys are not comparable with estimates from the current CAI-based surveys. Although the design of the 2002 through 2010 NSDUHs is similar to the design of the 1999 through 2001 surveys, there are also important methodological differences that affect the comparability of the 2002 to 2010 estimates with estimates from prior surveys. The most important change was the incentive payment that started in 2002 and continued in subsequent surveys. Each NSDUH respondent completing the interview is given \$30. Also, the name of the survey was changed in 2002, from National Household Survey on Drug Abuse (NHSDA) to National Survey on Drug Use and Health (NSDUH). Improved data collection quality control procedures were introduced in the survey starting in 2001, and updated population data from the 2000

decennial census were incorporated into the sample weights beginning with the 2002 estimates. Analyses of the effects of these factors on NSDUH estimates have shown that 2002 and later data should not be compared with 2001 and earlier data from the survey series to assess changes over time. Appendix C of the 2004 NSDUH report on national findings discusses these changes to the survey in more detail (see OAS, 2005).

NSDUH questions about receipt of substance use treatment are asked of all respondents who report having used alcohol or an illicit substance at least once during their lives. In addition to alcohol, the illicit drugs include the following:

- marijuana or hashish,
- cocaine (including crack),
- heroin,
- hallucinogens,
- inhalants,
- prescription pain relievers used nonmedically (i.e., that were not prescribed for the respondent or were taken only for the experience or feeling they caused),
- prescription tranquilizers used nonmedically,
- prescription stimulants used nonmedically, and
- prescription sedatives used nonmedically.

Data analyzed in this report include those from interviews completed with persons aged 12 or older in the 2005, 2006, 2007, 2008, 2009, and 2010 NSDUHs. Approximately 406,900 completed interviews were obtained from persons aged 12 or older in the 2005 to 2010 NSDUHs.

1.2.2 TEDS

TEDS is a compilation of data detailing the demographic and substance use characteristics of admissions to and discharges from substance use treatment. TEDS is part of the Behavioral Health Services Information System (BHSIS), formerly known as the Drug and Alcohol Services Information System (DASIS), a cooperative program among SAMHSA

and State substance abuse agencies to collect data on substance use treatment services. BHSIS is coordinated and managed by CBHSQ. TEDS data collection and analysis are currently conducted under contract with Synectics for Management Decisions, Inc. This data collection effort was developed in response to the 1988 Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments (P.L. 100-690), which established a revised Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and mandated Federal data collection on clients receiving treatment for either alcohol or drug abuse. This section briefly describes the data collection methodology; Appendix A provides a more complete description. Reports on results from TEDS data are available on the SAMHSA Web site (<http://www.samhsa.gov/data/DASIS.aspx?qr=t#TEDS>).

The TEDS system comprises two major components—the Admissions Data Set and the Discharge Data Set—which are linked at the record level for approximately 85 percent of admissions included in these analyses. Information on substance use treatment admissions and discharges that State administrative systems routinely collect is submitted to TEDS in a standard format on a monthly or quarterly schedule. Data are reported on approximately 2 million annual admissions to treatment by approximately 10,000 facilities, programs, or administrative units in the 50 States, the District of Columbia, and Puerto Rico.

The scope of facilities included in TEDS is affected by differences in State licensure, certification, and accreditation practices, as well as disbursement of public funds. Most State substance abuse agencies require facilities that receive any State/public funding (including Federal block grant funds) for the provision of alcohol and/or drug treatment services to report TEDS data to the State. States differ widely in the amount of public funding available for substance use treatment and in the constraints placed on the use of funds. Some State substance abuse agencies license or monitor facilities operating in their State that do not receive any public funding and also require them to report TEDS data. In States where not all facilities are required to report TEDS data, some facilities do

so voluntarily. Facilities operated by Federal agencies (e.g., the Bureau of Prisons [BOP], the Department of Defense [DOD], and the Department of Veterans Affairs [VA]) generally do not report TEDS data to the State, although some facilities operated by the Indian Health Service (IHS) are included. Hospital-based substance use treatment facilities are frequently not licensed through the State substance abuse agency (Single State Authority [SSA]) and typically do not report TEDS data. To the extent that hospital-based facilities do report to TEDS, the records include those from specialty substance use treatment units within hospitals. Correctional facilities (State prisons and local jails) report TEDS data in some States but not in others. A table summarizing the State data system reporting characteristics for 2007, 2008, and 2009 is provided in Appendix A (see Table A.1).

The primary goal of TEDS is to monitor the characteristics of clients admitted to planned, continuing treatment regimens. Thus, TEDS excludes early intervention and crisis intervention programs that do not lead to enrollment in continued treatment.

This review focuses on TEDS data collected for the years 2007, 2008, and 2009. TEDS data used in this report are from the Admissions Minimum Data Set, a core set of data elements collected at admission by all States, and the Discharge Data Set, for which 44 States, the District of Columbia, and Puerto Rico reported clients discharged in 2007; 48 States, the District of Columbia, and Puerto Rico reported clients discharged in 2008; and 48 States, the District of Columbia, and Puerto Rico reported clients discharged in 2009. Ultimately, analyses were conducted on data from 47 States. Data from Alabama, Alaska, the District of Columbia, and Georgia were not included in these analyses because they submitted no or incomplete data for 1 or more of the 3 years analyzed. In order to establish as much comparability between TEDS and NSDUH as possible, data from Puerto Rico are not included in the estimates from TEDS shown in this report.

The TEDS Minimum Data Set includes the following information for each admission: date of admission; type of service; age; gender; race; ethnicity; number of prior treatment episodes; education; employment

status; principal source of referral; primary, secondary, and tertiary substance problems and their usual route of administration, frequency of use, and age of first use; and planned use of medication-assisted opioid therapy. Information on use of primary, secondary, and tertiary problem substances is collected for the following substances:

- alcohol;
- cocaine/crack;
- marijuana/hashish;
- heroin;
- nonprescription methadone;
- other opiates and synthetics (including codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects);
- phencyclidine (PCP);
- other hallucinogens (including but not limited to LSD, DMT, STP, hallucinogens, mescaline, peyote, psilocybin);
- methamphetamine;
- other amphetamines (including amphetamines, MDMA, phenmetrazine, and other unspecified amines and related drugs);
- other stimulants (including methylphenidate and any other stimulants);
- benzodiazepines (including alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other unspecified benzodiazepines);
- other nonbenzodiazepine tranquilizers (including meprobamate and other nonbenzodiazepine tranquilizers);
- barbiturates (including but not limited to amobarbital, pentobarbital, secobarbital);
- other nonbarbiturate sedatives or hypnotics (including chloral hydrate, ethchlorvynol,

- glutethimide, methaqualone, and other nonbarbiturate sedatives or hypnotics);
- inhalants (including but not limited to chloroform, ether, gasoline, glue, nitrous oxide, paint thinner);
- over-the-counter medications (including aspirin, cough syrup, diphenhydramine and other antihistamines, sleep aids, any other legally obtained nonprescription medication); and
- other (including but not limited to diphenylhydantoin, GHB/GBL, ketamine).

TEDS observations represent admissions to or discharges from substance use treatment, not individuals. For example, one individual admitted to treatment twice within a calendar year would be counted as two separate admissions. For the purposes of comparability with the other data sets, we have used data from multiple years of the TEDS Admission Data Set, Discharge Data Set, and the unique person identifiers to produce estimates of the unduplicated number of persons who received treatment. Admission and discharge records linked by a unique identifier represent clients who had been both admitted and discharged. Admission records with no linked discharge should indicate that a client had been admitted but not yet discharged. However, because the discharge system was not fully operational in all States during the years examined, it was assumed that a number of these admissions had, in fact, been discharged. For each admission with no linked discharge, a probability of having been discharged was computed in order to provide estimates of the unduplicated number of persons who received treatment. More information on this is provided in Section 1.3 of this report.

1.2.3 N-SSATS

N-SSATS is an annual census of all known drug and alcohol abuse treatment facilities in the United States. N-SSATS, along with TEDS, is part of BHSIS, a cooperative program between SAMHSA and State substance use treatment agencies to collect data on substance abuse services. BHSIS is coordinated and managed by CBHSQ. N-SSATS data collection

and analysis are currently conducted under contract with Synectics for Management Decisions, Inc., and Mathematica Policy Research, Inc.

N-SSATS is a paper/Web/telephone census designed to collect information from all facilities in the United States, both public and private, that provide substance use treatment. N-SSATS is designed to collect data on the location, characteristics, and utilization of services at public and private alcohol and drug use treatment facilities throughout the 50 States, the District of Columbia, and other U.S. jurisdictions. N-SSATS provides a mechanism for tracking the changing character and composition of the U.S. substance use treatment delivery system. The N-SSATS questionnaire covers the characteristics of the treatment facility, including client payment sources, services provided, hospital and residential capacity, as well as the number of treatment admissions in the past 12 months and a single-day client census. The objective of the census is to collect multipurpose data that can be used to

- assist SAMHSA and State/local governments in quantifying the nature and extent of services provided in State-supported and other substance use treatment facilities and in forecasting substance use treatment resource requirements;
- update SAMHSA's Inventory of Behavioral Health Services (I-BHS), formerly known as Inventory of Substance Abuse Treatment Services (I-SATS), which includes all known drug and alcohol use treatment facilities and mental health treatment facilities; I-BHS is used as a sampling frame for N-SSATS as well as other special surveys of treatment providers and their clients; and
- analyze trends in substance use treatment services and perform comparative analyses for the United States, regions of the country, States, counties, and populated areas (metropolitan statistical areas [MSAs] and core-based statistical areas [CBSAs]).

This section briefly describes the survey methodology; Appendix A provides a more complete description. Reports on N-SSATS data are available on the SAMHSA Web site (<http://www.samhsa.gov/data/DASIS.aspx>).

This review focuses on N-SSATS data collected in the 3-year period from 2007 through 2009. N-SSATS collects data on approximately 14,000 facilities, with some 1.2 million clients in treatment on the survey reference date (the last working day of March) and 3.6 million admissions to treatment in the previous 12 months. Information is collected at the site of delivery of services rather than according to administrative structure. A Web-based version of the paper questionnaire was introduced in 2002. Participation using the Web-based survey has increased over the years; in 2007, about 40 percent of survey responses were submitted via the Web and in 2009 about 58 percent of surveys were completed on the Web.

Although N-SSATS is a voluntary census, response rates are consistently about 95 percent. The incentive for participation is the opportunity to be included in SAMHSA's online Substance Abuse Treatment Facility Locator and annual *National Directory of Drug and Alcohol Treatment Services*. This searchable directory of

drug and alcohol treatment programs shows the location of facilities around the country that treat alcohol use and drug use problems.

1.2.4 Key Differences between Data Sources

NSDUH, TEDS, and N-SSATS have important differences in data collection methodology and inclusion or exclusion criteria that can affect the interpretation of data from these sources. Table 1.1 summarizes some key differences between these three data sources.

Data Collection Methodology/Unit of Analysis.

NSDUH provides self-reported data at the person level among noninstitutionalized civilians who live in households. TEDS provides information at the admission level about the characteristics of persons served by (mainly) publicly funded programs; for the increasing number of States that submit unique individual identifiers, TEDS data can also be analyzed at the person or episode level. As mentioned previously,

Table 1.1 Key Methodological Differences Related to Substance Use Treatment Data from NSDUH, TEDS, and N-SSATS

Category	CBHSQ Data Sources		
	NSDUH	TEDS	N-SSATS
Methodology	National household self-report survey of noninstitutionalized civilians who live in households	Compilation of data on the demographic and substance use characteristics of admissions and discharges, primarily from publicly funded substance use treatment facilities	Annual census of all known substance use treatment facilities
Unit of Analysis	Individuals aged 12 or older	Admission records and linked admission/discharge records	Facilities
Time Frame	Continuous and annual; includes persons in treatment during the past year, currently in treatment, and in treatment on October 1 of the year before the interview; age at first treatment	Continuous and annual; data are submitted monthly or quarterly; back- or resubmissions are permitted	Annual; includes single-day count of number of persons in treatment on the last working/business day in March of each year as well as count of admissions to treatment in the previous 12 months
Facility Type Inclusions and Exclusions	Includes self-reports of treatment received at: <ul style="list-style-type: none"> • public and private facilities • solo practices • IHS, DOD, and VA facilities if patient is living in a household at time of interview but not if institutionalized 	<ul style="list-style-type: none"> • For most States, only includes admissions to facilities receiving public funds • Does not include admissions to solo practices or facilities operated by DOD, VA, or BOP • Includes some facilities operated by IHS 	<ul style="list-style-type: none"> • Includes all known facilities • Does not include solo practices or facilities treating incarcerated clients only • Includes IHS, DOD, and VA facilities • In hospital settings, includes single-day treatment count of number of persons treated in specialty substance use treatment units, but not in other units/departments of the hospital
Substances Included	<ul style="list-style-type: none"> • Includes treatment for use of alcohol and illicit drugs, including nonmedical use of prescription-type drugs • Excludes over-the-counter drugs 	<ul style="list-style-type: none"> • Includes treatment for use of both illicit and prescription-type drugs as well as alcohol and over-the-counter substances • TEDS allows reporting of up to three "problem drugs" at the time of admission 	<ul style="list-style-type: none"> • Does not specify substances for which clients received treatment • Includes data on percentage of clients in treatment for alcohol problems, drug problems, or problems with both alcohol and drugs • Includes data on Opioid Treatment Programs, which specialize in the treatment of dependence on opioid drugs

NSDUH = National Survey on Drug Use and Health; TEDS = Treatment Episode Data Set; N-SSATS = National Survey of Substance Abuse Treatment Services; CBHSQ = Center for Behavioral Health Statistics and Quality; IHS = Indian Health Service; DOD = Department of Defense; VA = Department of Veterans Affairs; BOP = Bureau of Prisons.

analyses in this report mainly focus on the person-level TEDS data. N-SSATS provides information at the facility level about characteristics of treatment facilities, their operations, a single-day client census, and an estimate of admissions in the previous 12 months.

Inclusion and Exclusion Criteria. All three data sources have differing inclusion and exclusion criteria. NSDUH collects data on treatment received at both public and private facilities, as well as treatment received from solo practitioners, whereas it excludes active duty military members and persons who do not live in households (homeless persons not in shelters and persons in institutions such as jails or prisons, hospitals, or residential treatment facilities) during the majority of the quarter of the year in which they were interviewed. The facilities that report TEDS data are primarily those that receive State alcohol and/or drug agency funds for the provision of drug or alcohol services. These facilities often do not include facilities that do not receive funding through the SSA, IHS facilities, or hospital-based programs. TEDS does not include VA and military treatment facilities or Federal prisons. N-SSATS is a voluntary census with a very high response rate that includes IHS, DOD, and VA facilities but excludes most solo practitioners and facilities in jails, prisons, or other correctional facilities that exclusively treat incarcerated clients. These variations should be considered when interpreting differences in substance use treatment data between these data sources or when specific subgroups are being considered for analysis.

Seasonal Variation. Because of differences in reference dates used to compute the NSDUH estimates and TEDS/N-SSATS counts, it is possible that differences between TEDS/N-SSATS and NSDUH in the single-day counts may reflect seasonal variation in treatment utilization. Chapter 2 of this report includes analyses of the seasonality of admissions based on TEDS data and a discussion of this topic.

1.3. Measures of Receipt of and Need for Substance Use Treatment

This section provides descriptions of measures of substance use treatment receipt and need for treatment

from NSDUH, TEDS, and N-SSATS that are included in this report. Three main measures of receiving substance use treatment were examined—total number of persons receiving substance use treatment in a given year, average number of persons receiving treatment on a single day in a given year, and total number of substance use treatment admissions in a given year. All three data sets allow for classification of persons who received alcohol treatment only, drug treatment only, or both alcohol and drug treatment. Among those who received alcohol and drug treatment, NSDUH and TEDS allow for the identification of which substances (alcohol or drugs) were the primary and secondary reasons for treatment.

In addition to the total number of persons who received treatment in a given year, another important measure when tracking changes in substance use treatment is the number of persons who received treatment for the first time in a given year. Both the NSDUH and TEDS provide information that allows for the estimation of the number of persons who received substance use treatment for the first time in a given year.

1.3.1 Receipt of Substance Use Treatment in the Past Year

NSDUH and TEDS data were used to derive estimates of the number of persons in specialty treatment in the past year.

NSDUH. The NSDUH measure of receipt of substance use treatment in the past year is derived from a series of questions about treatment received for alcohol use or illicit drug use (including the nonmedical use of prescription type drugs). NSDUH asks about treatment received in the past year at any location, such as a hospital (inpatient), rehabilitation facility (outpatient or inpatient), mental health center, emergency room, private doctor's office, prison or jail, or self-help group, such as Alcoholics Anonymous or Narcotics Anonymous. Persons could report having received treatment at more than one location. For comparison purposes, this report focuses only on "specialty treatment," or treatment for substance use at a specialty treatment facility. Specialty treatment is defined as treatment received at any of the following

types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. The definition of specialty treatment does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient.

TEDS. TEDS data provide an overall count of the annual number of admissions for substance use treatment at facilities including outpatient, residential, and hospital inpatient facilities. The total number of persons admitted to treatment in a calendar year and the total number of persons who received treatment in a calendar year (including those who were admitted to treatment in a prior year but remained in treatment during the target year) were determined using the unique person identifier and linked admission and discharge data or, if there was no unique identifier, they were estimated using the probabilities of discharge prior to the start of the reference year. A unique identifier was defined as having a unique combination of State of residence, client ID, age, gender, and race/ethnicity. Multiple treatment episodes in a given year linked by a single unique identifier were counted as one person. For those admissions with no linked admission and discharge data, no attempt was made to account for multiple admissions by a single individual, which means that the annual count of persons who received treatment may be an overcount. Records for codependents (persons who do not have a substance use disorder but who receive treatment because a loved one has a substance use disorder) were excluded.

For the count of the number of persons receiving treatment in the past year, records were used for persons admitted on or before December 31 of that year and discharged on or after January 1 of that year. Each estimate is made up of two parts: (1) a direct count from linked admission/discharge records and (2) an estimate, based on the probability of being in treatment on January 1 of the given year if admitted in a different year, for those admissions not linked to discharges. For States with linked admissions and discharge data, this algorithm should identify any client who has been admitted and not yet discharged. However, because the discharge system was not fully operative in all States for

the years we examined, it can be assumed that a number of these admissions without linked discharges had, in fact, been discharged. Therefore, a probability of having been discharged by each reference date (January 1) was computed for each unlinked admission record, based on the assumption that the unlinked admission records would have the same probability of being discharged on a given day following treatment as the linked admission records. The probability of being in treatment on the reference date was calculated as 1 minus the cumulative frequency. That is, if 0.34 (34 percent) of clients had been discharged by day 10, then a record with date of admission 10 days before the reference date had a $1.00 - 0.34 = 0.66$ (66 percent) chance of being in treatment on the reference date. Probabilities of being in treatment were summed for each reference date. Thus, if 100 clients were admitted 10 days before the reference date, each would have a probability of 0.66, yielding a total of 66 clients likely to be in treatment on the reference date.

N-SSATS. N-SSATS data provide an overall count of the annual number of admissions for substance use treatment at all substance use treatment facilities that respond to the census and cannot be used to determine the number of persons who received treatment services in the prior 12 months.

1.3.2 Single-Day Counts of the Number of Persons in Drug or Alcohol Treatment

All three sources of data were used to derive single-data counts or estimates of the number of persons in drug or alcohol treatment.

NSDUH. For this report, two different estimates of the number of persons in specialty substance use treatment (i.e., substance use treatment received from a hospitals [inpatient only], drug or alcohol rehabilitation facility [inpatient or outpatient], or mental health center) on a single day were derived from NSDUH. One estimate was based on whether a respondent reported current treatment at the time of the survey.² Respondents who indicated that they had received specialty alcohol or drug treatment in the past year were asked if, at the time of the survey, they were currently receiving treatment for alcohol or drug use. The second measure of single-day

treatment counts was derived from a question in which respondents who had received drug or alcohol treatment in their lifetime were asked if they had been enrolled in a treatment program at a hospital, drug rehabilitation facility, or mental health center on October 1 of the year prior to the survey. From this question, an estimate was derived of the number of persons in treatment on that specific day.

TEDS. For this report, estimates were computed for the number of clients in treatment on the last working day in March each year from 2007 to 2009 (March 30, 2007; March 31, 2008; and March 31, 2009) using linked admission and discharge records from TEDS data processed through October 10, 2011. Records for codependents (persons who do not have a substance use disorder but who receive treatment because a loved one has a substance use disorder) were excluded. The last working day of March was selected for these counts in order to be as consistent as possible with the counts provided by the N-SSATS data. Counts included total clients and the numbers of clients by treatment for alcohol only, drugs only, alcohol and drugs, primary alcohol/secondary drug, and primary drug/secondary alcohol. Admission records with date of admission on or after January 1, 2000, were included. Even though annual averages for 2007 to 2009 are presented in the report, as a data quality check, estimates for reference dates of the last working day in March were calculated for each year from 2000 to 2008 to check that this method yielded plausible data even when discharge records were sparse.

Estimates comprised the sum of two parts:

1. Linked records representing clients who had been both admitted and discharged. The number of clients who were admitted on or before the reference date and discharged on or after the reference date was calculated.
2. Admissions records with no linked discharge. This situation should indicate that a client has been admitted and not yet discharged. However, because the discharge system was not fully operative in all States for the years we examined, it can be assumed that a number

of these admissions without linked discharges had, in fact, been discharged. Therefore, a probability of having been discharged by each reference date was computed for each unlinked admission record, based on the assumption that the unlinked admission records would have the same probability of being discharged on a given day following treatment as the linked admission records. The probability of being in treatment on the reference date was calculated as 1 minus the cumulative frequency. That is, if 0.34 (34 percent) of clients had been discharged by day 10, then a record with date of admission 10 days before the reference date had a $1.00 - 0.34 = 0.66$ (66 percent) chance of being in treatment on the reference date. Probabilities of being in treatment were summed for each reference date. Thus, if 100 clients were admitted 10 days before the reference date, each would have a probability of 0.66, yielding a total of 66 clients likely to be in treatment on the reference date.

N-SSATS. The N-SSATS census provides a single-day count of the number of persons in hospital inpatient, residential (nonhospital), and outpatient substance use treatment on the last working day of March of each year. For outpatient clients, the count is the number of active clients; an active outpatient client is defined as someone who was seen at the facility for substance use treatment or detoxification at least once during the month of March and was still enrolled in treatment on the last working day of March.

1.3.3 Need for and Receipt of Substance Use Treatment

NSDUH. Using NSDUH data, an individual is defined as needing treatment for an alcohol or drug use problem if he or she met the diagnostic criteria for dependence on or abuse of alcohol or illicit drugs in the past 12 months specified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994), or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months. The questions related to dependence ask about having health and

emotional problems associated with substance use, making unsuccessful attempts to cut down on use, developing tolerance, experiencing withdrawal, reducing other activities to use substances, spending a lot of time engaging in activities related to substance use, or using the substance in greater quantities or for a longer time than intended. The questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law because of substance use. Dependence is considered to be a more severe substance use disorder than abuse because it involves the psychological and physiological effects of tolerance and withdrawal.

For the purpose of this study, individuals needing treatment for an illicit drug use problem are defined as receiving treatment for their drug use problem only if they reported receiving specialty treatment for drug use in the past year. Thus, individuals who needed treatment for illicit drug use but only received specialty treatment for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility are not counted as receiving treatment for drug use. Similarly, individuals who needed treatment for an alcohol use problem are only counted as receiving alcohol use treatment if the treatment was received for alcohol use at a specialty treatment facility. Individuals who reported receiving specialty substance use treatment but are missing information on whether the treatment was specifically for alcohol use or drug use are not counted in estimates of specialty drug use treatment or in estimates of specialty alcohol use treatment; however, they are counted in estimates for “drug or alcohol use” treatment.

1.3.4 Admissions in a Given Year

Substance use disorders are chronic and remitting conditions that often require multiple treatment episodes before they are effectively managed. Annual admissions are another important measure of substance use treatment receipt. N-SSATS and TEDS data provide counts of the number of admissions to specialty treatment in a given year.

1.4. Demographic Variables

This section describes key measures of demographic and geographic characteristics that are presented in this report to compare the distributions of numbers of persons in treatment.

Comparisons between NSDUH and TEDS of the number of persons who received substance use treatment in the past year are presented by racial/ethnic group. Data are presented for racial/ethnic groups based on current guidelines for collecting and reporting race and ethnicity data (Office of Management and Budget [OMB], 1997). Because respondents were allowed to choose more than one racial group, a “two or more races” category is presented that includes persons who reported more than one category among the basic groups listed in the survey question (white, black or African American, American Indian or Alaska Native, Native Hawaiian, other Pacific Islander, Asian, other). Respondents choosing both the Native Hawaiian and the other Pacific Islander categories but none of the other categories are classified in the combined “Native Hawaiian or other Pacific Islander” category instead of the “two or more races” category. Except for the “Hispanic or Latino” group, the racial/ethnic groups discussed in this report include only non-Hispanics; the category “Hispanic or Latino” includes Hispanics of any race. Data reported to TEDS³ allow for reporting of the same race/ethnicity categories included in NSDUH. Race and ethnicity data about clients are not collected as part of N-SSATS.

Comparisons of single-day treatment counts are presented for States and for four U.S. geographic regions. These regions and divisions, defined by the U.S. Census Bureau, consist of the following groups of States:

- **Northwest Region**—*New England Division*: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; *Middle Atlantic Division*: New Jersey, New York, and Pennsylvania
- **Midwest Region**—*East North Central Division*: Illinois, Indiana, Michigan, Ohio, and Wisconsin; *West North Central Division*: Iowa, Kansas,

Minnesota, Missouri, Nebraska, North Dakota, and South Dakota

- **South Region**—*South Atlantic Division*: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia; *East South Central Division*: Alabama, Kentucky, Mississippi, and Tennessee; *West South Central Division*: Arkansas, Louisiana, Oklahoma, and Texas
- **West Region**—*Mountain Division*: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming; *Pacific Division*: Alaska, California, Hawaii, Oregon, and Washington

It should be noted that NSDUH States/geographic regions reflect where the respondents lived at the time they completed the survey, which is not necessarily the State or region in which they received substance use treatment during the past year. N-SSATS data give the facility location, which is not necessarily where the person receiving treatment lived. The geographic data in TEDS correspond to the location of the facility to which the person was admitted, but may also reflect the location of, for example, the administrative unit of a multicounty health service region.

NSDUH estimates of the number of persons who needed and received treatment are presented for those classified as having “low income.” Individuals are classified as low income if their family income is less than 100 percent of the Federal poverty threshold. Poverty level is based on income level, size of family, number of children in family, and additional family relationships such as foster children.

1.5. Organization of This Report

This report contains separate chapters that provide estimates of persons receiving substance use treatment and persons needing but not receiving substance use treatment. Chapter 2 presents national, regional, and State estimates from the NSDUH, TEDS, and N-SSATS data about the numbers of persons receiving past year and single-day substance use treatment as well as total admissions to treatment, including a discussion of the variations in seasonality of substance

use treatment admissions and comparisons between NSDUH and TEDS in the number of persons who received treatment for the first time. Chapter 3 focuses on national and State estimates of the number of adults who needed but did not receive substance use treatment, with a focus on a new technique of estimating this statistic by combining NSDUH and TEDS data. A final chapter discusses the information provided by these three data sources and how this information can be used to provide a better understanding of substance use treatment in this country and the current unmet need for treatment services.

Tables, text, and figures in this report present estimates of numbers of past year substance use treatment admissions, numbers of persons receiving treatment in the past year (including those admitted during the past year and those admitted prior to the past year), treatment outcomes, and numbers of persons needing but not receiving substance use treatment. In all tables and figures, estimates are presented based on data combined from 2 or more years to increase precision of the estimates; those estimates are annual averages based on multiple years of data.

Statistical tests have been conducted for all statements appearing in the text of the report that compare estimates between data sources (e.g., NSDUH vs. TEDS) or between subgroups within a given survey (e.g., by age group within NSDUH). Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level. Differences are described using terms such as “higher,” “lower,” “more likely,” and “less likely.” Statements that use terms such as “similar,” “no difference,” or “same” to describe the relationship between estimates denote that a difference is not statistically significant. In addition, a set of estimates for a given data source or for population subgroups may be presented without a statement of comparison; in these instances, a statistically significant difference between these estimates is not implied, and testing may not have been conducted.

All estimates presented in the report have met the criteria for statistical reliability. Estimates that do not meet these criteria are suppressed and do not appear in tables, figures, or text. Subgroups with suppressed estimates are not included in statistical tests of comparisons. Appendix B of the 2012 NSDUH report on national findings discusses these suppression criteria in more detail (see CBHSQ, 2013).

All statistical tables produced for this report are provided in Appendix C.

2. Comparisons between Data Sources in Receipt of Substance Use Treatment

This chapter presents comparisons of estimates of the number of persons who received substance use treatment from NSDUH, TEDS, and N-SSATS and counts of the number of substance use treatment admissions reported in TEDS and N-SSATS. The first section of this chapter presents estimates of the number of persons who received substance use treatment in a given year based on annual averages from 2005 to 2010 NSDUH data and combined 2007 to 2009 TEDS data. The second section presents estimates of the number of persons who received substance use treatment for the first time in the past year based on NSDUH and TEDS data. The third section presents estimates of single-day counts of the number of persons in treatment for alcohol use, drug use, or both alcohol and drug use, based on annual averages for combined 2008 to 2010 NSDUH, combined 2007 to 2009 TEDS, and combined 2007 to 2009 N-SSATS data. The fourth section presents counts of annual treatment admissions for 2007 through 2009, based on annual averages for counts from TEDS and N-SSATS. Combining data from multiple years increases the sample size to support detailed estimates and is particularly useful for examining demographic and geographic correlates of receipt of alcohol use and drug use treatment.

2.1. Number of Persons Who Received Treatment in the Past 12 Months

This section presents comparisons between NSDUH and TEDS estimates of the numbers and characteristics of persons who received substance use treatment in the past year.

2.1.1 NSDUH Estimates

Description of NSDUH Estimates

In NSDUH, estimates of the number of persons who received substance use treatment in the past year are based on self-reports of treatment received. So that NSDUH estimates would be more comparable to TEDS data, we have used NSDUH estimates of the number of persons who received treatment in the past year in a *specialty treatment facility*, which includes treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. Specialty treatment does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. Persons could report receiving treatment at more than one location; persons who reported receiving treatment from at least one specialty treatment location were counted as having received treatment at a specialty treatment facility. Likewise, persons could report receiving treatment for more than one type of substance (e.g., alcohol, marijuana, and cocaine).

NSDUH data can also be used to estimate the number of persons who received treatment in the past year at any location. This includes specialty treatment facilities, as defined previously, or nonspecialty treatment facilities, such as an emergency room, a private doctor's office, a prison or jail, or a self-help group such as Alcoholics Anonymous or Narcotics Anonymous. For comparison, we have included a table in Appendix C that provides estimates and percentages of persons who received substance use treatment at any location based on NSDUH data (see Table C.2.1AL).

Limitations of the NSDUH Estimates

NSDUH is a household survey that relies on the sampled respondents to provide accurate and honest reports of their substance use and substance use treatment experiences. The NSDUH sample is drawn to represent the noninstitutionalized population of the United States aged 12 or older. It excludes persons who are in jail or prison, persons who are in a hospital or residential treatment during the majority of the quarter

when the survey is conducted, and homeless persons who do not reside in shelters.

2.1.2 TEDS Counts

Description of TEDS Counts

The TEDS counts of the number of persons who received past year substance use treatment are derived from linked admission and discharge records from *specialty substance use treatment facilities*. More specific information about how these counts are derived is provided in Section 1.3 of this report. Persons could receive treatment at more than one type of treatment facility during a given year. Likewise, TEDS records include up to three types of substances (e.g., alcohol, marijuana, and cocaine) that a person could have received treatment for.

Limitations of the TEDS Counts

TEDS does not include all admissions to substance use treatment. It typically includes admissions to facilities that are licensed or certified by an SSA to provide substance abuse treatment, as well as admissions that are administratively tracked for other reasons. TEDS typically does not include clients treated in a jail/prison not run with State agency-administered funds, emergency room, private doctor's office, or self-help group. As Section 1.2 notes, many States require only publicly funded facilities to report data to TEDS, and some States only require facilities to report TEDS data for patients for whom treatment is publicly funded. Also noted in Section 1.2, hospital inpatient substance use treatment facilities are frequently not licensed through the SSA and may not be required to report TEDS data. A detailed list of institutions/clients included or excluded in each State is provided in Table A.1 in Appendix A.

2.1.3 National Estimates

This section compares the numbers and demographic/treatment characteristics of persons who received substance use treatment services in a specialty treatment facility in the past year. Alabama, Alaska, the District of Columbia, and Georgia were excluded from TEDS estimates because no or incomplete TEDS data were submitted for 1 or more of the 3 years examined

(2007 to 2009) in these areas. In addition to NSDUH estimates based on all 50 States plus the District of Columbia, NSDUH estimates were also restricted to the subset of 47 States that were used to generate TEDS estimates; these are referred to as the "TEDS States." These estimates are presented in Appendix C (Table C.2.1). The NSDUH estimate for all States is approximately 4.5 percent higher than the NSDUH estimate for the TEDS States. In terms of the total count/estimate of the number of persons who received substance use treatment from specialty treatment facilities in the past year, the NSDUH estimate for the TEDS States was greater than the TEDS count (2,357,118 vs. 1,928,578).

Treatment Characteristics

A comparison of the treatment characteristics of persons who received substance use treatment from a specialty facility in the past year also shows several differences between the two data sources. NSDUH estimates were higher than TEDS counts across the three principal modality categories (hospital inpatient, residential rehabilitation—inpatient, and outpatient). Although the NSDUH estimate and the TEDS count reflected a similar proportion of persons who received treatment in an outpatient setting (81.3 and 78.2 percent, respectively), the NSDUH estimate included a notably greater percentage of persons who received treatment in an inpatient hospital setting than the TEDS count (31.3 vs. 3.2 percent). The NSDUH estimate also reflected a greater percentage of persons who received treatment in a residential rehabilitation facility than the TEDS count (40.6 vs. 28.2 percent).

Figure 2.1 shows the percentages of persons treated for specific substances or substance groups. The percentage of persons in the NSDUH estimate who were treated for marijuana use problems was lower than the percentage in the TEDS count who reported marijuana as a problem drug at the time of treatment admission (30.9 vs. 39.7 percent for NSDUH TEDS States only and TEDS, respectively). The NSDUH estimates for TEDS States only included greater percentages of persons treated for prescription drugs, inhalants, hallucinogens, and alcohol than did the TEDS counts (26.3 vs. 12.5 percent for prescription drugs, 6.0 vs.

0.2 percent for inhalants, 10.9 vs. 0.6 percent for hallucinogens, and 69.3 vs. 59.5 percent for alcohol). One possible explanation for the difference between the percentage of persons treated for prescription drugs reflected in the NSDUH estimate and the TEDS count is that TEDS queries treatment for methamphetamine use as a separate category, whereas NSDUH includes treatment for methamphetamine use as treatment for prescription drugs. The NSDUH estimate included a lower proportion of injection drug users than the TEDS count did (7.3 vs. 12.4 percent; data not shown). Note that restricting the NSDUH findings to the TEDS States does not have an appreciable effect on the percentage of persons receiving treatment for any of the substances.

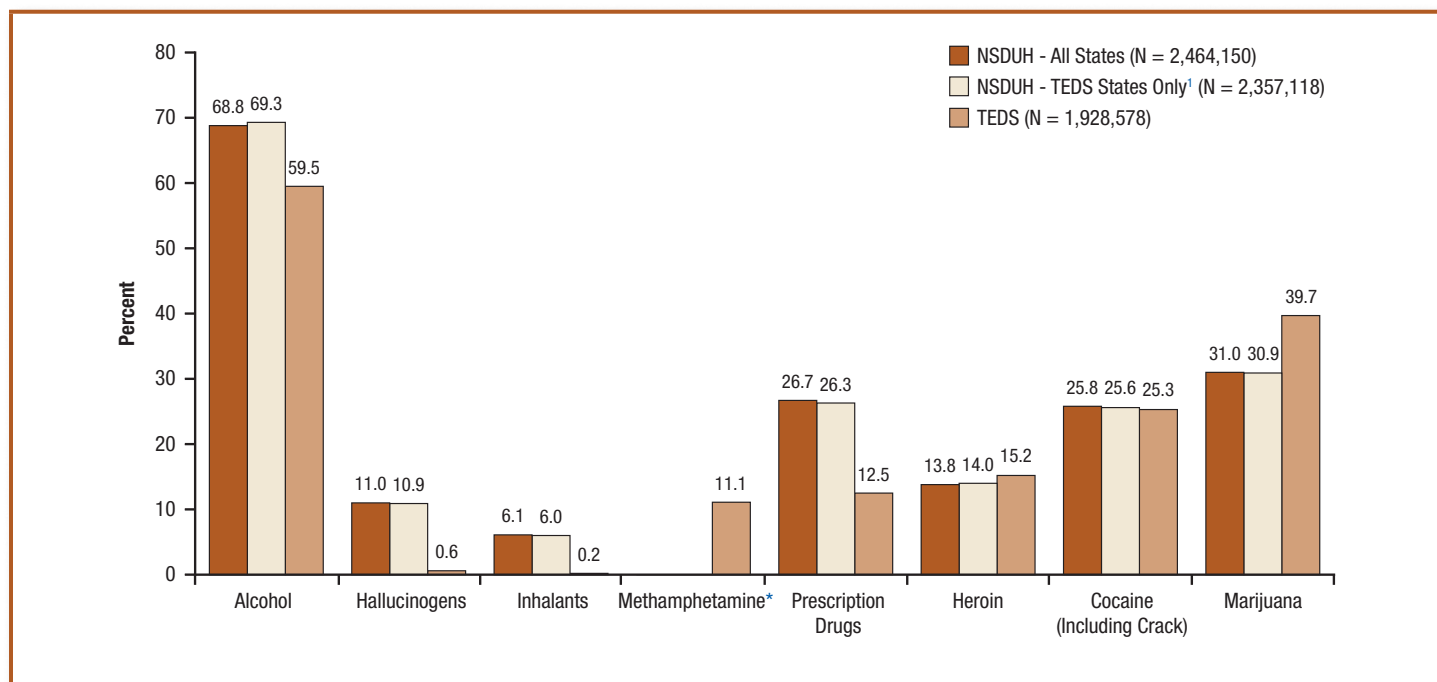
Demographic Characteristics

There was some variation between the treatment counts from the two data sources on several demographic characteristics. Figure 2.2 shows the distribution across age groups of persons receiving specialty treatment. The NSDUH estimate included a lower percentage

of youths and a greater percentage of older persons. Specifically, in the NSDUH estimate, 6.4 percent were aged 12 to 17 (150,083 persons), and in the TEDS count, 8.8 percent were aged 12 to 17 (170,289 persons). In the NSDUH estimate, 29.0 percent were aged 45 or older (683,673 persons), and in the TEDS count, 22.5 percent were aged 45 or older (433,924 persons). The restriction of the NSDUH sample to include only the TEDS States did not affect the percentage distribution across age groups; the percentages of the four age groups were nearly identical for the full NSDUH sample and for the NSDUH TEDS States only sample.

Differences were also seen between NSDUH and TEDS distributions across racial ethnic groups and educational attainment. As shown in Figure 2.3, the NSDUH estimate included a greater proportion of non-Hispanic whites and lower percentages of non-Hispanic blacks and Hispanics than the TEDS count. The NSDUH estimates were greater than the TEDS counts for both genders, although the proportions of males and

Figure 2.1 Distribution of Treatment for Specific Substances among Persons Who Received Treatment from Specialty Treatment Programs in the Past Year: NSDUH 2005 to 2010 and TEDS 2007 to 2009



* Treatment specifically for methamphetamine use is not measured in NSDUH.

¹ TEDS States exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years (2007-2009).

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2005 to 2010; and Treatment Episode Data Set (TEDS), 2007 to 2009.

Figure 2.2 Distribution of Age Groups among Persons Who Received Treatment from Specialty Treatment Programs in the Past Year: NSDUH 2005 to 2010 and TEDS 2007 to 2009

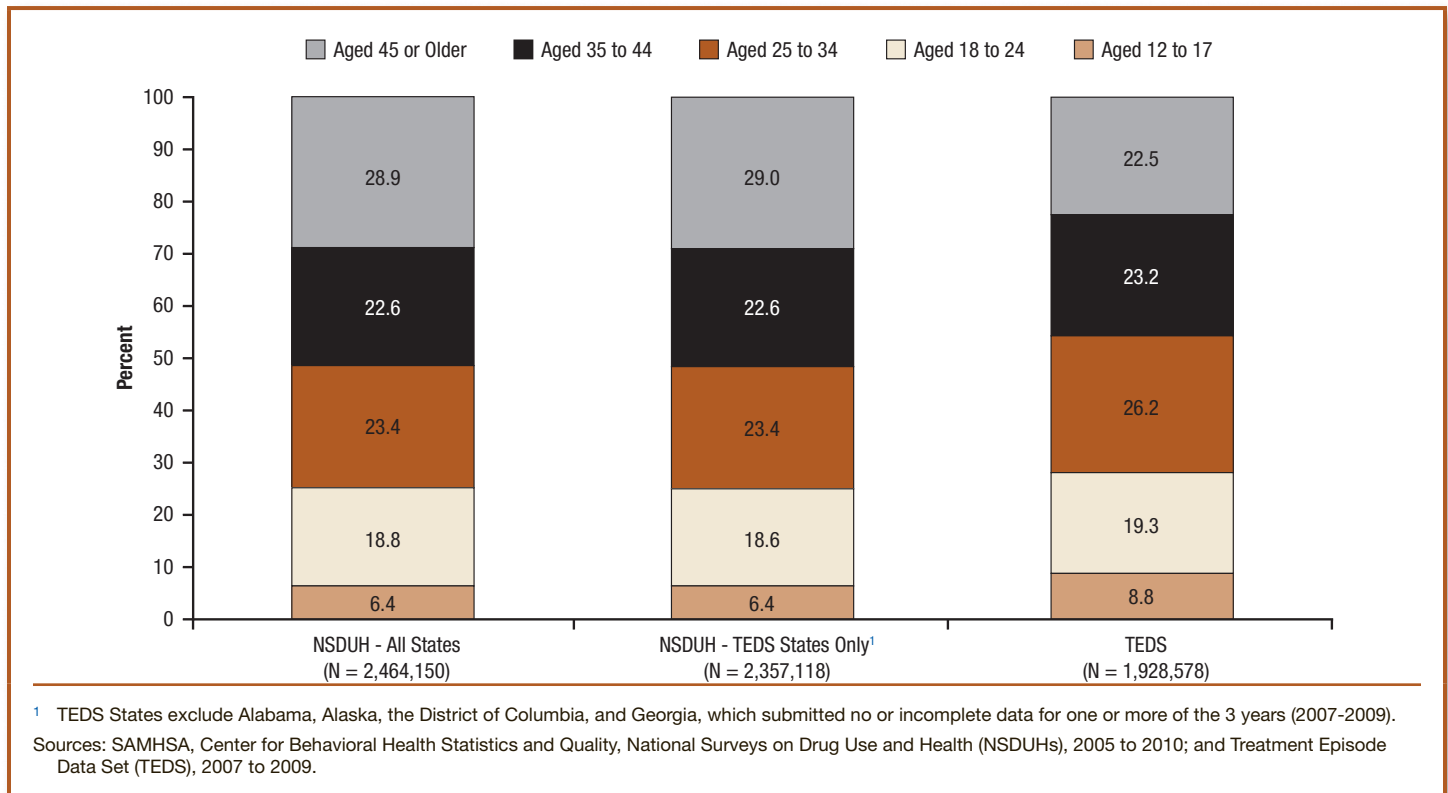
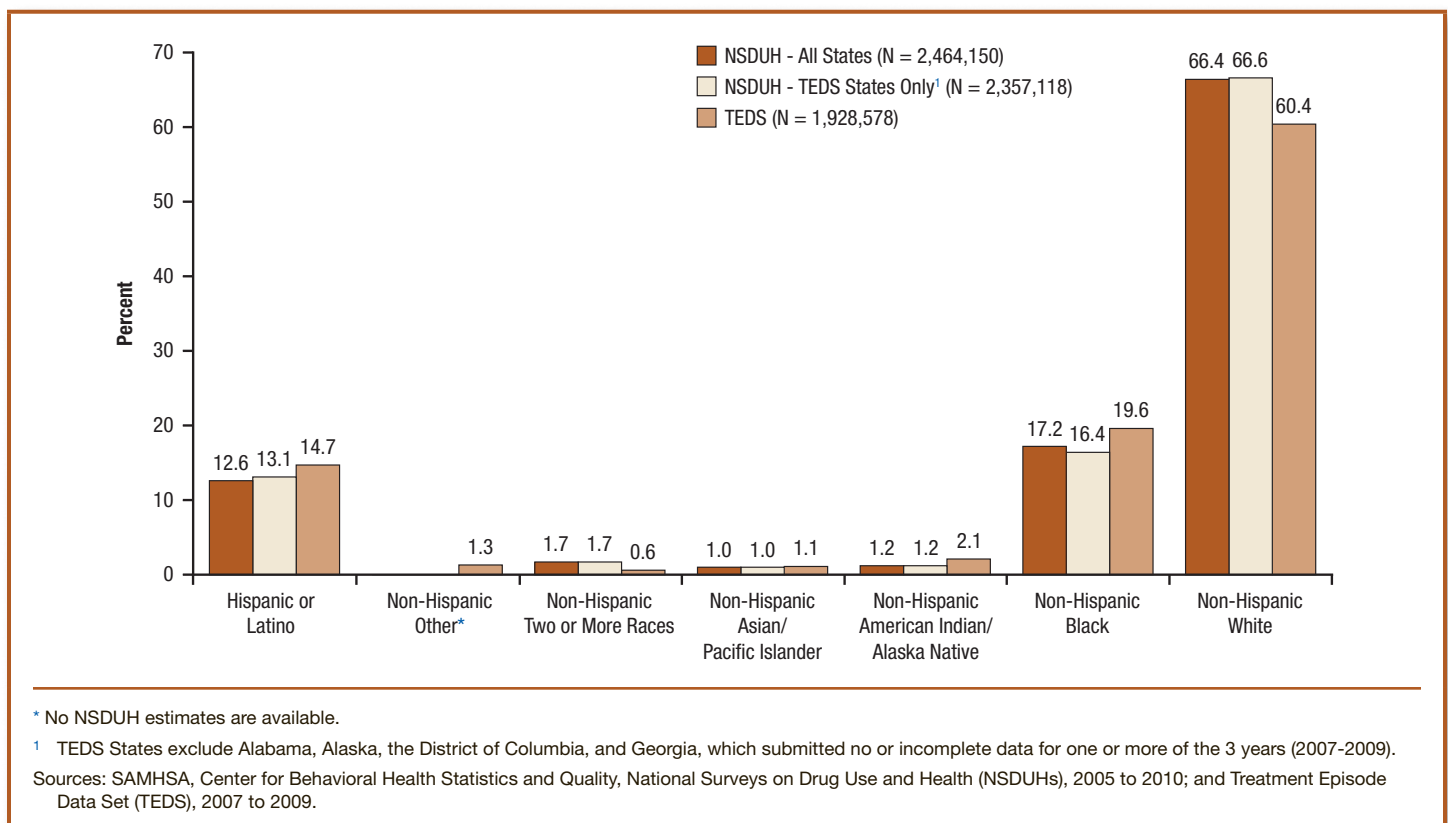


Figure 2.3 Distribution of Racial/Ethnic Groups among Persons Who Received Treatment from Specialty Treatment Programs in the Past Year: NSDUH 2005 to 2010 and TEDS 2007 to 2009



females were similar between the two data sources. A comparison of the education status reflected in the two data sources shows the NSDUH estimate included a higher percentage of persons with more than a high school education and a lower percentage of persons with 8 or fewer years of education than the TEDS count. In the NSDUH estimate, 34.3 percent of persons had more than 12 years of education, and 5.7 percent had 0 to 8 years of education; in the TEDS count, 22.1 percent had more than 12 years of education, and 9.5 percent had 0 to 8 years of education.

Figure 2.4 shows the results of a comparison of the NSDUH 2005 to 2010 specialty treatment data for employment status,⁴ with the TEDS data reported for those variables (CBHSQ, 2011a). When compared with estimates from TEDS, estimates from NSDUH show a higher percentage of persons employed full time (37.3 vs. 16.3 percent for NSDUH and TEDS, respectively) and part time (12.9 vs. 7.6 percent for NSDUH and TEDS, respectively). TEDS estimates include a higher percentage than NSDUH of persons who were

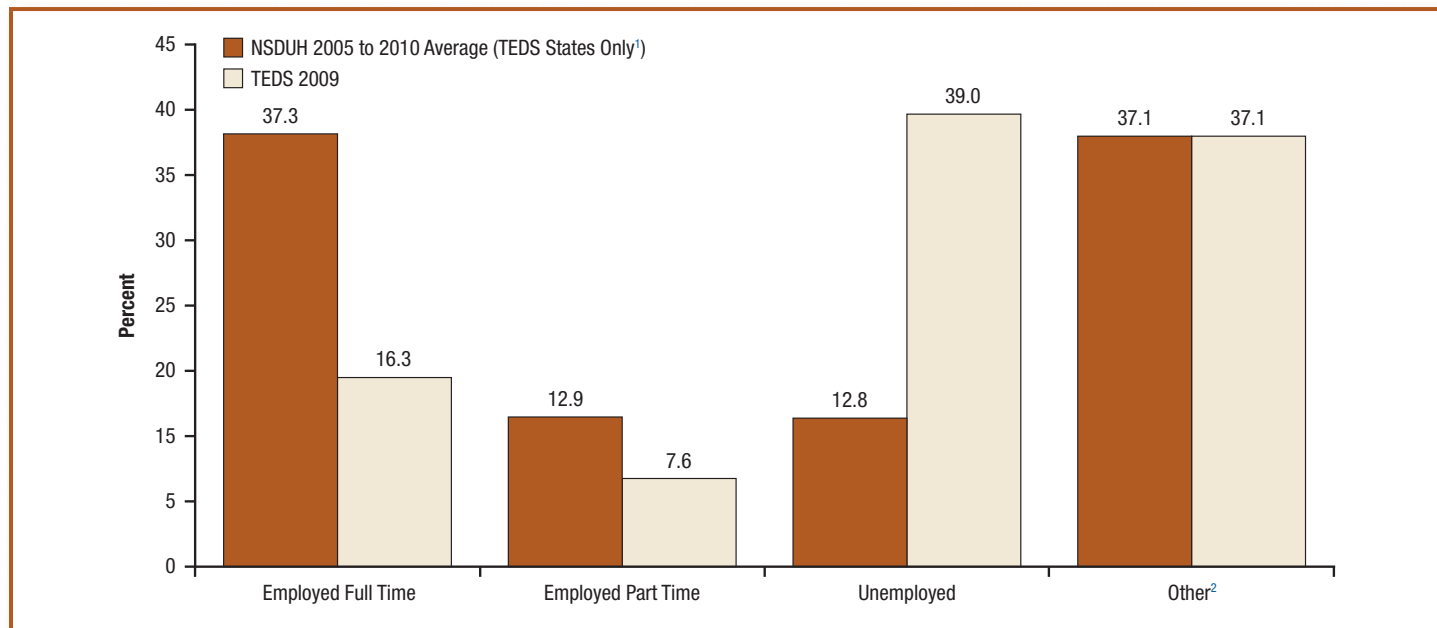
unemployed (39.0 vs. 12.8 percent for TEDS and NSDUH, respectively). One possible explanation for these findings is that many States require only publicly funded facilities to report data to TEDS, and some States only require facilities to report TEDS data for patients for whom treatment is publicly funded.

The findings for health insurance status were consistent with the pattern for employment, with a higher percentage of TEDS counts being uninsured (59.8 percent) compared with the NSDUH estimate (30.9 percent; data not shown).⁵

2.1.4 State Estimates

State-level NSDUH and TEDS estimates for the eight most populous States in the Nation (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) are presented in Tables C.2.1.1-C.2.1.8. Estimates from the other States and the District of Columbia are not presented because of the lack of precision of NSDUH estimates from these States due to the relatively small sample sizes; there were

Figure 2.4 Distribution of Employment Status among Persons Who Received Treatment from Specialty Treatment Programs in the Past Year: NSDUH 2005 to 2010 and TEDS 2009



¹ TEDS States exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years (2007-2009).

² The Other employment category includes students, persons keeping house or caring for children full time, retired or disabled persons, or other persons not in the labor force, and, in the NSDUH estimates, persons aged 12 to 17.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2005 to 2010; and Treatment Episode Data Set (TEDS), 2009.

approximately 3,600 interviews per year in the eight most populous States and approximately 900 interviews per year in the remaining States and the District of Columbia.

In six of the eight States examined, the TEDS count of the number of persons who received substance use treatment in the past year was smaller than the NSDUH estimate. Notable differences between the overall TEDS count and the NSDUH estimate were found in five States. For example, in Florida, the NSDUH estimate (138,035) was greater than the TEDS count (67,305). There were similar disparities between the NSDUH estimates and TEDS counts in Illinois (95,950 vs. 69,483), Michigan (102,203 vs. 57,956), Pennsylvania (108,068 vs. 46,990), and Texas (84,936 vs. 41,930). In two States, the TEDS count was larger than the NSDUH estimate, but the disparities were not statistically significant. In New York, the TEDS count was 245,898 persons, and the NSDUH estimate was 207,852. In Ohio, the TEDS count was 105,443 persons, and the NSDUH estimate was 96,729.

Treatment Characteristics

A comparison of the treatment characteristics showed several differences between the counts from the two data sources at the State level. Similar to the comparisons made at the national level, the State-level NSDUH estimates for all eight States reflected greater percentages of persons who received treatment in an inpatient hospital setting or residential rehabilitation setting than the TEDS counts. The State-level NSDUH estimates for five of the eight States reflected greater percentages of persons who received treatment in an outpatient setting than the TEDS counts, though only the differences in Pennsylvania were statistically significant; the exceptions were California (72.6 vs. 79.9 percent), Florida (70.2 vs. 81.7 percent), and Ohio (83.6 vs. 94.7 percent).

In some States, we found the two data sources produced similar percentages of persons treated for most substances, whereas in others, there was a large gap between many of the NSDUH estimates and the

TEDS counts. The more notable differences include the following:

- In California, the NSDUH estimate showed that 32.5 percent of persons in specialty treatment were treated for prescription drug use problems, whereas the TEDS count was 6.5 percent. For inhalants, the NSDUH estimate was 8.8 percent, and the TEDS count was 0.1 percent. Similarly, for hallucinogens, the NSDUH estimate was 12.5 percent, and the TEDS count was 0.2 percent. The percentage of persons in specialty treatment in California for alcohol use problems based on the NSDUH data (72.8 percent) was greater than the percentage based on TEDS counts (39.7 percent).
- In Florida, the NSDUH estimate showed that 34.0 percent of persons in specialty treatment were treated for marijuana use problems, whereas the TEDS count was 47.7 percent. For heroin, the NSDUH estimate was 11.2 percent, and the TEDS count was 3.8 percent. For inhalants and hallucinogens, the NSDUH estimates were that 9.3 and 15.3 percent, respectively, were treated for problems with these drugs, and the TEDS counts were 0.2 and 0.5 percent, respectively. The percentage of persons in specialty treatment in Florida for alcohol use problems based on the NSDUH data (67.0 percent) was also greater than the percentage based on the TEDS counts (46.7 percent).
- In Illinois, the NSDUH estimate showed that 22.9 percent of persons in specialty treatment were treated for marijuana use problems, whereas the TEDS count was 40.5 percent. For heroin, the NSDUH estimate was 15.5 percent, and the TEDS count was 24.1 percent. For prescription drugs, the NSDUH estimate was 17.0 percent, and the TEDS count was 5.6 percent. The percentage of persons in specialty treatment in Illinois for hallucinogen use problems based on the NSDUH data (2.9 percent) was also greater than the percentage based on the TEDS counts (0.3 percent).

- In Michigan, the NSDUH estimate showed that 30.3 percent of persons in specialty treatment were treated for marijuana use problems, whereas the TEDS count was 41.9 percent. For inhalants and hallucinogens, the NSDUH estimates were that 4.2 and 8.7 percent, respectively, were treated for problems with these drugs, and the TEDS counts were 0.1 and 0.3 percent, respectively.
- In New York, the NSDUH estimate showed that 32.7 percent of persons in specialty treatment were treated for marijuana use problems, whereas the TEDS count was 42.8 percent. For inhalants and hallucinogens, the NSDUH estimates were that 3.4 and 12.1 percent, respectively, were treated for problems with these drugs, and the TEDS counts were 0.1 and 0.3 percent, respectively.
- In Ohio, the NSDUH estimate showed that 31.5 percent of persons in specialty treatment were treated for marijuana use problems, whereas the TEDS count was 46.2 percent. For prescription drugs, the NSDUH estimate was 23.5 percent, and the TEDS count was 11.3 percent. Similarly, for inhalants and hallucinogens, the NSDUH estimates were that 5.3 and 9.1 percent, respectively, were treated for problems with these drugs, and the TEDS counts were 0.2 and 0.5 percent, respectively.
- In Pennsylvania, the NSDUH estimate showed that 5.9 percent of persons in specialty treatment were treated for inhalant use problems, whereas the TEDS count was 0.2 percent. For hallucinogens, the NSDUH estimate was 9.6 percent, and the TEDS count was 0.7 percent.
- In Texas, the NSDUH estimate showed that 9.5 percent of persons in specialty treatment were treated for inhalant use problems, whereas the TEDS count was 0.2 percent. For hallucinogens, the NSDUH estimate was 18.4 percent, and the TEDS count was 0.4 percent. The percentage of persons in specialty treatment in Texas for alcohol use problems based on the NSDUH data (66.8 percent) was also greater than the percentage based on the TEDS counts (48.1 percent).

In two of the eight States (California and Texas), the NSDUH estimate included a lower proportion of injection drug users than the TEDS counts, reflecting the pattern seen in the national comparisons. In Ohio, Michigan, and Illinois, the NSDUH estimate indicated a lower proportion of injection drug users than the TEDS count for the State, but the difference between the two data sources was not statistically significant. In Florida and Pennsylvania, the two data sources had similar proportions of injection drug users (5.2 percent in both surveys for Florida, and 11.8 percent in TEDS and 12.0 percent in NSDUH for Pennsylvania). In New York, no NSDUH estimate of injection drug use was reported due to low precision.

Demographic Characteristics

Across the eight States, we observed some patterns of demographic characteristics of persons in treatment that were consistent with national comparisons, as well as some patterns that differed from national comparisons. For example, in five of the eight States (California, Florida, Illinois, Ohio, and Pennsylvania), the NSDUH estimates showed lower percentages of youths than the TEDS counts, as we found in the national estimates/counts. In the remaining three States (Michigan, New York, and Texas), the percentages of youths identified in the two sources were more similar to one another.

In the national comparisons, we found that the NSDUH estimate included a greater proportion of non-Hispanic whites and lower percentages of non-Hispanic blacks (not statistically significant) than the TEDS count. In Illinois, we found the same pattern. In Pennsylvania, the NSDUH estimate included a greater proportion of whites and similar proportion of blacks than the TEDS count. However, in the six remaining States, we found that the NSDUH estimates and TEDS counts of non-Hispanic whites were similar to each other. When comparing the two sources for each State, we found that in six States (California, Illinois, Michigan, New York, Ohio, and Pennsylvania), the NSDUH estimate included a lower percentage of non-Hispanic blacks than the TEDS count, although this difference was only statistically significant in Illinois and Ohio. In Florida and Texas, no NSDUH estimate of non-Hispanic blacks was reported due to low precision.

In looking at State-level estimates of Hispanics, we found that in Pennsylvania, the NSDUH estimate had a lower percentage of Hispanics than the TEDS count, although this difference was not statistically significant. We found the converse to be true in Ohio, and the difference was statistically significant. In New York and Texas, no NSDUH estimates of Hispanics were reported due to low precision; in California, Florida, Illinois, and Michigan, the NSDUH estimates and TEDS counts were similar.

In the national comparisons, the NSDUH estimate included a higher percentage of persons with more than a high school education and a lower percentage than the TEDS count of persons with 8 or fewer years of education. The discrepancy between the two sources with regard to the percentage that had 8 or fewer years of education was present in all States. The most drastic, and only statistically significant difference between sources, was found in Pennsylvania, where the NSDUH estimate was that 6.7 percent of persons treated in specialty treatment had 8 or fewer years of education and the TEDS count reflected that 57.1 percent had that level of education. One possible explanation for this difference is that there were technical problems with the education variable in Pennsylvania during 1 or more of the years examined. It may also be possible that persons with little formal education are the recipients of publicly funded substance use treatment in that State or that persons with little formal education in Pennsylvania do not participate in the NSDUH. The pattern of NSDUH estimates having higher percentages of persons with more than a high school education was also found in seven of the eight States. In Texas, no NSDUH estimate of more than 12 years of education was reported due to low precision.

2.1.5 Conclusions and Limitations

At the national level, there were some differences between the treatment characteristics of the TEDS counts and those of the NSDUH estimates. As would be expected, the national TEDS estimate for persons receiving treatment in a hospital inpatient setting was much lower than the NSDUH estimate (61,382 vs. 738,366).

Treatment Characteristics

Because privately funded treatment facilities often are not included in TEDS but NSDUH collects data from persons who received treatment from both publicly and privately funded facilities, the TEDS count of persons who received substance use treatment in the past year was lower than the estimate from NSDUH for the 47 TEDS States (approximately 1.9 million vs. 2.4 million). A comparison of treatment modality also produces several expected differences between the two data sources. Although the TEDS count and the NSDUH estimate reflected a similar proportion of persons who received treatment in an outpatient setting (78.2 and 81.3 percent, respectively), the TEDS count included a notably lower proportion of persons who received treatment in an inpatient hospital setting than the NSDUH estimate (3.2 vs. 31.3 percent). This may be because hospital-based substance use treatment facilities are frequently not licensed through the State and therefore are often not required to report TEDS data. The TEDS count of persons receiving treatment in a residential rehabilitation setting also reflected a lower percentage than did the NSDUH estimates (28.2 vs. 40.6 percent).

To provide a comparison of the two data sources that is more equivalent with regard to inclusion/exclusion of hospital-based inpatient facilities, two additional tables are included in Appendix C (see Table C.2.1NH) that show demographic and other characteristics of persons who received substance use treatment from specialty treatment facilities excluding persons receiving treatment solely from hospital-based facilities. Despite the exclusion, the NSDUH estimate for the TEDS States (2,227,200) was greater than the TEDS count presented in Table C.2.1 (1,928,728).

Methodological differences between NSDUH and TEDS in the collection of data on specific substances of abuse may partially explain the differences found between data sources in the percentages of persons treated for specific substances. In the NSDUH, respondents who report past year treatment are asked whether they received that treatment for each of the substances (including alcohol) that they had used in their lifetime. If a respondent reports that he or she

was treated for more than one substance, he or she is asked to identify the one substance that was the main reason for their treatment. The nature of substance use treatment might encourage the inclusion of most or all substances that have been abused. Treatment in many cases is generic and in instances of broad spectrum drug use is not linked to a specific substance. In TEDS, the client's primary, secondary, and tertiary problem substances are reported, which we infer to be the substances for which they are receiving treatment. The specific problem substances are provided by the client, but if more than one substance is reported, there are no specific guidelines concerning how to determine which substance is primary or which substances to include if a client has been misusing more than three substances. There may also be administrative reasons that influence which drugs are classified as primary and which are classified as secondary or tertiary.

The NSDUH percentages are significantly higher than the TEDS percentages for prescription drugs, inhalants, hallucinogens, and alcohol. One possible explanation is that these substances are less likely to be identified as problem substances at the time of treatment admission when other drugs (e.g., heroin and cocaine) have been identified as primary or secondary problem drugs. Being specifically asked whether or not a respondent was treated for use of each substance used in his or her lifetime may lead to a more inclusive list of substances than making a report of the primary, secondary, and tertiary problem substances at admission to treatment. In nearly 15 percent of cases, NSDUH respondents reported four or more substances for which treatment was received over the past year (which could have included multiple admissions).

Additionally, differences exist between the ways that NSDUH and TEDS define inhalants. In NSDUH, respondents are given a general description of inhalants (substances persons sniff or inhale for kicks or to get high) and then are provided with a list of the more common inhalants when they are asked about use of these types of drugs. The NSDUH list contains: amyl nitrite ("poppers," locker room odorizers, "rush"); correction fluid, degreaser, or cleaning fluid; gasoline or lighter fluid; glue, shoe polish, or toluene;

halothane, ether, or other anesthetics; lacquer thinner or other paint solvents; lighter gases, such as butane or propane; nitrous oxide or "whippits"; spray paints; or other aerosol sprays. In TEDS, problem substance information is collected during the admission process. The TEDS guidelines for which drugs should be categorized as inhalants include the following: chloroform, ether, gasoline, nitrous oxide, and paint thinner. It is possible that the greater percentage of persons treated for inhalant use in NSDUH when compared with TEDS could be due, at least in part, to the more inclusive list of inhalants provided in NSDUH. However, it could also not be a reason because the definition in the manual provides examples rather than an exhaustive list, but States would still cross-walk the type of substances in the NSDUH list to the inhalants category in the TEDS. The person being admitted to treatment would not see or be limited to the examples in the TEDS manual.

The proportion of injection drug users in TEDS was higher than the proportion of injection drug users in the NSDUH. The TEDS estimates included only those admissions for which injection was the *usual route of administration* of their primary, secondary, or tertiary problem drug, whereas the NSDUH estimates included anyone who had injected one of the three queried substances (heroin, methamphetamine or Desoxyn®, and Methedrine®) one or more times in the past year. Although asking about injection as the usual route of administration in TEDS versus asking about any injection use in NSDUH would suggest that NSDUH estimates would be higher than TEDS counts; however, the opposite pattern was found. One possible explanation is that NSDUH respondents were queried about injection administration of only three drugs, whereas injection of any drug was included in TEDS counts. For example, cocaine was frequently named as an injection drug in TEDS, but it was not included in the NSDUH list of queried drugs for injection administration. Another possible explanation is that NSDUH estimates included a higher percentage of persons in treatment for alcohol use than did the TEDS counts, and injection is not a common route of administration of alcohol. The NSDUH injection

questions were also included in a different module than the questions about the substances used and may be subject to reporting bias (respondents not wanting to reveal behaviors that are stigmatized or socially undesirable). Injection drug use might also be underreported in NSDUH due to conditioning (decreasing tendency of respondents to answer “yes” to questions that came later in an interview as a way of avoiding being asked additional follow-up questions) and social desirability concerns of respondents. Finally, in TEDS, accurate reporting of the typical route of drug administration at admission was relevant to the client’s treatment plan and services received (i.e., injection drug use may increase the risk of contracting certain illnesses such as hepatitis C and HIV), whereas this was not the case when NSDUH respondents were retroactively reporting on their injection of drugs. It is likely that there are multiple such variations in methodology between NSDUH and TEDS, as well as variations in methodology in the collection of substance use data between States, facilities, and admissions in TEDS, which could impact these comparisons. It is not possible to determine the magnitude or the direction of the influence of each of these types of potentially biasing factors on these comparisons.

Demographic Characteristics

Differences between TEDS and NSDUH estimates of specific racial or ethnic groups might be related to the broader definition of treatment in NSDUH but might also be associated with differences in the way that data concerning race and ethnicity were collected for the two data sources. In NSDUH, the interviewer asked two questions about racial and ethnic identity, whereas in TEDS, the questions, definitions, and process used to identify a person’s race/ethnicity varied somewhat between individual treatment facilities.

State-Level Estimates

Differences between TEDS and NSDUH State estimates of the number of persons who received past year treatment were likely to have been largely a consequence of the broader inclusiveness of treatment used in NSDUH. For example, in TEDS, hospital inpatient cases include only those treated in the

chemical dependence unit of the hospital, whereas NSDUH does not make that distinction. State-level differences might also reflect requirements within the State for reporting TEDS data. (For a more detailed explanation of differences in State reporting requirements, see Table A.1 in Appendix A.) One limiting factor might include the types of facilities that were required to report TEDS data within an individual State. For example, in Texas, only facilities that received State/public funding were required to report, and those facilities were only required to report data on clients whose individual treatment was funded by State/public funds. For Texas, the NSDUH estimate of persons who received treatment in the past year was twice as great as the estimate from TEDS (84,936 vs. 41,930). In New York, all facilities that received State/public funding as well as those that were licensed/certified by the SSA were required to report TEDS data on all clients in their facilities. For New York, the NSDUH estimate of persons treated in the past year was less than the estimate from TEDS (207,852 vs. 245,898), although this difference was not statistically significant. Notably, the NSDUH estimates at the State level are less precise than the national NSDUH estimates due to the smaller sample size.

2.2. Numbers of Persons Who Received Treatment for the First Time in a Given Year

2.2.1 NSDUH Estimates

Description of NSDUH Estimates

NSDUH respondents who indicated that they had ever received treatment or counseling for their use of alcohol or any drug were asked to report the age at which they first received treatment or counseling for alcohol or other drug use. By subtracting the current age of the respondent from the age of first treatment, it is possible to identify respondents who received treatment for the first time in a given calendar year, and therefore estimate the number of persons who received treatment for the first time in any calendar year. Note that data from different survey years could be used to provide different estimates of the number of persons who received treatment for the first time in any one calendar year. For example, the number of persons who

received treatment for the first time in 2006 could be estimated by determining the number of persons whose current age in 2007 was 1 year older than their age at first treatment or by determining the number of persons whose current age in 2008 was 2 years older than their age at first treatment. In this report, NSDUH estimates of the number of persons who received treatment for the first time in different years are based on combined 2008 and 2009 NSDUH data and represent the number of persons who had received treatment in their lifetime who first received treatment in each year from 1995 to 2007. The questions about first substance use treatment included treatment received *at any location*. This included treatment received at

- a hospital (inpatient);
- a rehabilitation facility (outpatient or inpatient);
- a mental health center;
- an emergency room;
- a private doctor's office;
- a prison or jail; or
- a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous.

Limitations of the NSDUH Estimates

The limitations of these estimates are similar to the limitations discussed previously for the number of persons who received treatment in the past year. The NSDUH is a household survey that relies on sample members to provide accurate and honest reports of their substance use and substance use treatment experiences; this may be especially problematic if asking persons who have been in treatment multiple times over many years to recall their age when they first received treatment. As a household survey, NSDUH also excludes persons who are in jail or prison, persons who are in a hospital or residential treatment, and homeless persons who do not reside in shelters for the majority of the quarter that their dwelling unit has been sampled. Finally, it should be noted that the NSDUH sample has been weighted to produce accurate estimates of substance use among the noninstitutionalized population of the United States aged 12 or older.

2.2.2 TEDS Counts

Description of TEDS Counts

Each TEDS admission record included the number of previous treatment episodes the client had received in any drug or alcohol treatment facility. Each admission for which there were no reported prior admissions for substance use treatment was considered a first-time admission. In this report, TEDS counts include the number of admissions in each year from 1995 to 2007 that reported no previous substance use treatment admissions. The TEDS counts of the number of persons who first received substance use treatment in a given year are derived from records for admissions.

Limitations of the TEDS Counts

As is true for the other counts discussed in this chapter, the generalizability of the TEDS counts is limited by the inclusion/exclusion criteria for the TEDS database and also by the State-level differences in reporting requirements that affect which data are reported to TEDS from the individual States. TEDS counts do not represent a census of all admissions to substance use treatment in a given year because TEDS includes primarily facilities that receive State-administered public funds. Privately funded facilities are generally not required to report to TEDS and are unlikely to do so; those that are operated by the Federal Government (e.g., those in VA hospitals or Federal prisons) are also unlikely to report to TEDS. TEDS explicitly excludes clients treated in an emergency room, a private doctor's office, a self-help group, or a jail/prison that is not run with funds administered by an SSA. Second, there are instances in which data submission is suspended temporarily for 1 or more years in some States or jurisdictions because of changes to their data collection systems (e.g., in 2006, Alaska, the District of Columbia, Georgia, and Vermont did not submit data to TEDS). Third, not every State that participates in TEDS submits all of the data about each client for all of the variables in the data set. For example, in 2006, there were incomplete or missing data from five States/districts for the previous treatment variable. In that year, there were 699,008 clients admitted to treatment who had not had a prior treatment episode and there

were 339,995 cases with missing data for the prior treatment episode variable. The information collected on the TEDS is also mostly self-reported by the persons admitted for treatment; however, the recall of certain data (e.g., prior treatment or substances used) may be different depending on the saliency of the topic and the differences in the context within which the data are being collected.

2.2.3 Annual Estimates from 1995 to 2007

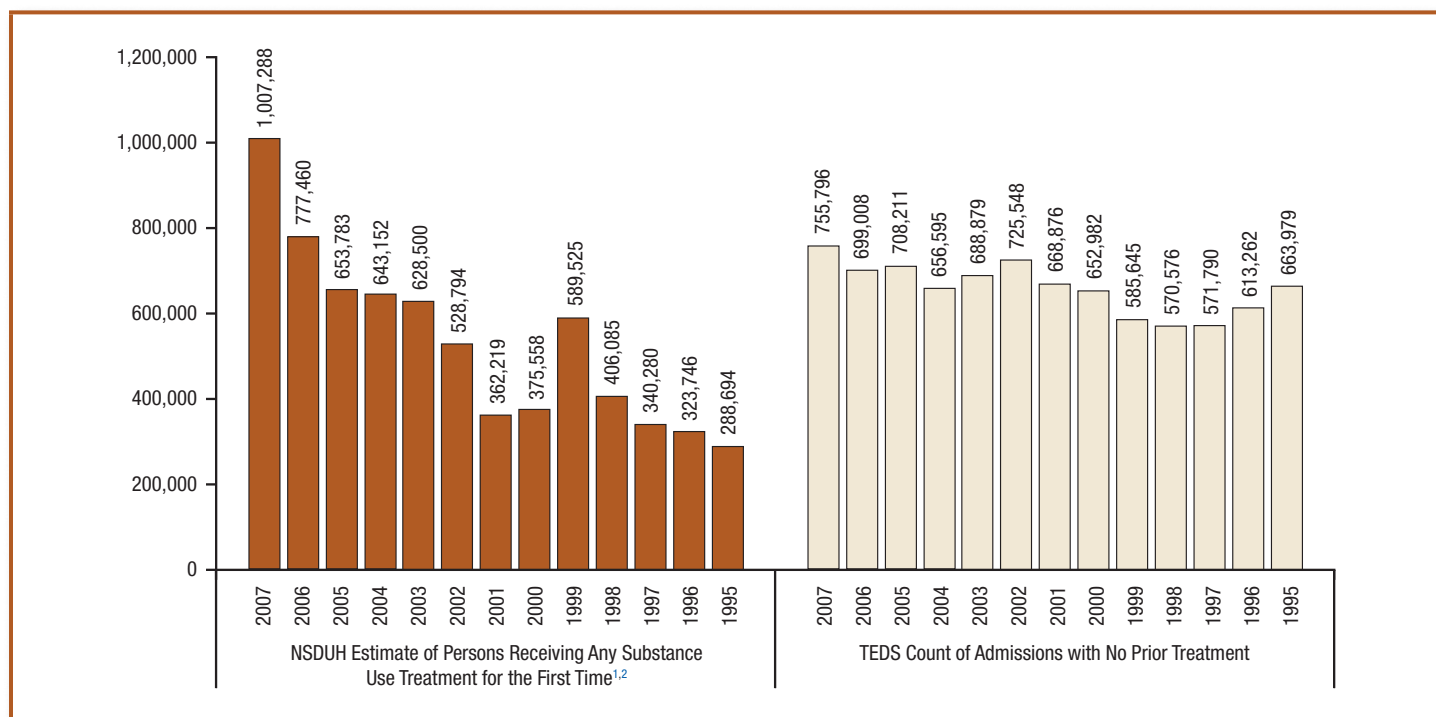
Figure 2.5 compares the annual estimates for the number of persons receiving substance use treatment for the first time in the years 1995 through 2007. Because the estimates from NSDUH included treatment or counseling received at any type of facility, whereas the TEDS counts included treatment received only at specialty treatment facilities, the number of persons who received treatment for the first time in any given year would be expected to be higher in NSDUH estimates than in TEDS counts. This was true for the estimates

from 2006 and 2007 but was not true for estimates from previous years. In each year from 1997 to 2005, either there was no difference between the NSDUH and TEDS estimates or the TEDS estimates were higher than the NSDUH estimates. The NSDUH estimates for each year that were based on having to recall treatment from more than 3 or 4 years ago generally became smaller as the time between the interview and the year of first treatment increased (smaller numbers for earlier years), whereas the TEDS estimates were more consistent over time.

2.2.4 Conclusions and Limitations

There are multiple reasons to expect the NSDUH estimates to be higher than the TEDS estimates for the recent years (i.e., where the recall period is 1 or 2 years). First, the NSDUH estimates include any type of substance use treatment or counseling in each State, whereas the TEDS estimates are limited to treatment in a specialty substance use treatment facility and often

Figure 2.5 Estimated Numbers of Persons Receiving Substance Use Treatment for the First Time in 1995 to 2007: NSDUH 2008 and 2009, TEDS 1995 to 2007



¹ Based on combined 2008 and 2009 NSDUH data (Year of first treatment = [Survey year + Age of first treatment] - Interview Age).

² Age of first treatment is defined as the minimum age of receipt of treatment for alcohol or drugs.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2008 to 2009; and Treatment Episode Data Set (TEDS), 1995 to 2007.

include only facilities that receive State-administered public funds. This suggests that, as expected, due to its design, the TEDS counts of admissions with no prior treatment are much lower than the estimate of total number of persons who received any treatment for the first time in any given year.

There are also multiple possible explanations for the lower numbers in the NSDUH estimates in nearly all but the most recent years. Because NSDUH is a self-report survey, it relies on respondents' memory for when certain events, such as going to substance use treatment, occurred. Consequently, these estimates are susceptible to memory biases such as "forward telescoping," in which respondents tend to report that an important event from their past occurred more recently than it actually did (Johnson & Schultz, 2005) or simply forgetting treatment that occurred further back in the past. Another possible explanation is that in the early years shown in Figure 2.5 (e.g., 1995), a subset of NSDUH respondents in 2008 and 2009 who had received treatment in their lifetime were not at an age at which substance use treatment would have been a likely issue. For example, a respondent who was 18 years old in 2008 when he participated in the NSDUH was born in 1990. That respondent would have been 5 years old in 1995 and thus would have been very unlikely to have received substance use treatment for the first time in that year. A third possible explanation is that because of the increased risk of morbidity and mortality among persons with substance use problems, some of the persons who were in substance use treatment in 1995 might not have been eligible to have participated in the 2008 or 2009 survey due to incarceration, hospitalization, or death. These results indicate that estimates for a given year using NSDUH should use data from no more than 1 or 2 survey years after the year of interest (e.g., estimates for 2005 should use data from 2006 or 2007, not data from 2008 or later) because of declining data quality.

2.3. Single-Day Treatment Counts

Single-day treatment counts are estimates of the number of persons who were receiving substance use treatment on a given day of the year. The single-day treatment measures included in this section are

- estimates from the 2008 to 2010 NSDUH data of the number of persons in substance use treatment at a hospital, drug rehabilitation facility, or mental health center on October 1 of the year prior to the survey;
- estimates from the 2007 to 2009 NSDUH data of the number of persons in specialty substance use treatment on an average day of the year (estimates are limited to treatment received at specialty facilities in order to increase their comparability with the NSDUH October 1 estimates and the TEDS counts);
- counts from the 2007 to 2009 TEDS data of the number of persons in specialty substance use treatment on the last working day of March of a given year to match N-SSATS;
- counts from the 2007 to 2009 N-SSATS data of the number of persons in substance use treatment in all treatment facilities on the last working day of March of a given year; and
- counts from the 2007 to 2009 N-SSATS data of the number of persons in substance use treatment facilities, except for hospitals, on the last day of March of a given year (estimates are limited to outpatient facilities in order to increase their comparability with TEDS).

In the sections that follow, national and regional single-day treatment counts from these three data sources are presented, followed by counts from the eight most populous States. Tables containing single-day treatment counts for the Nation, the four census regions, and the eight most populous States are provided in Appendix C, Tables C.2.2-C.2.6. For comparison purposes, tables containing single-day treatment counts for the 50 States plus the District of Columbia are also included in Appendix C (see Tables C.2.7-C.2.11). The State estimates other than for the eight most populous States are not discussed in the text for this section.

Individual single-day treatment counts were generated for alcohol or drugs, alcohol only, drugs only, both alcohol and drugs, as well as with alcohol as the primary substance, and with a drug as the primary substance.

N-SSATS data do not include sufficient detail to determine whether treatment received for both alcohol and drugs was primarily for alcohol or primarily for drugs; therefore, the alcohol primary and drug primary counts were not generated using N-SSATS data.

2.3.1 NSDUH Estimates

Description of NSDUH Estimates

Two different single-day treatment estimates can be generated using NSDUH data. One estimate uses data from a question about whether or not the respondent was receiving substance use treatment at the time of the interview,⁶ as well as the outcome of their last treatment episode. Respondents who indicated that they were currently receiving treatment were asked whether or not they were receiving this treatment for each of the substances they had used during their lifetime. This estimate will be referred to as the “average-day single-day treatment estimate.”

In NSDUH, respondents who were receiving treatment at the time of the interview were asked whether they were receiving treatment for each of the substances they had used during their lifetime.⁷ If the respondent indicated this treatment was for more than one substance, they were asked to identify the main substance for which this treatment was received. These responses were used to determine which substances were the focus of the treatment they received during their current treatment episode.

The second estimate is based on responses to a question that asks respondents whether or not they were in substance use treatment on October 1 of the year prior to the survey. This estimate will be referred to as the “October 1 single-day treatment estimate.” Due to a significant percentage (36.2 percent) of cases with unknown information about the substance(s) for which treatment was received, we present only estimates of treatment for either alcohol or drug use.

Both the average-day single-day treatment estimates and the October 1 single-day treatment estimates include only reports of *specialty substance use treatment*, which includes treatment received at a hospital, a drug rehabilitation facility, or a mental health center.

The overall average-day single-day treatment count was 1,196,460 persons. Among those persons, 36.7 percent were treated for alcohol use only, 26.3 percent were treated for drug use only, 33.2 percent were treated for both alcohol and drug use, and for 3.8 percent, this information was unknown. The October 1 single-day treatment count was 1,434,851 persons, who were treated for either alcohol or drug use.

Limitations of the NSDUH Estimates

As with the previous two sets of estimates discussed, the NSDUH sample is drawn to be representative of the noninstitutionalized population of the United States. In addition, NSDUH relies on respondents to remember accurately and report honestly their substance use and substance use treatment experiences.

The NSDUH questions do not specifically ask whether a person was in *specialty treatment* on the day of the interview. Respondents are asked what service types (modalities) they received in the past year and what the main type of treatment they are currently receiving is (for those who are still in treatment). Those who received specialty treatment in the past year and were in treatment on the day of the interview have been included in the average-day single-day treatment counts. Constructing the average-day single-day treatment counts in this way likely includes persons who were in specialty treatment in the past year but were not receiving specialty treatment at the time of the interview (e.g., had been receiving outpatient treatment at a mental health facility 6 months ago and is only participating in a self-help group at the time of the interview). Likewise, constructing the average-day single-day counts in this manner likely excludes persons who were receiving in-patient or residential treatment on the day of the interview (persons staying in a hospital or residential treatment center would not be available for an interview).

2.3.2 TEDS Counts

Description of TEDS Counts

The TEDS single-day treatment counts were computed for the number of persons in treatment on the last working day in March from 2007 to 2009 (March

30, 2007; March 31, 2008; and March 31, 2009). TEDS person-level treatment counts were obtained for 47 States, either through linking the admissions and discharge data processed through October 10, 2011, or through an alternate estimation method. A more detailed description of the methods used to link admission and discharge records is provided in Section 1.2. The TEDS single-day treatment counts are derived from counts of the number of admissions to a *specialty substance abuse facility*.

TEDS admission data include the primary, secondary, and tertiary problem substances. These data are used to determine which substances were the focus of the treatment received. The average single-day treatment count for 2007 to 2009 was 532,109 persons. Among those persons, 19.3 percent were treated for alcohol use only, 40.9 percent were treated for drug use only, 37.4 percent were treated for both alcohol and drug use, and 2.4 percent had no reported substance use at the time of admission.

Limitations of the TEDS Counts

As mentioned previously, the generalizability of the TEDS counts is somewhat limited by the inclusion/exclusion criteria for the TEDS database and also by State-level differences in reporting requirements that affect which data are reported to TEDS from the individual States. TEDS explicitly excludes clients treated in an emergency room, a private doctor's office, a self-help group, or a jail/prison not run with State agency-administered funds. As Section 1.2 notes, many States require only publicly funded facilities to report data to TEDS, and some States only require facilities to report TEDS data for patients for whom treatment is publicly funded.

2.3.3 N-SSATS Counts

Description of N-SSATS Counts

N-SSATS includes a single-day census of the number of persons in hospital inpatient substance use treatment units, residential (nonhospital) treatment, or outpatient substance use treatment on the last working day of March of each year (March 30, 2007; March 31, 2008; and March 31, 2009). For outpatient facilities,

the count includes only active clients (those who were seen at the facility for substance use treatment or detoxification at least once during the month of March and who were still enrolled in treatment on the last working day of March).

N-SSATS data include the percentages of clients treated for only alcohol use, only drug use, or both alcohol and drug use, but it does not include information on whether alcohol or drugs were primary for those in treatment for both alcohol and drug use. The average single-day treatment count for 2007 to 2009 among all facilities was 1,153,617 persons. Among those persons, 18.8 percent were treated for alcohol use only, 36.0 percent were treated for drug use only, and 45.2 percent were treated for both alcohol and drug use.

2.3.4 National and Regional Estimates

Single-Day Treatment Counts for Alcohol or Drug Treatment

The single-day treatment counts in Figure 2.6 include persons who received treatment for either alcohol or drug use (also see Table C.2.2). As would be expected, the TEDS count (532,109) was significantly lower than either of the NSDUH or the N-SSATS counts. The NSDUH October 1 count (1,434,851) was the highest count, followed by the NSDUH average-day count (1,196,460). The N-SSATS all-facilities count (1,153,617) was somewhat lower than the NSDUH counts, followed by the N-SSATS count that excluded persons receiving treatment in hospitals (1,139,670). Regional counts for alcohol or drug treatment are consistent with the national counts for alcohol or drug treatment in that the NSDUH October 1 counts for alcohol or drug treatment were highest in all regions except the Northeast, followed by the NSDUH average-day counts, and the N-SSATS all-facilities counts. The TEDS counts were lowest in all regions.

Single-Day Treatment Counts for Alcohol-Only Treatment

Figure 2.7 and Table C.2.3 show single-day treatment counts (NSDUH average day, TEDS, and N-SSATS) of persons who were receiving treatment for alcohol use problems but not for other drugs. There was considerable variation across the four estimates. The NSDUH average-day count (438,665) was the highest,

followed by the N-SSATS count that included all facilities (216,832). The TEDS count was less than one third of the NSDUH average-day count and less than half of the N-SSATS all-facilities count. Because the facilities that report to TEDS are a subset of the facilities that report to N-SSATS, it is not surprising that the TEDS counts were less than the N-SSATS counts; as with all tables included in Appendix C, excluding hospitals from N-SSATS had a minimal impact on the single-day treatment counts. TEDS also represents mainly admissions to publicly funded substance use treatment facilities, perhaps explaining why this count was lower for TEDS than for NSDUH, which reflected treatment received at both public and private facilities.

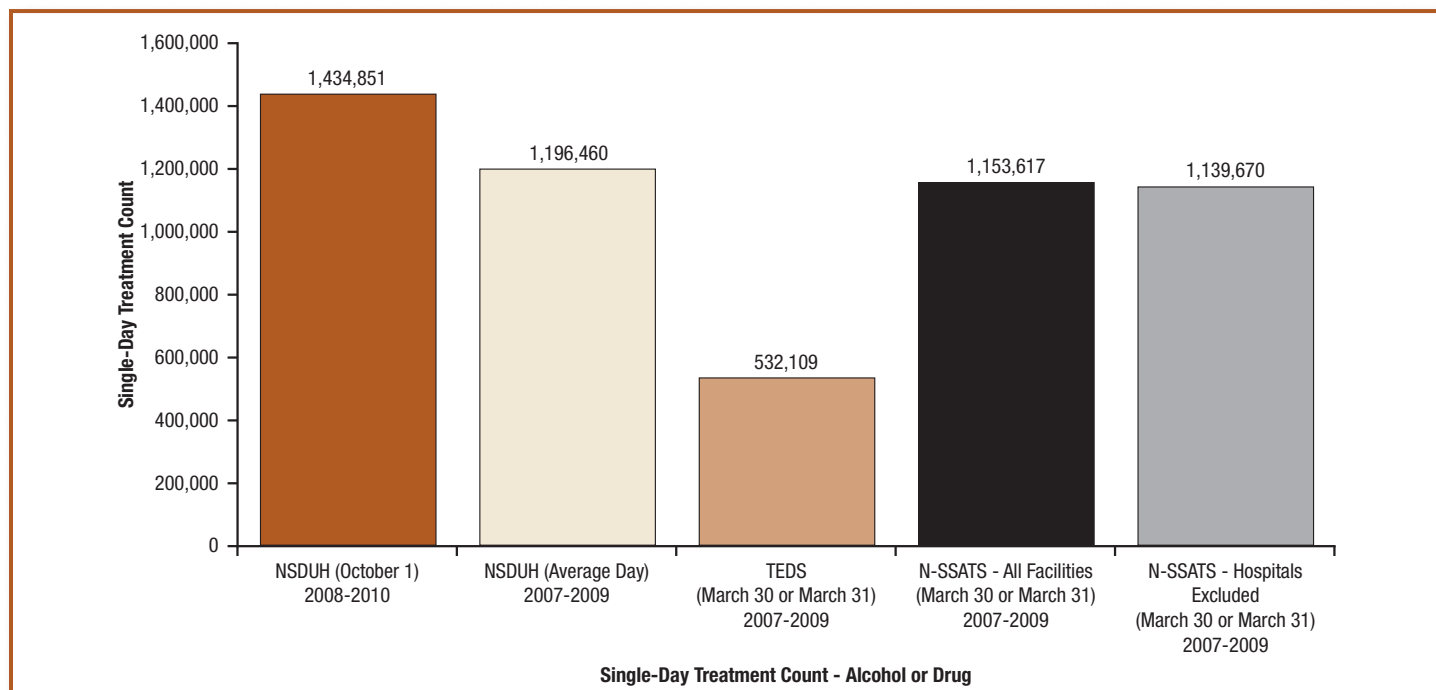
Table C.2.3 also shows regional single-day counts for alcohol-only treatment. The regional counts followed the same pattern as the national counts. The NSDUH average-day counts were significantly higher than the N-SSATS all-facilities counts except the Northeast,

and the TEDS counts were appreciably lower than the N-SSATS counts.

Single-Day Treatment Counts for Drug-Only Treatment

The pattern of estimates across data sources for single-day treatment counts for persons receiving treatment for drug use but not alcohol use problems was different than the pattern for alcohol or drug treatment and alcohol-only treatment (Figure 2.8; Table C.2.4). For example, the N-SSATS counts including all facilities (414,845) and excluding hospitals (411,654) were higher than the NSDUH average-day count (314,806). As was true of the alcohol-only and alcohol or drug counts, the TEDS count (217,502) was appreciably lower than the other counts. One possible explanation of this shift between the counts for alcohol-only treatment and drug-only treatment in NSDUH and N-SSATS is that the increased stigma of receiving treatment for a drug use problem relative to that for receiving treatment for an alcohol use problem suppressed the self-reports of drug treatment receipt in

Figure 2.6 National-Level Single-Day Treatment Counts for Alcohol or Drug Treatment: NSDUH 2008 to 2010 and 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined*



* TEDS national-level counts exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2007 to 2010; Treatment Episode Data Set (TEDS), 2007 to 2009; and National Surveys of Substance Abuse Treatment Services (N-SSATS), 2007 to 2009.

Figure 2.7 National-Level Single-Day Treatment Counts for Alcohol-Only Treatment: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined*

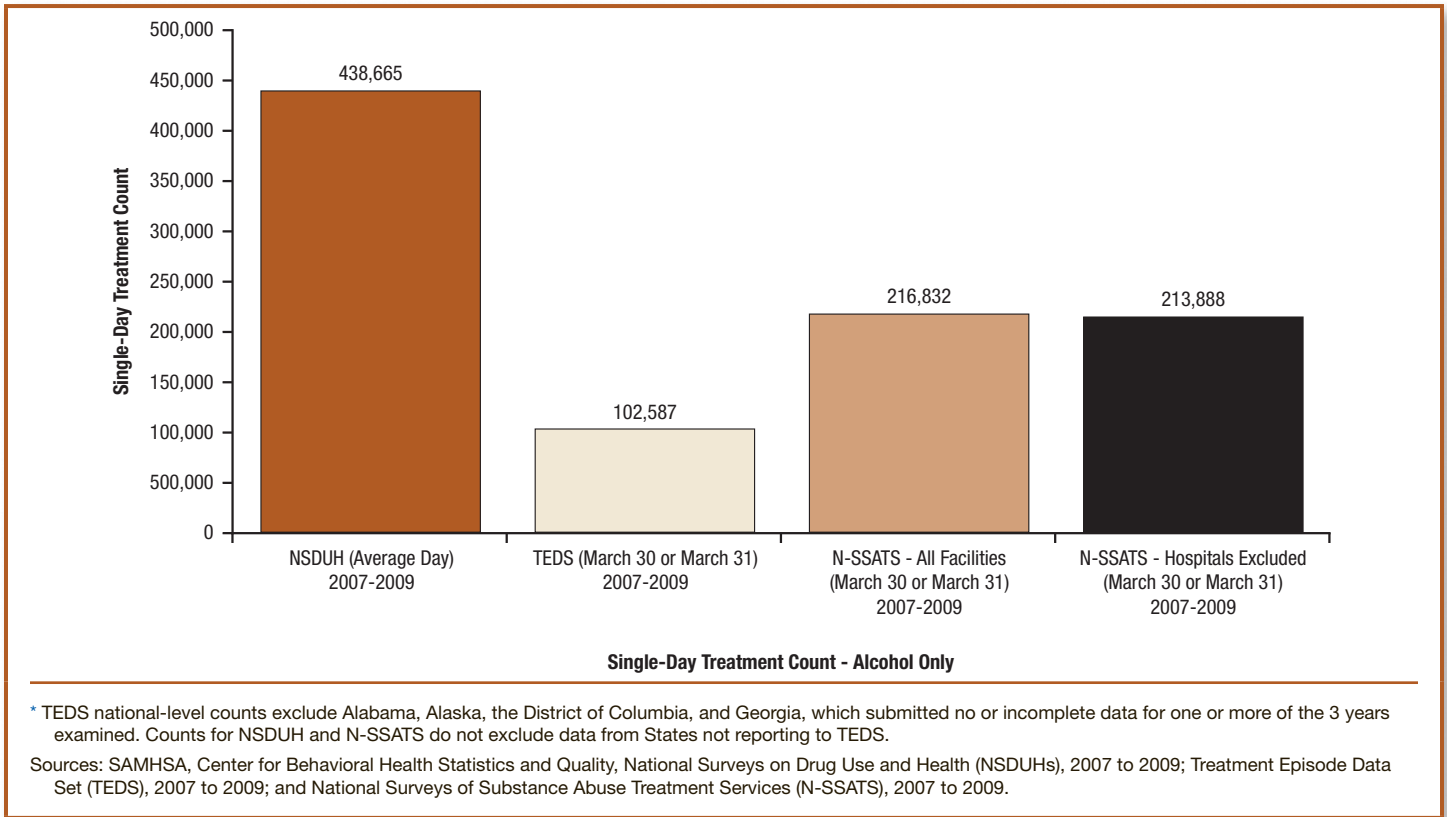
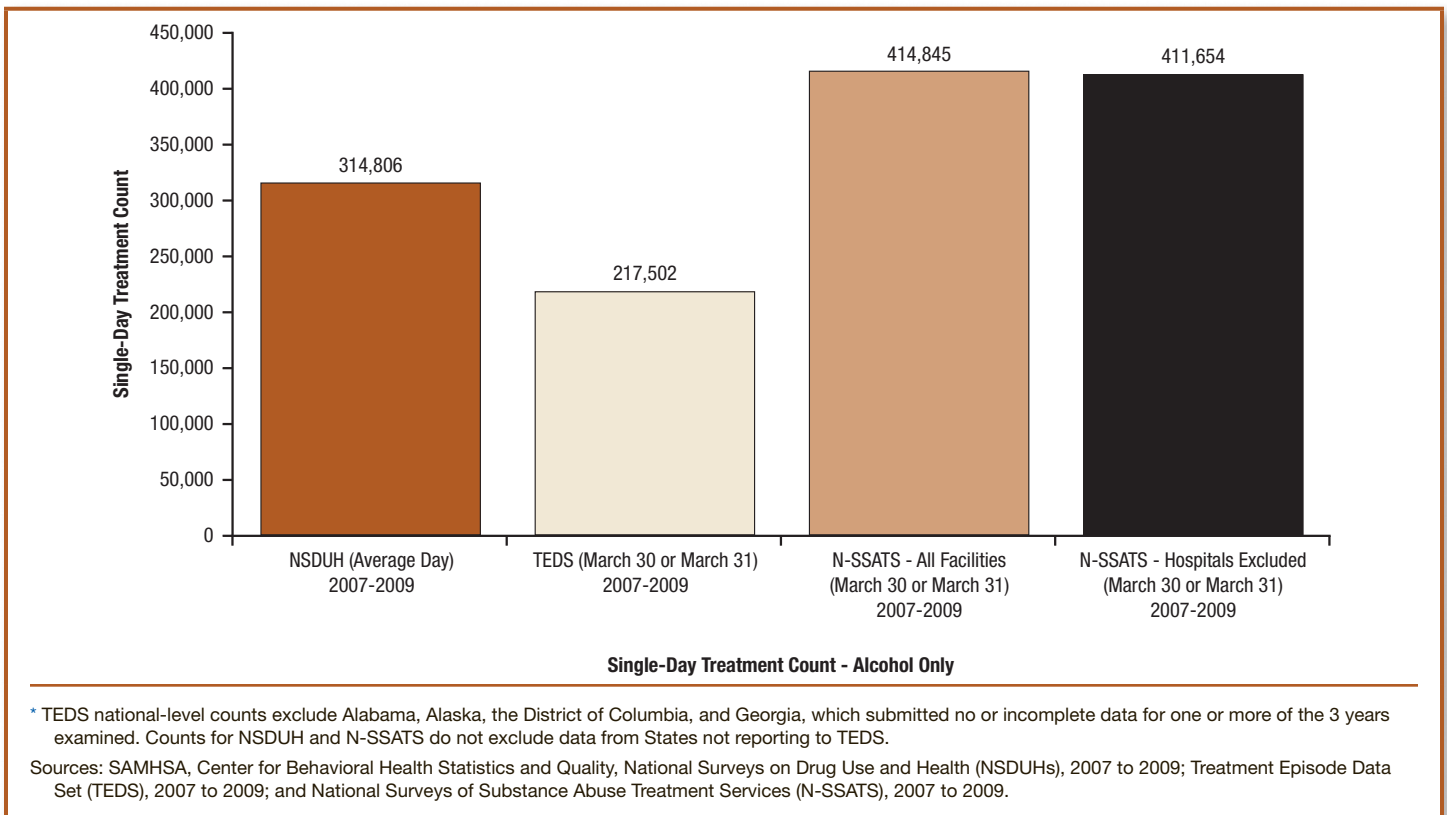


Figure 2.8 National-Level Single-Day Treatment Counts for Drug-Only Treatment: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined*



NSDUH more than self-reports of alcohol treatment receipt. There was considerable variation at the regional level in the pattern of single-day counts for drug-only treatment. In the West, for example, the N-SSATS counts were the highest (96,774 and 96,368), followed by the TEDS count (68,868), with the NSDUH average-day count (62,355) as the lowest. In contrast, in the South, the N-SSATS counts were the highest (128,179 and 127,076), but the TEDS count (31,364) was less than one third of the NSDUH average-day count (Table C.2.4).

Single-Day Treatment Counts for Alcohol and Drug Treatment

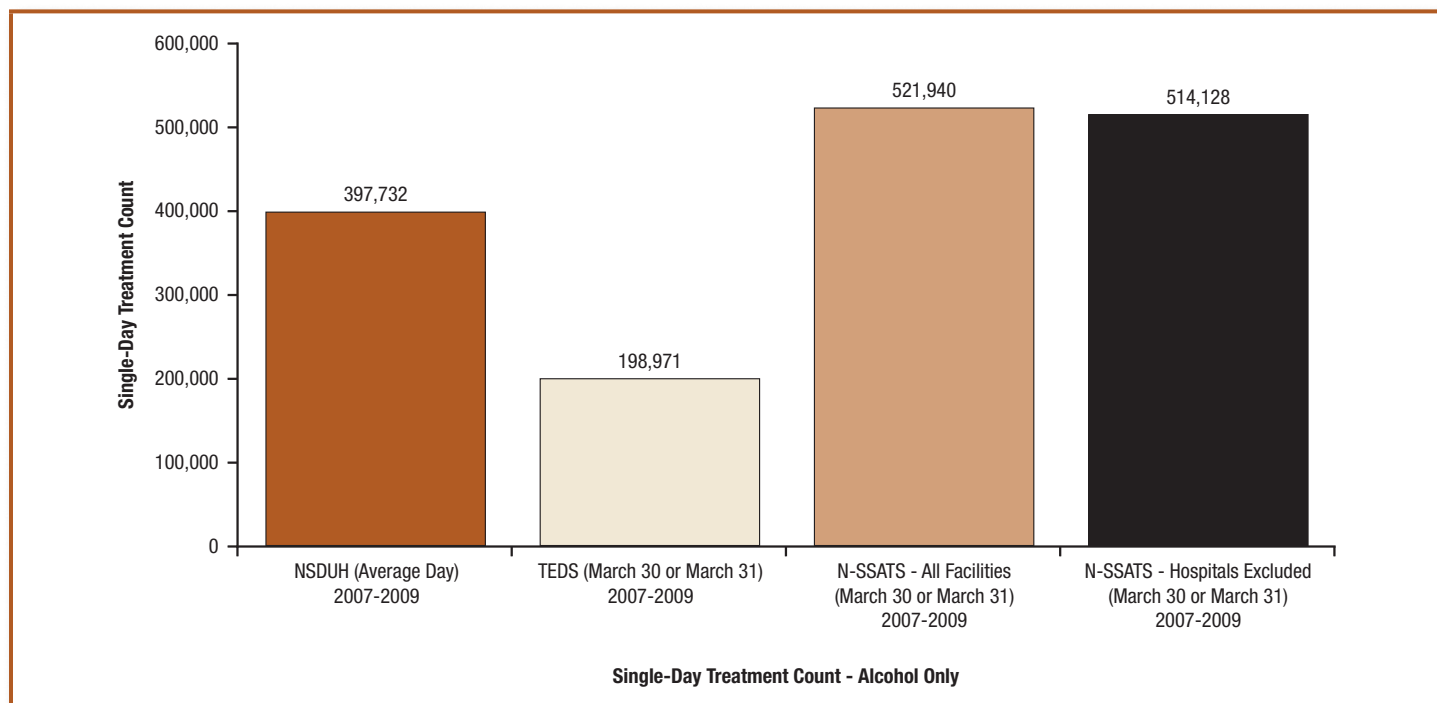
Figure 2.9 presents single-day treatment counts for persons receiving treatment for both alcohol and drug use problems (also see Table C.2.5). These counts show a pattern similar to those seen in the drug-only counts in that the N-SSATS counts (521,940 and 514,128) were significantly higher than both the NSDUH average-day count (397,732) and the TEDS count

(198,971), and the NSDUH average-day count was significantly higher than the TEDS count. Several of the regional counts for alcohol and drug treatment show a different pattern than do the national counts. For example, in the Midwest, the TEDS count (61,125) was not significantly lower than the NSDUH average-day count (63,211), although both were appreciably lower than the N-SSATS counts (109,918 and 108,793). In the South, the NSDUH average-day count (120,097) was not significantly lower than the N-SSATS counts (134,368 and 131,470), and both were more than 4 times higher than the TEDS count (26,589). These regional differences are difficult to interpret, which may be due to regional variations in collecting N-SSATS and/or TEDS data.

Single-Day Treatment Counts for Primary Alcohol with Secondary Drug Treatment

Figure 2.10 presents single-day treatment counts (NSDUH average day and TEDS) for persons receiving treatment for both alcohol and drug use problems

Figure 2.9 National-Level Single-Day Treatment Counts for Alcohol and Drug Treatment: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined*



* TEDS national-level counts exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2007 to 2009; Treatment Episode Data Set (TEDS), 2007 to 2009; and National Surveys of Substance Abuse Treatment Services (N-SSATS), 2007 to 2009.

and for whom alcohol was the primary substance of abuse (information on the primary substance of abuse for persons in treatment for both alcohol and drug problems is not available from N-SSATS) (also see Table C.2.6). These counts show a pattern similar to those seen in all of the previously reported counts in that the NSDUH average-day count (165,571) was significantly higher than the TEDS count (86,898). In two of the regional counts, however, the TEDS counts were not significantly lower than the NSDUH counts. In the Northeast, the NSDUH count was 29,702, and the TEDS count was 25,999. In the Midwest, the NSDUH count was 22,992, and the TEDS was 28,262, although the difference was not statistically significant.

Single-Day Treatment Counts for Primary Drug with Secondary Alcohol Treatment

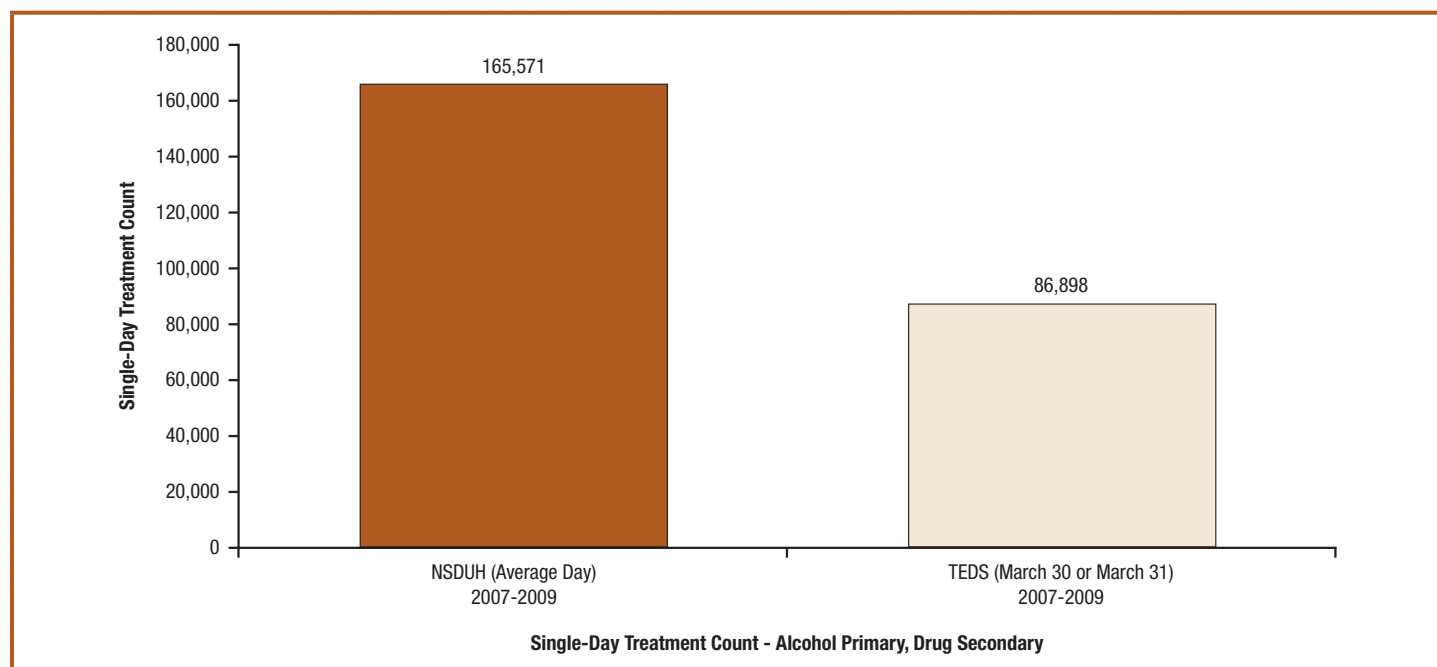
Figure 2.11 presents single-day treatment counts from NSDUH (average day) and TEDS for persons receiving treatment for both alcohol and drug use problems and for whom a substance other than alcohol was their primary substance of abuse (information on the

primary substance of abuse for persons in treatment for both alcohol and drug problems is not available from N-SSATS) (also see Table C.2.7). Similar to what was found with other counts, the TEDS count (111,973) was significantly lower than the NSDUH average-day count (228,813). Regional counts for primary drug with secondary alcohol treatment are consistent with the national counts in that the TEDS counts were lower than the NSDUH average-day counts. These differences were statistically significant in all regions but the Midwest.

2.3.5 State Estimates

The single-day treatment counts presented previously at the national and regional levels were also estimated for each of the 50 States and the District of Columbia. This section of the report focuses on the single-day treatment counts from the eight States with the largest populations (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas). These States were selected for inclusion because the NSDUH sample size for these eight States was roughly 4 times

Figure 2.10 National-Level Single-Day Treatment Counts for Primary Alcohol with Secondary Drug Treatment: NSDUH 2007 to 2009 Combined and TEDS 2007 to 2009 Combined*



* TEDS national-level counts exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined. Counts for NSDUH do not exclude data from States not reporting to TEDS.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2007 to 2009; and Treatment Episode Data Set (TEDS), 2007 to 2009.

the sample size for the other States, resulting in more precise estimates for these States. The estimates for the eight largest States are given at the bottom of Tables C.2.2-C.2.7, and single-day treatment counts for all 50 States plus the District of Columbia are presented in Tables C.2.8-C.2.12.

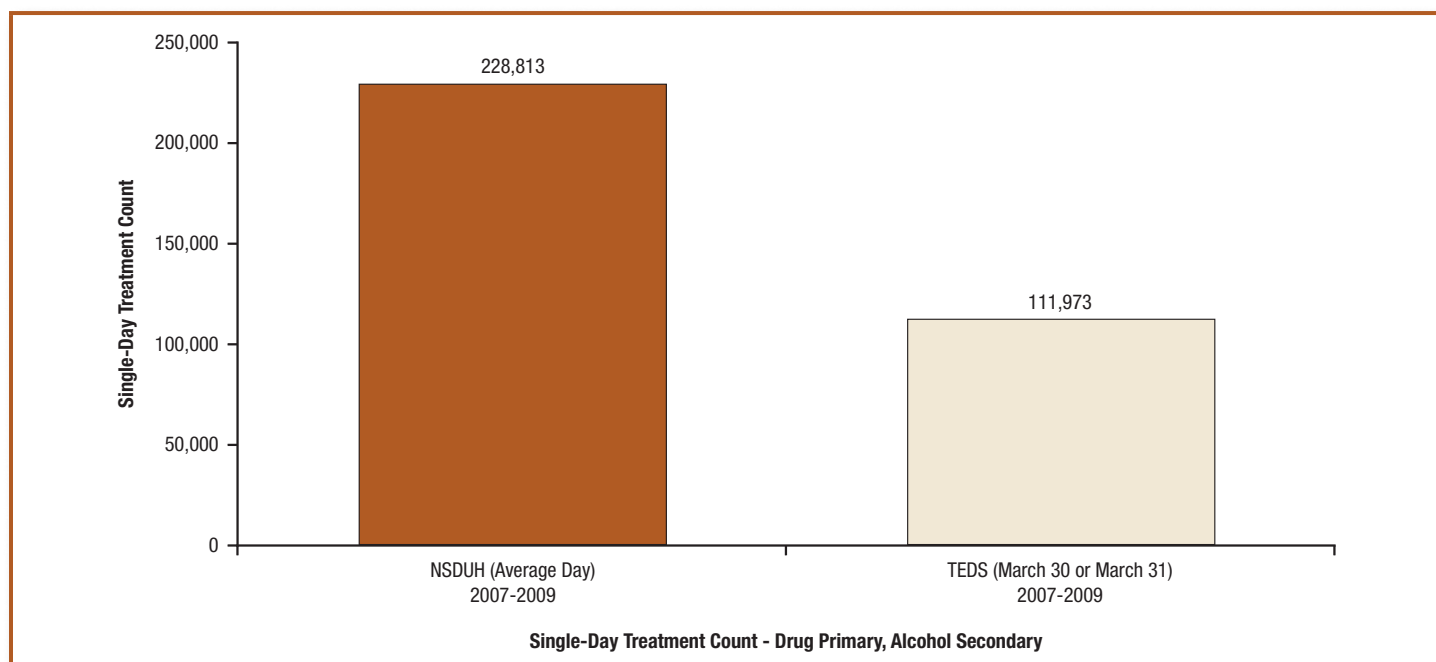
Single-Day Treatment Counts for Alcohol or Drug Treatment

The single-day treatment counts in Figure 2.12 include persons who received treatment for either alcohol or drug use (also see Table C.2.2). The estimates for these counts from seven of the eight States show a similar pattern to those of the national and several of the regional counts, in that the NSDUH October 1 count is the highest among the five data source estimates. The exception is New York, for which the N-SSATS count (117,075) is higher than both the NSDUH October 1 count (110,008) and the NSDUH average-day count (100,975), although neither difference is statistically significant. In six of the eight States, the TEDS estimates are the lowest, though not always statistically significantly so.

Single-Day Treatment Counts for Alcohol-Only Treatment

Figure 2.13 shows single-day treatment counts for persons receiving treatment for alcohol use problems but not for other drugs, among the eight largest States (also see Table C.2.3). As with the counts for the Nation as a whole, all States had a higher NSDUH average-day count than any other count, although the differences between NSDUH and N-SSATS all-facilities counts in Illinois and New York were not statistically significant. Note that there is less variability between the counts in New York than between those in the other States, with a range from 20,683 (the NSDUH average-day count for New York) to 13,131 (the TEDS count for New York). In other States, such as California, there is a much larger gap between estimates. These differences in variability between estimates are likely caused by variability in individual State reporting requirements for TEDS data. In New York, all facilities that receive State/public funding and all facilities that are licensed/certified by the SSA are required to report data on all clients in the facility, whereas in Florida, facilities that receive State/public funding are required to report data on all clients,

Figure 2.11 National-Level Single-Day Treatment Counts for Primary Drug with Secondary Alcohol Treatment: NSDUH 2007 to 2009 Combined and TEDS 2007 to 2009 Combined*



* TEDS national-level counts exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined. Counts for NSDUH do not exclude data from States not reporting to TEDS.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2007 to 2009; and Treatment Episode Data Set (TEDS), 2007 to 2009.

and in Illinois, facilities that receive funding through the SSA are required to report data on State-funded/ publicly funded clients only.⁸

Single-Day Treatment Counts for Drug-Only Treatment

Single-day treatment counts for persons receiving treatment for drug use but not alcohol use problems are shown in Figure 2.14 (and Table C.2.4). As was true for the national estimates, the single-day drug-only treatment counts from the eight States reflect a different pattern from the alcohol-only treatment counts. The N-SSATS count including all facilities is the highest count among the five estimates except those for Illinois, where the NSDUH average-day count is larger than the N-SSATS all-facilities count (20,963 vs. 16,527), and Pennsylvania, where the NSDUH average-day count is larger than the N-SSATS all-facilities count (29,081 vs. 19,470). Note that the differences between the N-SSATS count and NSDUH estimates in Florida, New York, Pennsylvania, and Texas are not statistically significant. There is considerable variation between the estimates for each of the eight States.

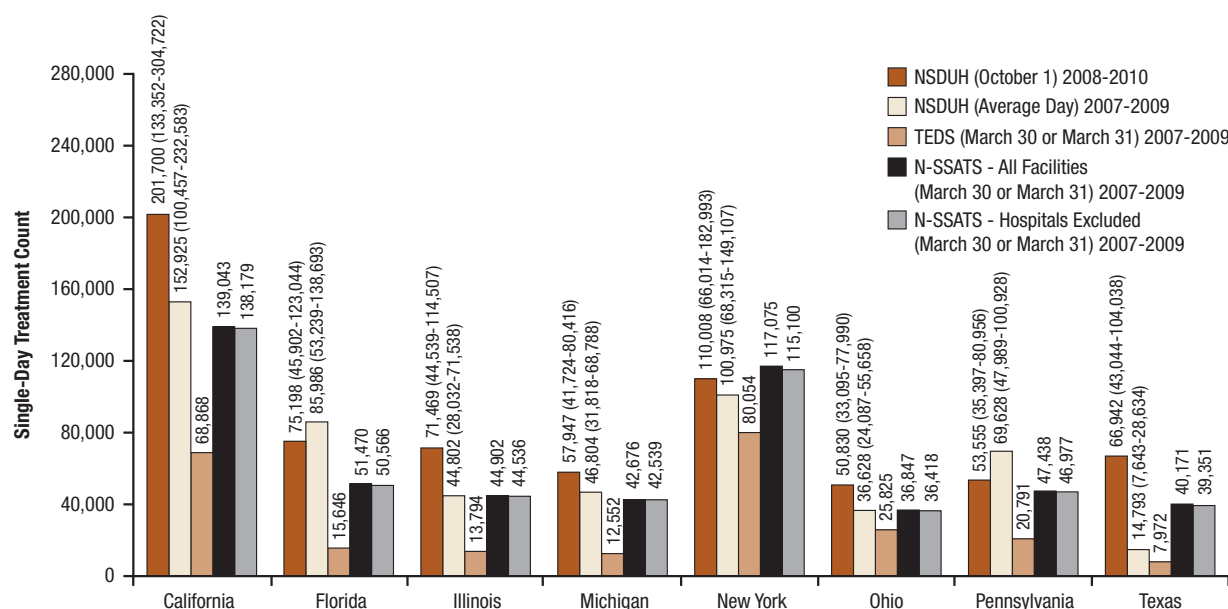
Single-Day Treatment Counts for Alcohol and Drug Treatment

Figure 2.15 shows single-day treatment counts (NSDUH average day, TEDS, and N-SSATS) for persons receiving treatment for both alcohol and drug use problems (also see Table C.2.5). There is a great amount of variation between estimates within individual States. The TEDS estimate is the lowest of the counts in all States, although not significantly so in Illinois, New York, Ohio, and Texas.

Single-Day Treatment Counts for Primary Alcohol with Secondary Drug Treatment

Figure 2.16 shows single-day treatment counts (NSDUH average day and TEDS) for persons receiving treatment for both alcohol and drug use problems and for whom alcohol was the primary substance of abuse (also see Table C.2.6). With the exceptions of Florida and New York, the NSDUH average-day estimates are higher than the TEDS counts. This difference was statistically significant only in California and Michigan. No NSDUH average-day estimate is reported for Illinois due to low precision.

Figure 2.12 Single-Day Treatment Counts for Alcohol or Drug Treatment for the Eight Largest States: NSDUH 2008 to 2010 and 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined



Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2007 to 2010; Treatment Episode Data Set (TEDS), 2007 to 2009; and National Surveys of Substance Abuse Treatment Services (N-SSATS), 2007 to 2009.

Figure 2.13 Single-Day Treatment Counts for Alcohol-Only Treatment for the Eight Largest States: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined

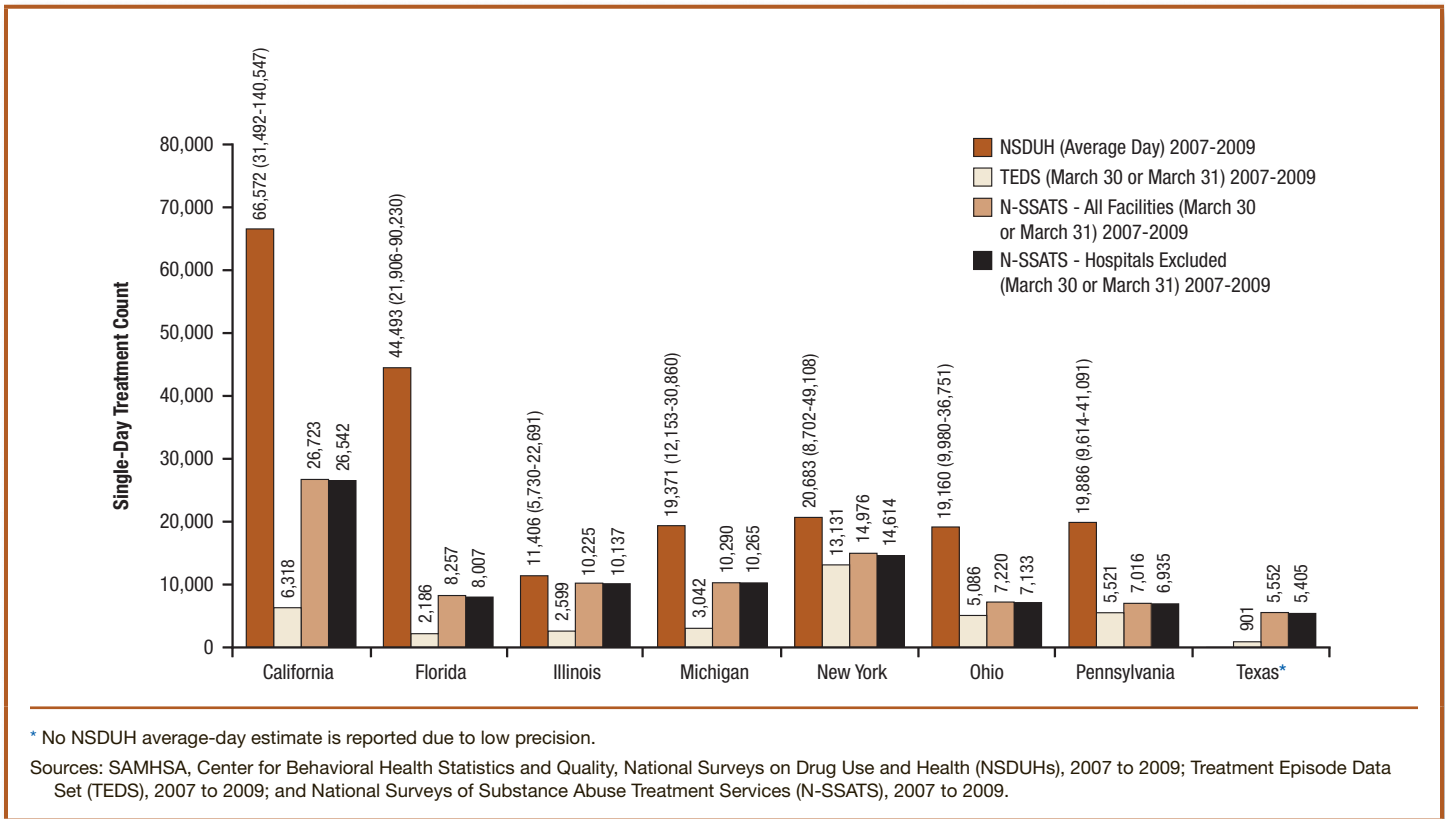


Figure 2.14 Single-Day Treatment Counts for Drug-Only Treatment for the Eight Largest States: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined

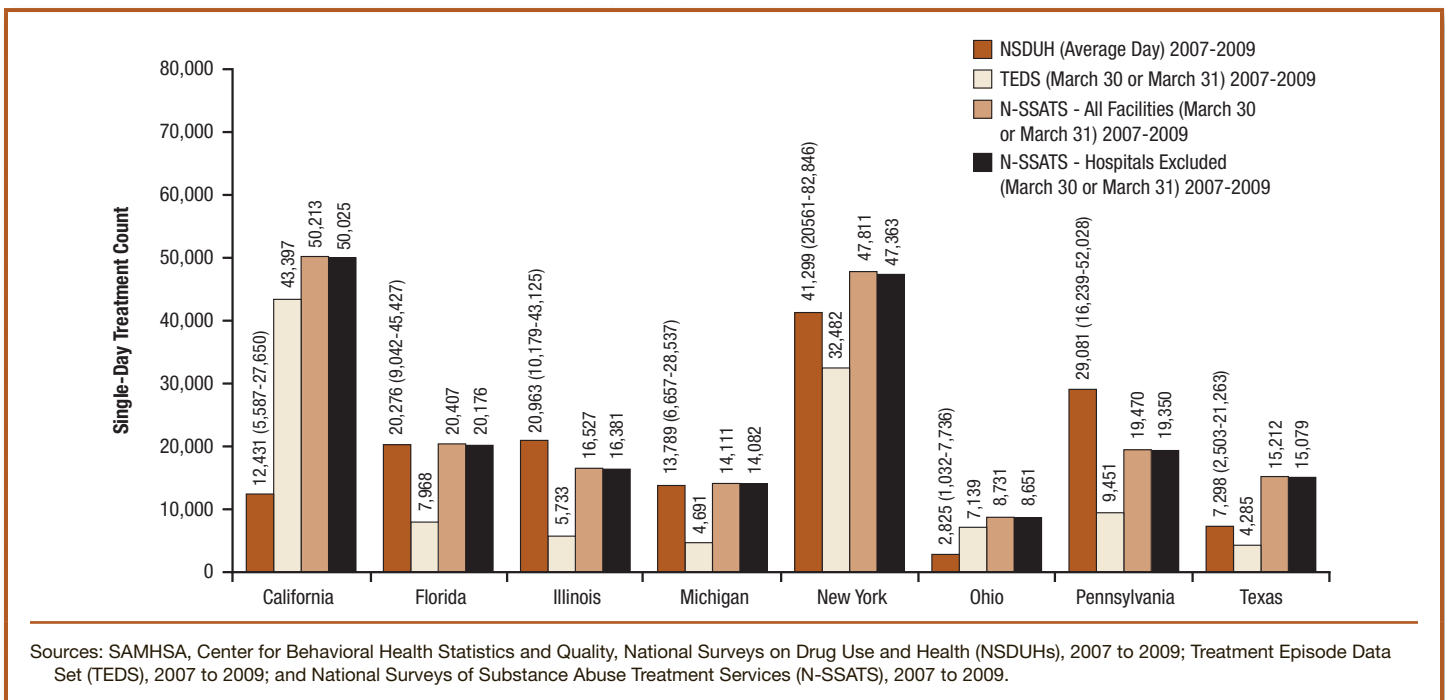


Figure 2.15 Single-Day Treatment Counts for Alcohol and Drug Treatment for the Eight Largest States: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined

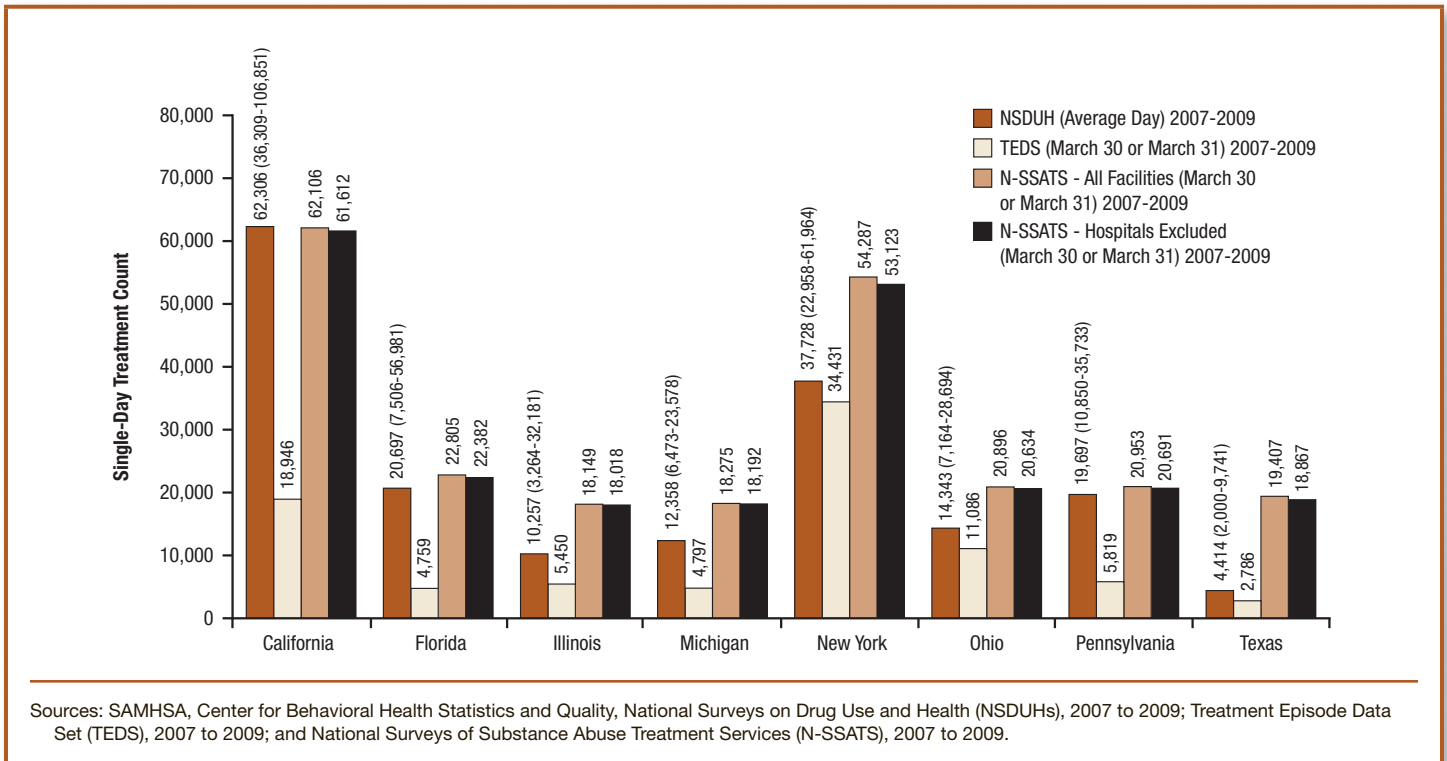
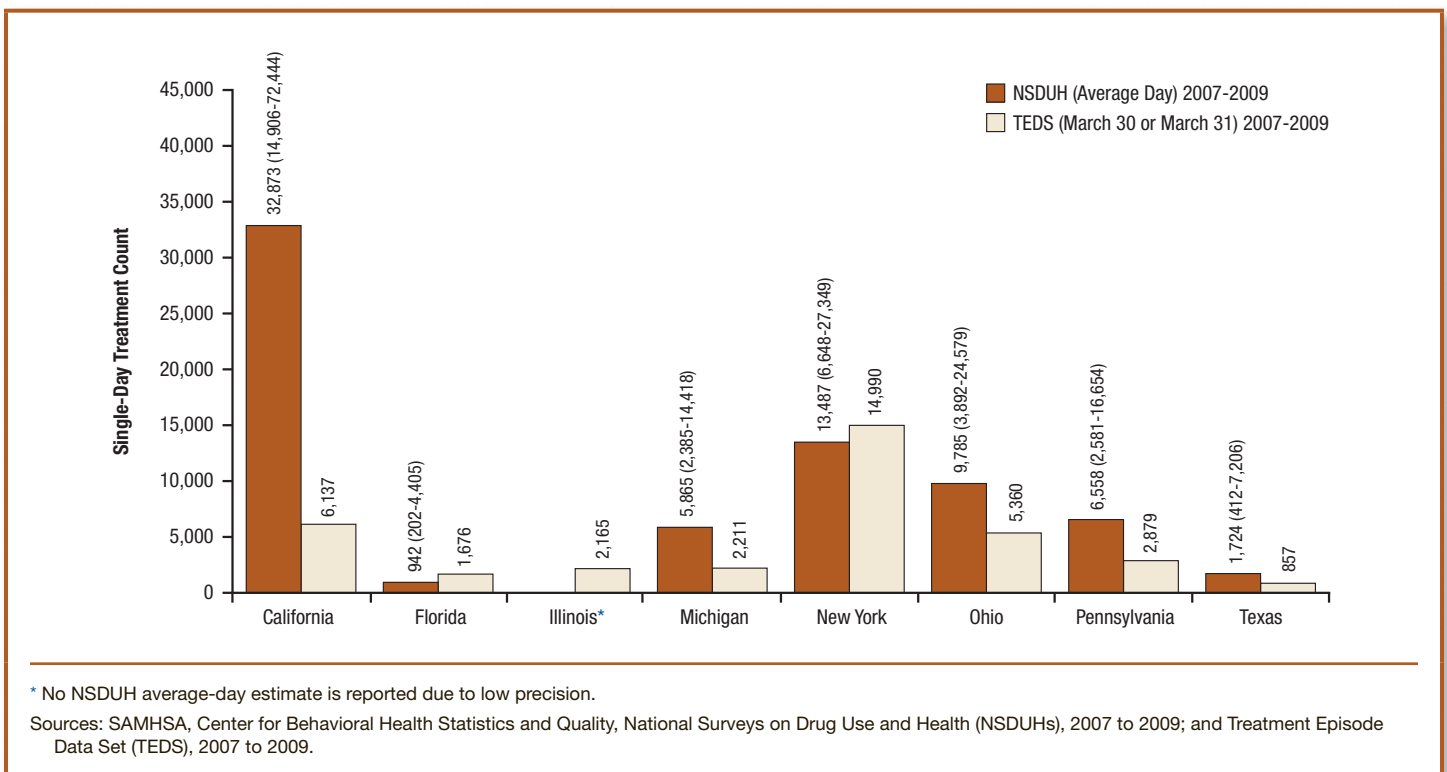


Figure 2.16 Single-Day Treatment Counts for Primary Alcohol with Secondary Drug Treatment for the Eight Largest States: NSDUH 2007 to 2009 Combined and TEDS 2007 to 2009 Combined



Single-Day Treatment Counts for Primary Drug with Secondary Alcohol Treatment

Figure 2.17 shows single-day treatment counts for persons receiving treatment for both alcohol and drug use problems and for whom a substance other than alcohol was the primary substance of abuse (also see Table C.2.7). With the exception of Ohio, the NSDUH average-day estimates are higher than the TEDS counts. This difference was statistically significant in California, Florida, and Pennsylvania.

Seasonality of Admissions

One issue that could impact comparisons between the single-day treatment counts based on the NSDUH October 1 measure and the TEDS and N-SSATS measures based on the last working day in March is seasonality of treatment admissions. If there are differences in the overall number of admissions around the times of these single-day treatment counts—for example, more admissions in the fall than in the spring—this could help explain the variation found in the counts between these data sources. In order to investigate whether there is seasonal variation in treatment admissions, we analyzed the TEDS

admissions data from 2006 and 2007. These data show variation in admissions across the year, and the admissions patterns in both years were similar (see Figure 2.18). Average daily admissions for 2006 and 2007 combined ranged from a low of 4,262 in December to a high of 5,606 in January.

Because substance dependence is a chronic disorder that often requires long-term treatment, we also looked at TEDS linked admission and discharge data from 2006 and 2007 to investigate whether there is seasonal variation in the number of clients receiving treatment. Among these clients, there were between 325,000 and 425,000 clients in treatment every day during 2006 and 2007. As Figure 2.19 shows, the patterns in both years were similar, with distinct dips in the number of persons receiving treatment at the end of June and the end of December. Note that one possible reason for the dip at the end of June is that the fiscal year ends at this time for some States, and resources for substance use treatment may be reduced during this period relative to other times of the year. Also note that the number of persons in treatment was somewhat higher at the end of March (an average of 410,906 persons in treatment on the last working day of March) than at the beginning of

Figure 2.17 Single-Day Treatment Counts for Primary Drug with Secondary Alcohol Treatment for the Eight Largest States: NSDUH 2007 to 2009 Combined and TEDS 2007 to 2009 Combined

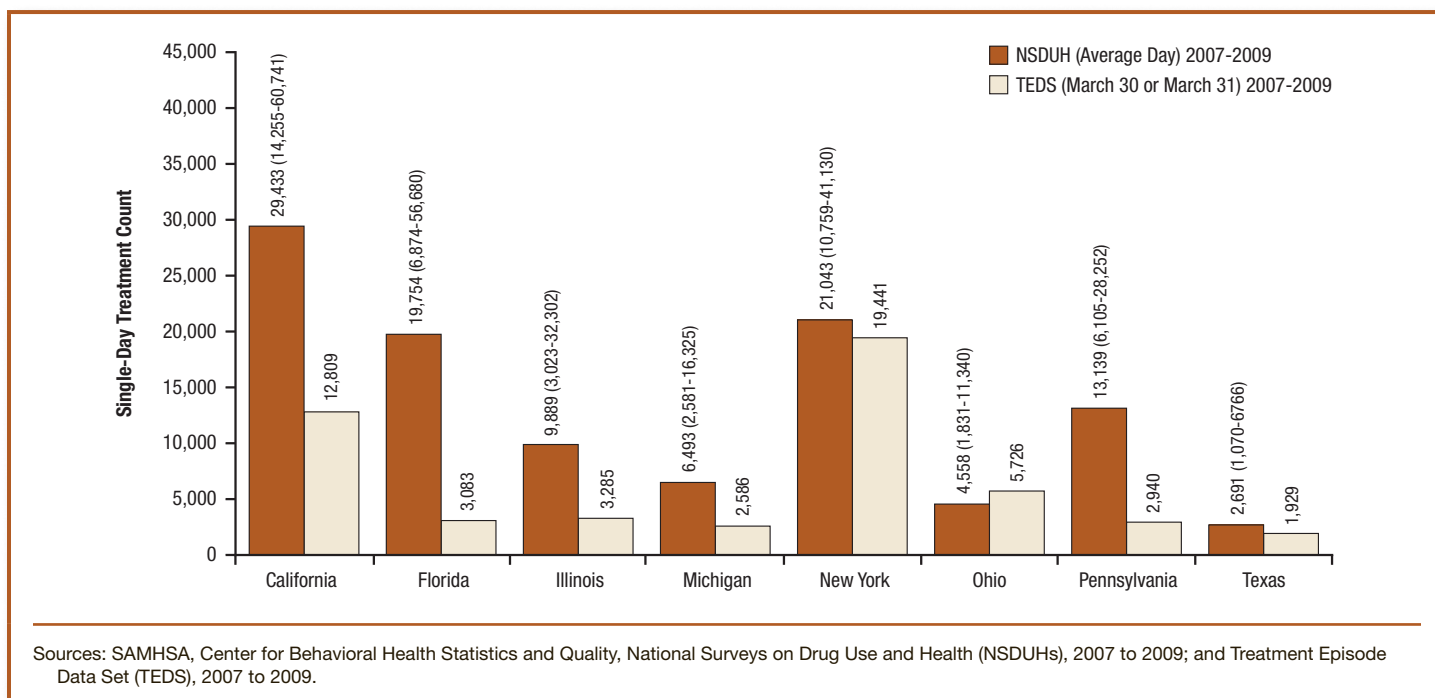


Figure 2.18 Average TEDS Admissions per Day,* by Month: 2006 and 2007

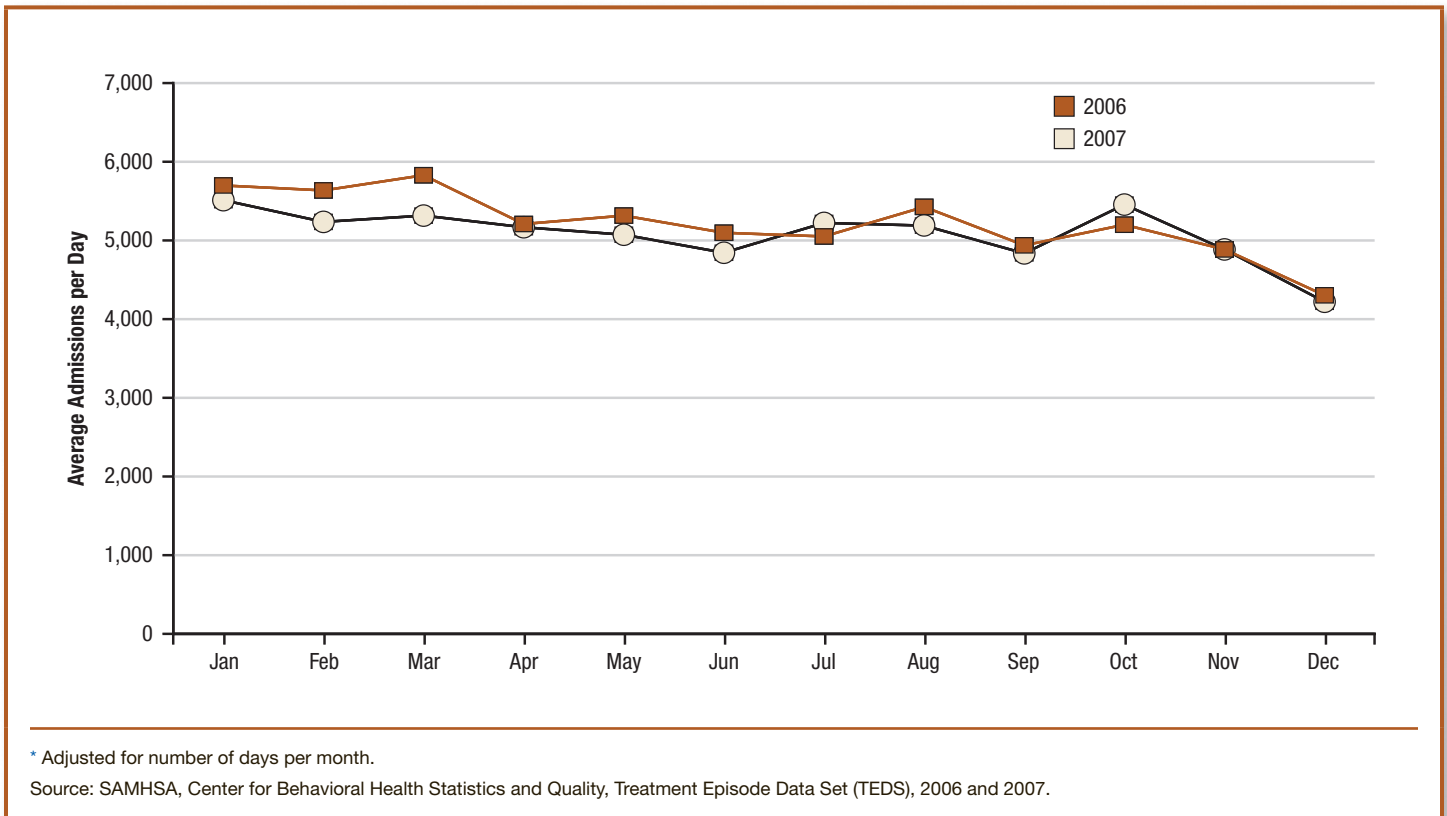
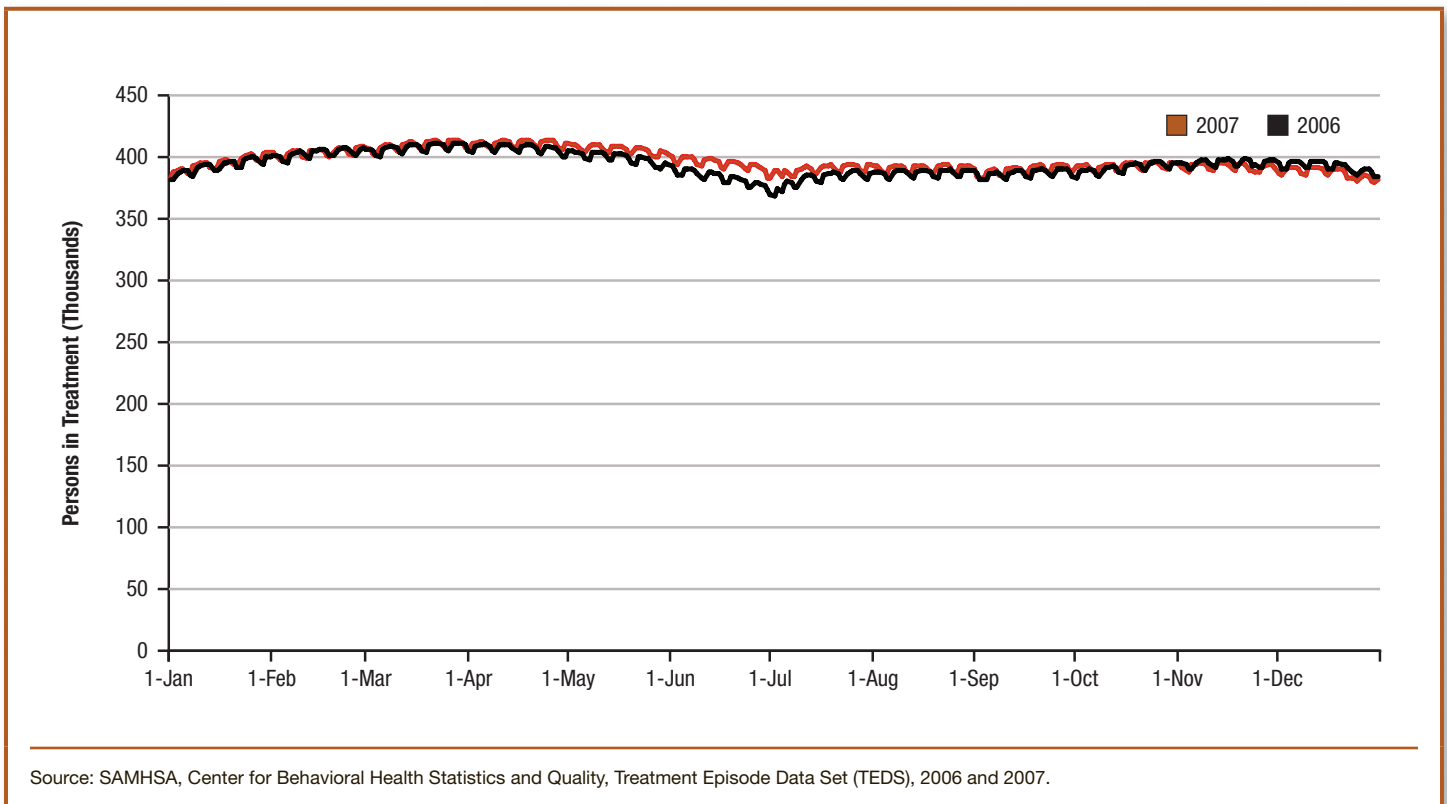


Figure 2.19 Daily Numbers of Persons in Substance Use Treatment: TEDS 2006 and 2007



October (an average of 390,277 persons in treatment on October 1). These data indicate that although there are seasonal differences in the number of persons receiving substance use treatment, the differences found between the end of March and the beginning of October do not seem to be marked enough to explain the differences found between NSDUH single-day treatment estimates and the single-day treatment counts from TEDS and N-SSATS.

2.3.6 Conclusions and Limitations

Table 2.1 shows the single-day treatment counts for all alcohol or drug treatment, as well as those for alcohol only, drugs only, and alcohol and drugs, including, when available, treatment for alcohol and drugs in which alcohol was the primary substance and treatment for alcohol and drugs in which a drug was the primary substance. Figure 2.20 illustrates the proportion of the overall single-day treatment counts from each source that received treatment for alcohol only, drugs only, and alcohol and drugs. The N-SSATS and NSDUH single-

day treatment counts for alcohol or drug treatment are nearly twice the TEDS count. It is unclear if this is solely because the facilities that report to TEDS and the clients that are reported about in TEDS are associated with the receipt of public funds, whereas NSDUH estimates and N-SSATS counts reflect treatment received at both publicly and privately funded facilities. Excluding clients receiving care at hospitals from N-SSATS had a minimal impact on the N-SSATS single-day treatment counts. The NSDUH single-day estimates range from more than 100 percent higher than the N-SSATS estimate (based on the average-day count for alcohol-only treatment) to 25 percent lower (based on the average-day count for drugs only).

The NSDUH single-day treatment count for alcohol-only treatment is more than 4 times the TEDS count, but the TEDS single-day treatment count for drug-only treatment is about two thirds the NSDUH count. One possible explanation for this shift in the difference between NSDUH and TEDS counts for alcohol-only and drug-only treatment is that the increased stigma

Table 2.1 Single-Day Treatment Counts¹ for Alcohol or Drug Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Substance for Which Treatment Was Received: NSDUH 2008 to 2010 Combined (October 1 and Average-Day Counts), N-SSATS 2007 to 2009 Combined (All Facilities), and TEDS 2007 to 2009 Combined

	NSDUH October 1 2008 to 2010		NSDUH Average Day 2007 to 2009 ^{2,3}		TEDS March 30 or March 31 2007 to 2009		N-SSATS – All Facilities March 30 or March 31 2007 to 2009	
	#	95% CI	#	95% CI	#		#	
Any Treatment	1,434,851	(1,278,112-1,610,688)	1,196,460	(1,066,843-1,341,740)	532,109		1,153,617	
Alcohol Only	NA	NA	438,665	(354,848-542,237)	102,587		216,832	
Drugs Only	NA	NA	314,806	(261,637-378,764)	217,502		414,845	
Alcohol and Drugs	NA	NA	397,732	(333,100-474,879)	198,871		521,940	
Alcohol Primary	NA	NA	165,571	(125,368-218,657)	86,898		NA	
Drug Primary	NA	NA	228,813	(180,823-289,525)	111,973		NA	
Unknown Substance	NA	NA	45,257	(29,579-69,242)	13,148		NA	

NA = not available.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. NSDUH "Treatment" includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43. "Alcohol or drug treatment" refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and those for whom the substance for which they were treated is unknown are included.

² NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

³ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

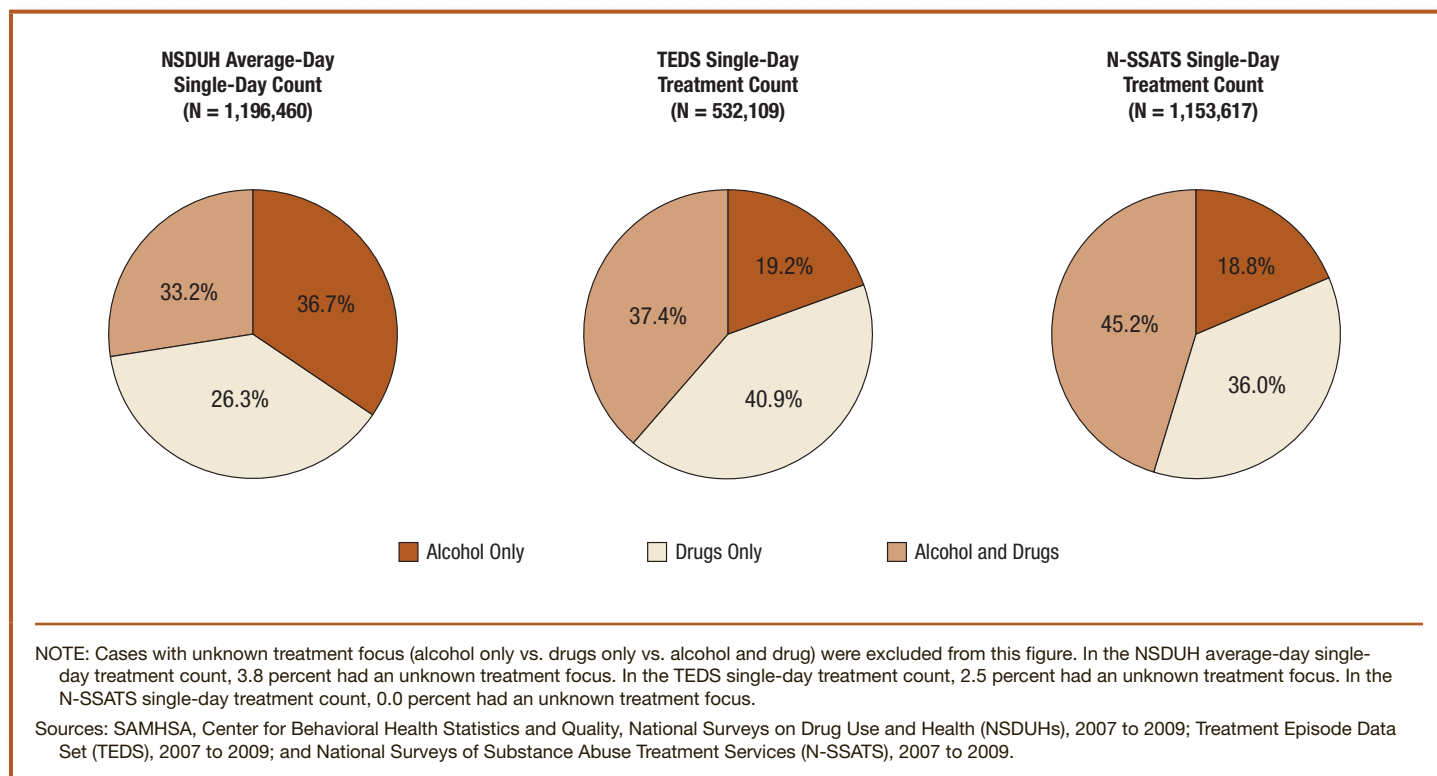
of receiving treatment for a drug use problem relative to receiving treatment for an alcohol use problem suppressed the self-reports of drug treatment receipt in NSDUH more so than self-reports of alcohol treatment receipt. Among other possible explanations, TEDS may not include a representative proportion of facilities that treat alcohol in the absence of other drug problems, problems related to alcohol use are minimized in the context of other drug use at the time of treatment admission, or a disproportionate number of persons who seek alcohol treatment receive the treatment at private facilities that are less likely to be included in TEDS.

There are two issues that limit the utility of national TEDS single-day treatment counts. First, a great deal of variability exists between States in data reporting requirements and, consequently, in the data reported to TEDS. In some States (such as New York), nearly all substance use treatment facilities are required to report TEDS data, whereas in other States, the reporting requirements are not as broadly applied. In many States, the only treatment facilities that report TEDS data are

those that receive public funding. The N-SSATS data for these estimates are based on counts of persons in treatment on a single day of the year, the last working day of March. About 80 percent of the N-SSATS single-day count is comprised of clients receiving outpatient treatment. For outpatient clients, all clients who received any outpatient service in the month of March who had not been discharged as of the last working day of March are included in the single-day count. Seasonal variation of admissions may affect the representativeness of these estimates.

Each of the national single-day treatment estimates (NSDUH, TEDS, and N-SSATS) provides unique information about the number of persons receiving treatment on a given day of the year. N-SSATS is designed to provide a single-day treatment count. The N-SSATS count across all facilities is likely the most inclusive and stable estimate. The counts from TEDS (with some exceptions, such as New York State) provide information that more likely reflects the number of persons receiving treatment in publicly funded substance use treatment facilities that provide

Figure 2.20 Percentages of Single-Day Treatment Counts Attributable to Alcohol Only, Drug Only, and Alcohol and Drug Treatment: NSDUH 2007 to 2009 Combined, N-SSATS 2007 to 2009 Combined, and TEDS 2007 to 2009 Combined



rehabilitation treatment services. The NSDUH estimates provide an estimation of the number of persons from the noninstitutionalized household population who were in substance use treatment (or specialty substance use treatment) on a single day of the year (October 1 of the year prior to the survey) or an average day of the year. The single-day count from TEDS was calculated using the last working day of March to match the date used in N-SSATS. The relative lack of seasonal differences in TEDS admissions indicates that comparisons of single-day counts from N-SSATS or TEDS with single-day counts from NSDUH (which uses an October 1 date) are reasonable. At the national level, the October 1 single-day treatment estimate from NSDUH is higher than the average-day estimates, although this pattern does not hold for all regions and States. These differences may reflect seasonal differences particular to a given region of the country, or they may be due to differences in the way the two estimates are derived (i.e., one is based on a question asking about having been in treatment on a particular day in the past and the other is based on the respondent currently being in treatment).

2.4. Past Year Admissions Counts

This section presents comparisons between TEDS and N-SSATS counts of the total number of substance use treatment admissions for a given calendar year.

2.4.1 TEDS Counts

Description of TEDS Counts

The TEDS counts of the number of persons who were admitted to substance use treatment are derived from admission records. As previously noted, TEDS data are less likely to include admissions for privately funded treatment than admissions for publicly funded treatment. The limitations of these counts are detailed subsequently.

Limitations of the TEDS Counts

TEDS does not include all admissions to substance abuse treatment. In some States, it includes admissions to facilities that are licensed or certified by an SSA to provide substance abuse treatment (or that are administratively tracked for other reasons). With few

exceptions, TEDS does not include clients treated in a jail/prison not run with State agency-administered funds, emergency rooms, private doctor's offices, or self-help groups. As Section 1.2 notes, many States require only publicly funded facilities to report data to TEDS, and some States only require facilities to report TEDS data for patients for whom treatment is publicly funded. Also noted in Section 1.2, hospital inpatient substance use treatment facilities are frequently not licensed through the SSA and may not be required to report TEDS data.

2.4.2 N-SSATS Counts

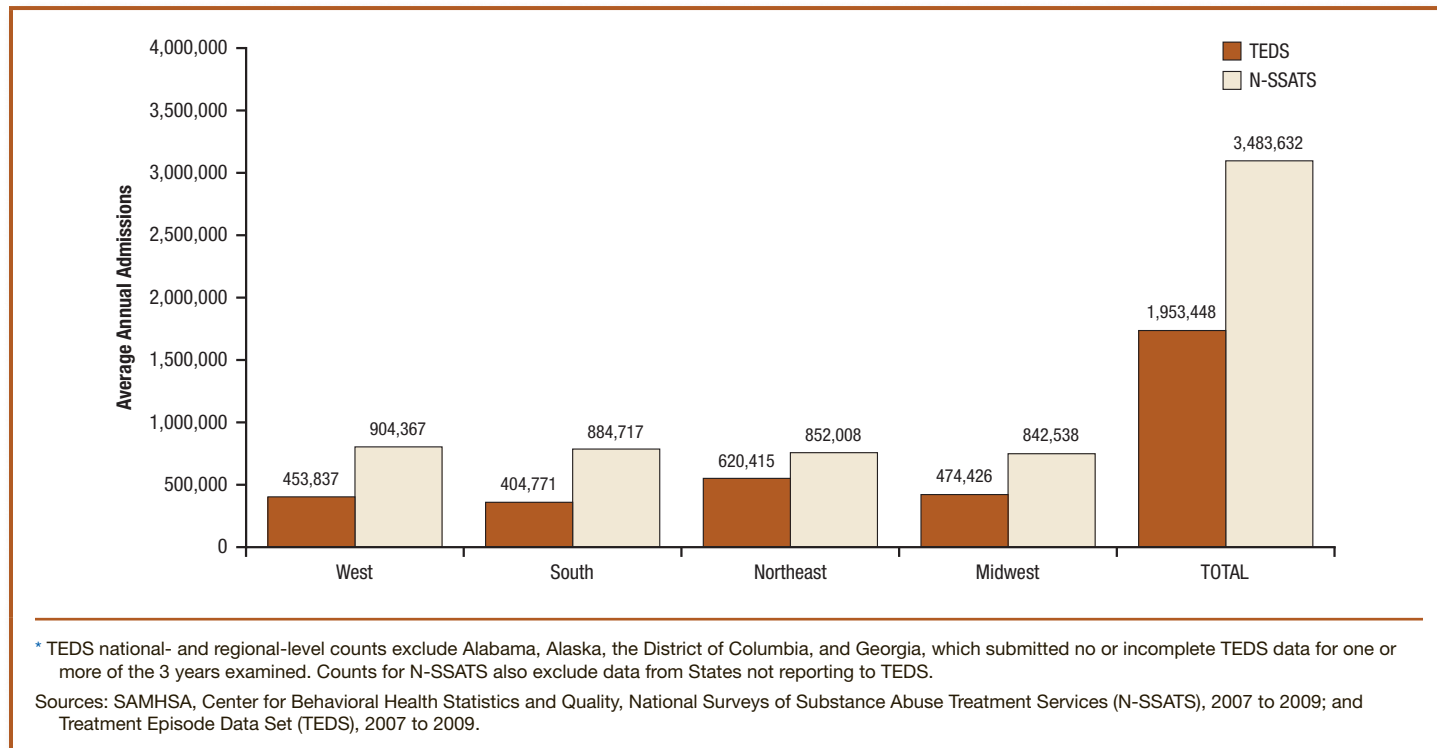
Description of N-SSATS Counts

The N-SSATS counts of the number of treatment admissions to substance use treatment are derived from a question in the N-SSATS survey that asks facilities to report how many admissions for substance abuse treatment the facility had in the 12-month period beginning April 1 of the prior year and ending the last working day of March in the current year. Most facilities report this information. The item response rate for this question was 97.7 percent in 2007, 98.1 percent in 2008, and 100.0 percent in 2009.

2.4.3 National Estimates

This section compares the counts of substance use treatment admissions for N-SSATS and TEDS. Alabama, Alaska, the District of Columbia, and Georgia were excluded from the TEDS counts estimates because no or incomplete TEDS data were submitted for one or more of the 3 years examined (2007-2009) in these areas. For the purpose of these comparisons, N-SSATS estimates were restricted to the subset of 47 States that were used to generate the TEDS counts. These counts, for 2007, 2008, 2009, and an average of the 3 years are presented in Appendix C (Table C.2.13). As Figure 2.21 shows, the total TEDS admissions count is less than 60 percent of the N-SSATS admissions count (1,953,448 vs. 3,483,632, respectively). This difference is seen in all geographic regions except the Northeast. The discrepancy between the TEDS count of national admissions and that of N-SSATS is even greater when the TEDS national count is compared with the

Figure 2.21 Counts of Annual Admissions for the Total Nation and for Geographic Regions: TEDS 2007 to 2009 Annual Averages and N-SSATS 2007 to 2009 Annual Averages*



N-SSATS count for all 50 States and the District of Columbia (1,953,448 vs. 3,606,668).

2.4.4 Conclusions and Limitations

The N-SSATS admission counts for alcohol or drug treatment are almost twice the TEDS counts. This is likely because the facilities that report to TEDS are a subset of the facilities that report to N-SSATS. There are less pronounced differences between the two counts in the Northeast. This is likely because the Northeast includes New York and Massachusetts, which require all substance use treatment facilities licensed or certified by their SSAs to report TEDS data on all of their clients.

3. Needing but Not Receiving Substance Use Treatment

This chapter discusses methods for estimating past year need for substance use treatment, methods for estimating the number of persons who have received substance use treatment in the past year at a *specialty treatment facility*, and the relation between those two measures. Specialty treatment, as defined in NSDUH, is treatment received at any one of the following types

of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. Specialty treatment facilities included in TEDS do include some hospital outpatient treatment.

The first section in this chapter presents the current method of assessing need for but not receiving specialty substance use treatment in the past year based on NSDUH data. The second section presents an alternative method of estimating the number of persons who needed but did not receive treatment in the past year based on data from NSDUH and TEDS. Note that it is not possible to assess the number of persons who received treatment in the past year using N-SSATS data because N-SSATS provides counts of past year treatment admissions but not counts of persons who received treatment. The third section provides estimates using both methods and a discussion of the comparability and limitations of the measures of substance use treatment.

3.1. Current Methods of Assessing Needing but Not Receiving Treatment

Currently in NSDUH, persons are classified as *needing treatment* for an alcohol or drug use problem if they met the diagnostic criteria of the DSM-IV (American Psychiatric Association, 1994) for dependence on or abuse of alcohol or an illicit drug in the past 12 months, or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months. A person is classified as having *received treatment* for an illicit drug or alcohol use problem if he or she has reported receiving specialty treatment for his or her drug or alcohol use problem in the past year. Thus, an individual who needed treatment for illicit drug use but only received specialty treatment for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility was not counted as having received treatment for drug use. Similarly, an individual who needed treatment for an alcohol use problem was only counted as having received alcohol use treatment if the treatment was received for alcohol use at a specialty treatment facility.

SAMHSA publishes annual national estimates of the numbers and percentages of persons who needed substance use treatment in the past year, as well as the numbers and percentages of persons who received specialty treatment among those who needed treatment (CBHSQ, 2011b). SAMHSA has published only one report providing State-level estimates of the percentage of persons who received specialty treatment among those who needed treatment (Han, Clinton-Sherrod, Gfroerer, Pemberton, & Calvin, 2011). Due to the relatively small sample size at the State level of the persons who needed treatment, multiple years of data had to be used for this report. SAMHSA also publishes State estimates of the percentage of the full population who needed treatment but did not receive specialty treatment using 2-year rolling averages based on small area estimation models (OAS, 2010). This measure has the advantage of higher precision for State estimates because the entire population is used in the denominator rather than just those who needed substance use treatment. A disadvantage of this measure is that it is not possible to determine whether

changes over time in this measure are due to changes in the number of persons who need treatment or the proportion of persons who need treatment and actually receive it.

This section focuses on persons who needed treatment but *did not* receive specialty treatment; this estimate was produced by dividing the number of persons who needed treatment by the number who received specialty treatment, and subtracting that figure from 100 percent.

3.2. An Alternative Method of Assessing Needing but Not Receiving Treatment

One possible criticism of the current measure of needing but not receiving treatment using NSDUH data is that it relies on estimates of the number of persons who have received specialty treatment in any year based on relatively small sample sizes. Available data sources, such as TEDS, that provide actual counts of the number of persons who have received substance use treatment present an alternative to using NSDUH data for estimates of both those who need treatment and those who receive treatment. It may be that using actual counts from TEDS of the number of persons who received treatment may result in a more accurate measure than estimating that number using NSDUH data. This may be of interest especially when producing measures at the State level, given the relatively low number of sampled persons who receive specialty treatment in each State.

In order to evaluate this alternate method, the percentages of persons needing but not receiving specialty substance use treatment were computed in two ways. The first method used the NSDUH estimate of treatment need, based on annual averages from the 2008 to 2010 surveys as the denominator and the NSDUH estimate of the number of persons receiving specialty treatment as the numerator. The second method used the NSDUH estimate of treatment need as the denominator and the TEDS count, based on annual averages from the 2007 to 2009 data, of the number of persons receiving treatment as the numerator.

3.3. National and State Estimates of Needing but Not Receiving Treatment

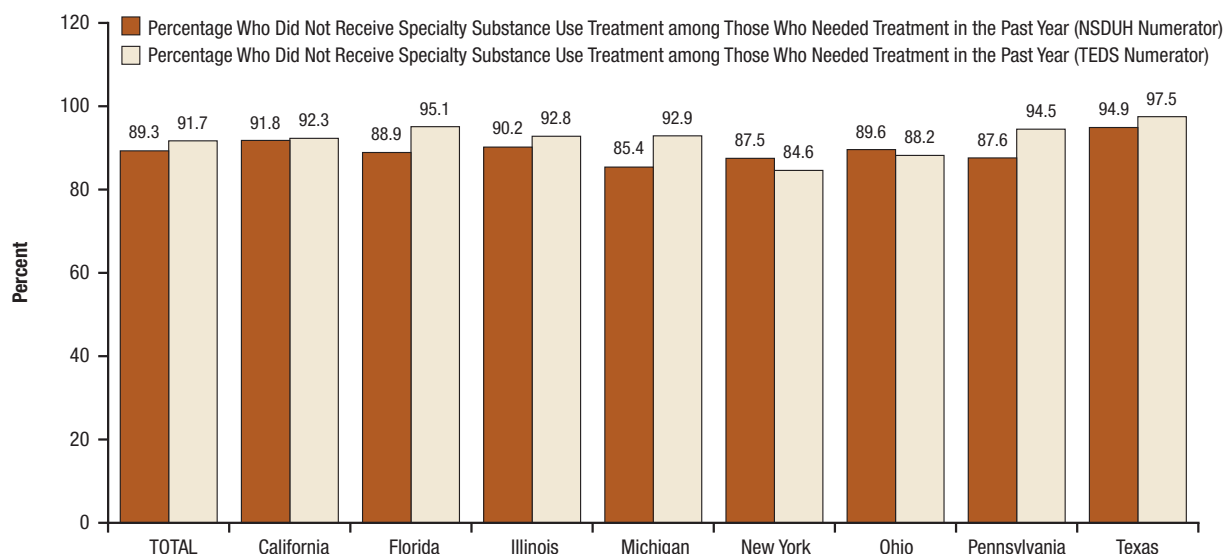
3.3.1 National and State Estimates

Table C.3.1 in Appendix C presents the estimates from NSDUH of the number of persons who needed treatment and the number of persons who received specialty treatment and counts from TEDS of the number of persons who received treatment. Table C.3.1 also includes two estimates of the percentage of persons who needed and received treatment, one using the NSDUH estimate of the number of persons who received specialty treatment as the numerator, and the second using the TEDS count of the number of persons who received treatment as the numerator. Because these counts reflect the number of persons who received treatment (as opposed to the number of treatment admissions), these estimates and percentages are available only for the 47 States for which we have

TEDS data (Alabama, Alaska, the District of Columbia, and Georgia are excluded) for all 3 years examined.

Figure 3.1 compares the percentages of persons who did not receive treatment among those who needed treatment in NSDUH (NSDUH estimate of the number of persons who received specialty treatment in the numerator) and TEDS (TEDS counts of the number of persons who received treatment in the numerator). Section 2.1.2 of this report provides details of how counts of persons who received treatment were computed using the TEDS data. The figure presents combined estimates or the set of 47 States for which sufficient data were available in TEDS (the “Total” bars) and presents separate estimates for the 8 most populous States. The total estimates of the number of persons who needed but did not receive treatment from NSDUH and TEDS are quite similar (89.3 and 91.7 percent, respectively). With the exceptions of Ohio and New York, the percentages of persons who needed but

Figure 3.1 Percentages of Persons Who Did Not Receive Specialty Substance Use Treatment among Those Who Needed Treatment in the Past Year in the Total Nation* and Selected States: NSDUH 2008 to 2010 Combined and TEDS 2007 to 2009 Combined



* The TEDS count for the total Nation of those receiving specialty substance use treatment does not include data from Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined.

NOTE: For NSDUH, respondents were classified as needing substance use treatment if they met at least one of three criteria during the past year: (1) were dependent on alcohol or an illicit drug; (2) abused alcohol or an illicit drug; or (3) received treatment for alcohol or illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions, not including methamphetamine use items added in 2005 and 2006.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2008 to 2010; and Treatment Episode Data Set (TEDS), 2007 to 2009.

did not receive treatment are higher in State estimates using the TEDS numerator than in those based on the NSDUH numerator, although the differences in California and Illinois are not statistically significant. In California, the estimates generated using the NSDUH data and those generated using the TEDS data are quite similar. The two States with the largest gaps between estimates are Michigan (92.9 vs. 85.4 percent unmet treatment need for NSDUH and TEDS estimates, respectively) and Pennsylvania (87.6 vs. 94.5 percent unmet treatment need for the NSDUH and TEDS estimates, respectively).

3.3.2 NSDUH Estimates for Persons with Low Income

The TEDS data in many States are representative of only the persons in that State who received substance use treatment in publicly funded treatment programs (e.g., Florida, Hawaii, Nevada) or only those clients in publicly funded programs whose individual treatment was publicly funded (e.g., Indiana, Louisiana, Nebraska). In an effort to make the NSDUH estimates of persons needing treatment more comparable with the TEDS counts of persons receiving treatment, an additional set of analyses were run using NSDUH data that were subset down to persons with a household income that is less than the Federal poverty threshold, and thus would be more likely to have received publicly funded treatment.

As a means of avoiding suppression of estimates due to lower sample sizes in this restricted group, we limited this analysis to the eight most populous States in the NSDUH data set (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas). Nonetheless, estimates for Florida and New York were suppressed due to low precision. We also conducted these analyses on the remaining States (the States other than the eight most populous States); however, due to lower sample sizes of respondents who received treatment, estimates were suppressed for all but one of these States.

Figure 3.2 compares the estimates of the percentage of persons who did not receive treatment among those who needed treatment generated using the NSDUH estimates among persons with low income and TEDS

counts of persons who received treatment in six of the eight most populous States for which we had sufficient sample size. As noted previously, in these analyses, we used NSDUH data from 2008 through 2010 and TEDS data from 2007 through 2009. Unlike the results of the analyses presented earlier, which were not restricted to persons with low incomes, the TEDS-based estimates are lower than those generated with NSDUH-based treatment estimates; however, for the Michigan estimates, this difference is not statistically significant. In some States, such as California, Illinois, and Ohio, there is a large difference between the percentage calculated using the TEDS numerator and the one in which the NSDUH numerator was used. For other States, such as Pennsylvania and Texas, the difference is less pronounced.

3.4. Conclusions and Limitations

These findings indicate that the percentage of persons who needed but did not receive treatment was slightly higher overall and in most States for which we could conduct analyses when using the TEDS counts of the number of persons who received treatment as the numerator rather than NSDUH estimates of the number of persons who received specialty treatment. Importantly, there was little difference between the two estimates at the State level, suggesting that using the TEDS counts in the numerator does not provide an advantage in generating State estimates over using the NSDUH estimates. Given the considerable differences between NSDUH and TEDS described throughout this report, as well as the relatively similar findings when using the NSDUH and TEDS estimates as the numerator of this statistic, these analyses do not suggest that using TEDS counts in the numerator of this statistic provides an advantage over using NSDUH estimates.

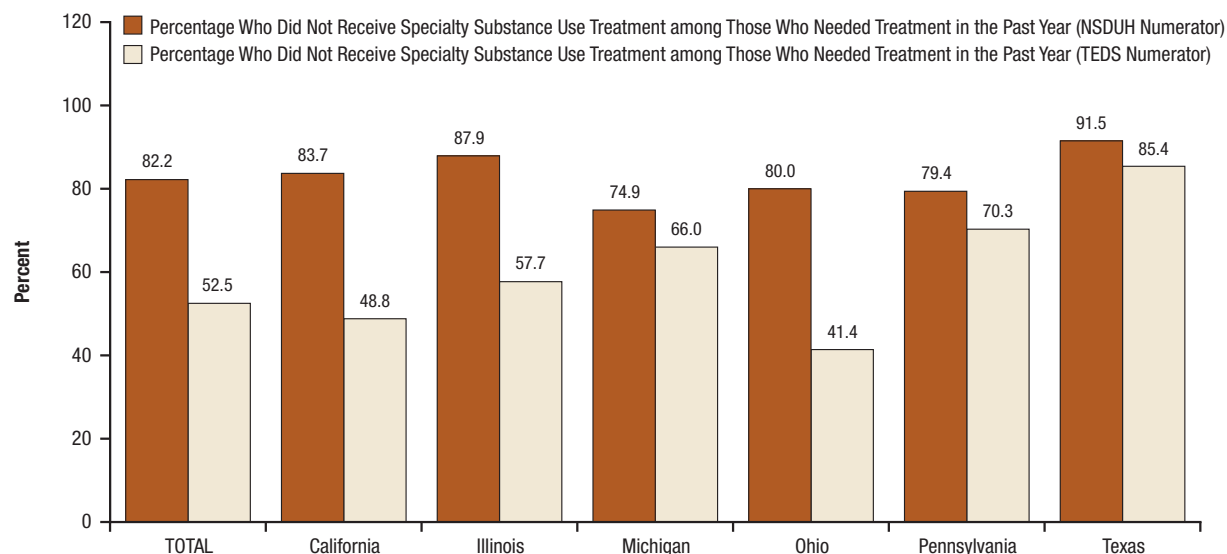
Of the 46 State-level comparisons made, the TEDS and NSDUH estimates are within 2 percent of one another in 13 States. The NSDUH estimate of needing but not receiving treatment is smaller than the TEDS estimate in 23 States, and the TEDS estimate is smaller than the NSDUH estimate in the remaining 10 (Colorado, Iowa, Louisiana, Maine, Maryland, New Jersey, New York,

South Dakota, Vermont, and Wyoming). Notably, all but 2 of these States (Vermont and Wyoming) require all facilities that are licensed or certified by the SSA to report data to TEDS on all clients, which generally indicates complete TEDS reporting from all facilities in the State. Among the other States that require more complete TEDS reporting, two had NSDUH estimates that were similar to the TEDS estimates (Arkansas and Connecticut), two had a NSDUH estimate of needing but not receiving treatment that was lower than the TEDS estimate (Montana and Rhode Island), and one had a TEDS estimate that was lower than the NSDUH estimate (New Jersey).

Regardless of which estimate of treatment receipt is used, the percentage of persons who did not receive treatment among those who needed it indicates that a large majority of persons who needed substance use

treatment did not receive it. It may be that the broad criteria for classifying treatment need (i.e., having either substance abuse or dependence or having received specialty treatment in the past year) has an impact on this estimate. Specifically, it may be that some persons who are classified with substance abuse but not substance dependence may not meet the admissions criteria of chronic severity of substance use required by some types of specialty treatment facilities. The two measures of treatment receipt presented in this chapter focus on self-report of treatment at specialty facilities (i.e., a drug or alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center) or admission to one of the substance use treatment facilities that report to TEDS. Admission criteria for these types of programs often include some level of chronic severity of substance use disorder

Figure 3.2 Percentages of Persons Aged 12 or Older Who Did Not Receive Specialty Substance Use Treatment among Those with Low Income Who Needed Treatment in the Past Year in the Total Nation and Selected States: NSDUH 2008 to 2010 Combined and TEDS* 2007 to 2009 Combined



* TEDS counts of those receiving specialty substance use treatment do not include data from Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years examined.

NOTE 1: For NSDUH, respondents were classified as needing substance use treatment if they met at least one of three criteria during the past year: (1) were dependent on alcohol or an illicit drug; (2) abused alcohol or an illicit drug; or (3) received treatment for alcohol or illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions, not including methamphetamine use items added in 2005 and 2006.

NOTE 2: Low-income NSDUH respondents are those who fall within a poverty level of <100% of the Federal poverty threshold. Poverty level is based on income level, size of family, and number of children in family. The POVERTY2 variable was used for 2006 to 2008.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2008 to 2010; and Treatment Episode Data Set (TEDS), 2007 to 2009.

symptoms, most typically focusing on symptoms of dependence rather than abuse. In fact, for Opioid Treatment Programs, opioid dependence (not abuse) is one of the primary admission criteria. According to the 2007 NSDUH, 9.5 percent of the population was classified as needing substance use treatment, with 4.1 percent of the population meeting the criteria for abuse but not for dependence. Further research is needed to determine whether the sizable portion of those classified with treatment need who did not meet the criteria for substance dependence meet the admission criteria of different types of specialty treatment facilities and, if not, how this impacts the percentage of persons who needed but did not receive treatment.

4. Conclusions

This chapter discusses some conclusions that may be drawn from the examination of estimates of receipt of substance use treatment derived from the NSDUH, TEDS, and N-SSATS data. As described throughout the report, there is considerable variation between these three data sources in important factors such as coverage, methods and timing of data collection, definitions, and information captured. As a result, each data source has its own strengths and limitations that must be considered when deciding which data source to use in order to address specific policy or research questions. This report is an attempt to document some of these key strengths and weaknesses and to examine how the methodological differences impact the estimates of substance use treatment from these three data sources. Next steps for further analyses and guidelines to be used in answering basic questions about substance use treatment are also discussed.

4.1. Summary of Findings

4.1.1 Single-Day Treatment Counts

Single-day treatment counts, which provide a count or estimate of the number of persons enrolled in substance use treatment programs on a single day, can be computed using data from each of the three data sources. In general, NSDUH and N-SSATS estimates of total persons in treatment are similar, while estimates based on TEDS are lower by more than 50 percent

(Table C.2.2). This was the case at the national level, and for most of the eight largest States, with some exceptions. A comparison of the NSDUH October 1 estimate and the NSDUH average-day estimate (i.e., the two methods that can be used to compute single-day treatment estimates from the NSDUH) shows that the average-day estimate is lower by 17 percent. Despite the similarity between the NSDUH and N-SSATS numbers, a concern with the NSDUH estimates is the inconsistencies in reporting across some treatment items. In particular, among the respondents whose interview occurred less than 12 months after the prior October 1 (i.e., quarters 1-3 of the following year), 25 percent of those respondents reporting that they had been in treatment on October 1 reported on separate questions that they had not received any treatment in the past 12 months.

While the overall single-day treatment counts between the N-SSATS and NSDUH are similar, there still is some variability among the single-day treatment counts for alcohol-only treatment (Table C.2.3) and drug-only treatment (Table C.2.4). For both drug-only and alcohol-only counts, the TEDS estimates are about 50 percent of the N-SSATS estimates, similar to the overall comparisons of persons in treatment. However, the NSDUH average-day alcohol-only estimate is higher than the corresponding N-SSATS estimate, while the NSDUH estimate for drug-only treatment is lower than the N-SSATS estimate. In terms of proportions, 37 percent of the estimated persons in treatment based on NSDUH were in treatment for alcohol only. Corresponding percentages for N-SSATS and TEDS were both 19 percent.

Figure 4.1 shows that the N-SSATS and TEDS single-day treatment counts were fairly stable across years, but the NSDUH estimates exhibited some variability from year to year. Overall, it appears that using a single-day treatment count to represent substance use treatment received on a typical day in a given year is acceptable because there is no significant seasonal variation in treatment receipt over the course of a year (Figure 2.18).

4.1.2 Number of Persons Who Received Treatment in the Past Year

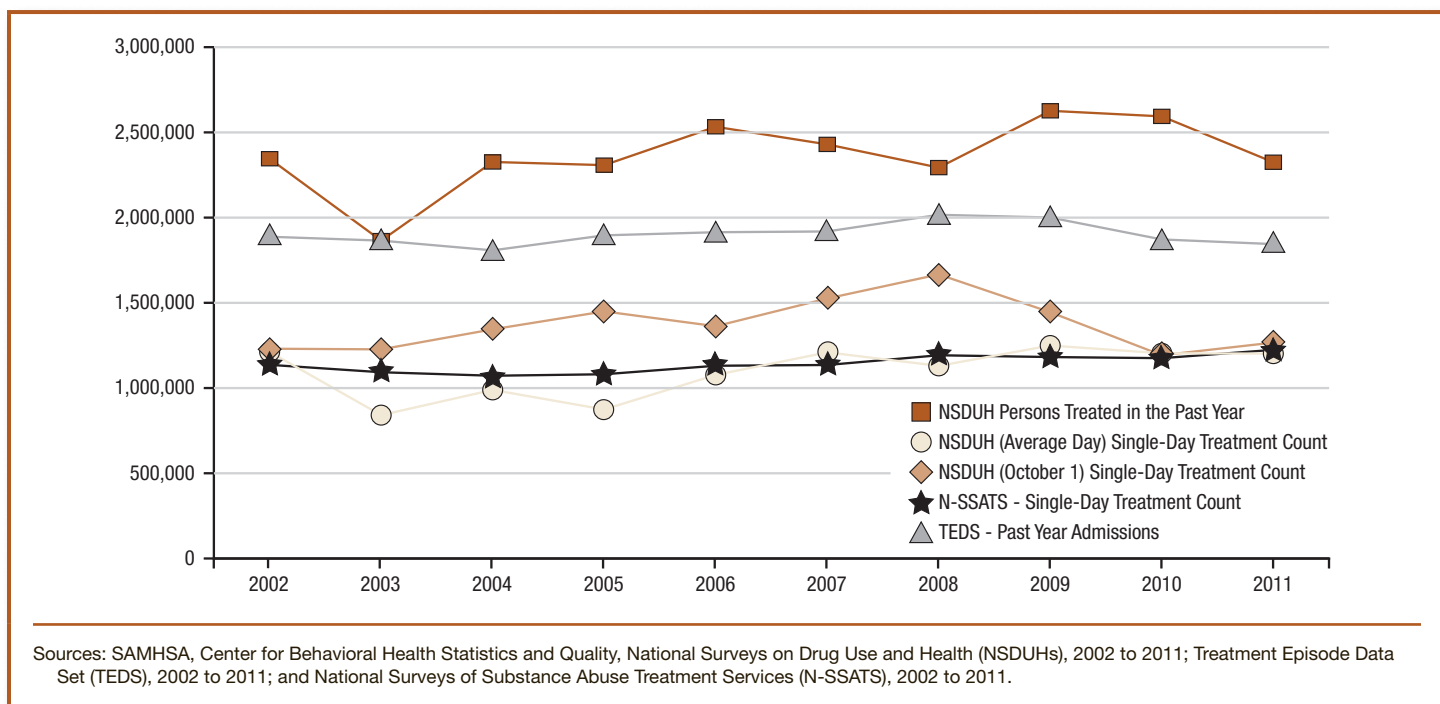
For this measure, comparisons were made between NSDUH and TEDS (Table C.2.1). The NSDUH national estimate is about 28 percent higher than the TEDS estimate. Limiting the NSDUH data to just the 47 States that reported to TEDS, the NSDUH estimate is still about 22 percent higher than the TEDS count.

The comparisons by treatment modality (i.e., hospital inpatient, residential rehabilitation, or outpatient) provide some insight on the sources of the underestimation in TEDS, and possibly NSDUH as well. The NSDUH estimates of the number of persons receiving inpatient treatment were substantially higher than the TEDS counts. In particular, NSDUH estimated more than 10 times the number of persons treated as an inpatient in a hospital (738,366 vs. 61,382 in the 47 TEDS States). Again comparing with N-SSATS single-day counts, the TEDS number is an undercount. N-SSATS indicates that during 2007 to 2009 there were about 14,000 persons receiving substance use treatment in a hospital inpatient setting on the single day surveyed. Given the typical length of stays for this type of treatment is short, the N-SSATS

count would project to several hundred thousand persons treated in a year. The NSDUH estimate for persons receiving outpatient treatment in the past year is higher than the TEDS estimate (1,916,780 and 1,507,988, respectively, in the 47 TEDS States), but both appear to be low when considering the annual N-SSATS single-day counts of clients in outpatient treatment (approximately 1 million) and the median length of stay across all outpatient clients. Likewise, a comparison of N-SSATS and TEDS counts of the number of past year treatment admissions (Table C.2.13) shows that TEDS admissions counts are more than 40 percent lower than those from N-SSATS. It is likely that the lower TEDS counts are due to (1) TEDS counts including mainly substance use treatment received at publicly funded facilities, whereas NSDUH and N-SSATS estimates include all facilities; and (2) the limited inclusion of hospital inpatient treatment patients in the TEDS sample.

The NSDUH estimates also were higher than the TEDS counts for receiving treatment for several substances: prescription drugs (620,335 vs. 240,288), inhalants (141,049 vs. 3,574), and hallucinogens (257,338 vs. 12,139). This is likely due to the methodological

Figure 4.1 Trends in Single-Day Treatment Counts, Numbers of Persons Treated, and Numbers of Admissions: NSDUH, N-SSATS, and TEDS 2002 to 2011



differences in the way these data are collected in the data sources. For example, in TEDS, the primary, secondary, and tertiary problem substances are recorded from the admission record, whereas in NSDUH, respondents are asked whether or not the treatment received in the past year was received for each substance they have used in their lifetimes.

Regarding client characteristics, the NSDUH estimates included a slightly lower percentage of youths aged 12 to 17 (6.4 vs. 8.8 percent) and a higher percentage of older adults (aged 45 or older; 29.0 vs. 22.5 percent) than the TEDS counts. The NSDUH estimates also included a higher percentage of persons with more than a high school education than the TEDS count (34.3 vs. 22.1 percent) and a lower percentage of persons with 8 or fewer years of education than the TEDS count (5.7 vs. 9.5 percent). Differences between TEDS and NSDUH estimates of specific racial or ethnic groups might be related to the broader inclusion of privately funded treatment in NSDUH but might also be associated with differences in the way that data concerning race and ethnicity were collected for the two data sources. Specifically, NSDUH respondents are asked to self-report the racial and ethnic groups with which they identify, whereas in TEDS, the processes for gathering this information vary between individual treatment facilities. NSDUH estimates show a higher proportion of clients who were white (66.6 vs. 60.4 percent) and lower proportions who were black (16.4 vs. 19.6 percent) or Hispanic (13.1 vs. 14.7 percent).

Comparisons of the client characteristics of NSDUH estimates of persons who received substance use treatment in the past year with TEDS data reported for those variables (CBHSQ, 2011a) reveal higher proportions of persons employed full time and part time in the NSDUH sample than in the TEDS counts (37.3 vs. 16.3 percent of persons employed full time for NSDUH and TEDS, respectively, and 12.9 vs. 7.6 percent of persons employed part time for NSDUH and TEDS, respectively). The findings for health insurance status were consistent with the pattern for employment, with a higher percentage of TEDS counts being uninsured (59.8 percent) compared with the NSDUH estimate (30.9 percent).

4.1.3 Receiving Treatment for the First Time

Though TEDS data are not typically presented in this manner, both NSDUH and TEDS can be used to compare estimates of the number of clients receiving substance use treatment for the first time in a given year. The NSDUH numbers are higher than the TEDS number for the year prior to interview, but the NSDUH numbers clearly decrease monotonically for estimates in previous years, indicating recall bias. A similar phenomenon has been shown for drug use initiation. Therefore, the NSDUH should not be used to look at first-time treatment retrospectively beyond 2 years.

4.1.4 Needing but Not Receiving Treatment

Percentages of persons who needed but did not receive treatment were computed in two ways: one using the NSDUH estimate of persons receiving treatment in the numerator (over the NSDUH estimate of persons needing treatment in the denominator), and the other using the TEDS count of persons receiving treatment (again using the NSDUH estimate of persons needing treatment in the denominator). Of the 46 State-level comparisons made, the TEDS and NSDUH estimates were similar in 12 States. In the remaining States, the NSDUH estimate of needing but not receiving treatment is smaller than the TEDS estimate in 25 States, and the TEDS estimate is smaller than the NSDUH estimate in 9 States. Using the TEDS numerator has the advantage that it does not have the sampling error that NSDUH estimates have, but given the coverage and response issues associated with TEDS, it is not clear that using TEDS data results in a substantial improvement of the estimates.

4.2. Implications for Using Substance Use Treatment Data from These Sources

4.2.1 Coverage

Across most measures, TEDS shows undercoverage relative to N-SSATS and NSDUH. Overall, N-SSATS appears to be a good source of data with regard to coverage for client counts nationally and at the State level for specialty treatment. If overall client counts are of interest, N-SSATS seems to be the best source of

data. Although NSDUH national estimates are similar to the N-SSATS counts, internal inconsistencies in NSDUH reporting of treatment suggest caution and further exploration.

TEDS includes persons who are homeless and those who are institutionalized in treatment facilities long term, whereas homeless or institutionalized persons have little chance of inclusion in the NSDUH. NSDUH includes persons who are treated in privately funded facilities and persons whose treatment is privately funded as well as those whose treatment was publicly funded, whereas TEDS is mainly limited to those whose treatment was publicly funded. NSDUH also includes a great deal of information about individuals who received treatment that can be tied to other covariates collected in the survey, allowing for more specific analyses regarding coverage for different demographic groups. N-SSATS includes a census of all facilities regardless of funding, although in some cases the counts reported are estimates rather than actual counts.

4.2.2 Comparisons across States

All three data systems produce counts or estimates by State. State-level analyses not only are useful to local and State officials but also can provide policy assessments based on differing laws, policies, and conditions in States. These analyses require consistent data collection methods, definitions, and coverage across States to ensure the data are comparable. While comparability is achieved in NSDUH and N-SSATS, small sample sizes by State is an important limitation of NSDUH for State-level comparisons. Reporting anomalies in TEDS require extra caution in drawing conclusions about differences in treatment by State:

- The number and characteristics of TEDS client records depends, to some extent, on external factors, including the availability of public funds. In States with higher funding levels, a larger percentage of the substance-abusing population may be admitted to treatment, including the less severely impaired and the less economically disadvantaged.

- The way an admission is defined may vary from State to State such that the absolute number of admissions is not a valid measure for comparing States.
- States continually review the quality of their data processing. As systematic errors are identified, revisions may be enacted in historical TEDS data files. While this system improves the data set over time, reported historical statistics may change slightly from year to year.
- States vary in the extent to which coercion plays a role in referral to treatment. This variation derives from criminal justice practices and differing concentrations of abuser subpopulations.
- Public funding constraints may direct States to selectively target special populations (e.g., pregnant women or adolescents).

4.2.3 Implications Concerning Trends

Some of the basic questions about substance use treatment concern trends over time in service need or utilization. In TEDS, there are two principal sources of variations in estimates of variation over time: reporting anomalies and true changes in admission and discharge patterns. N-SSATS and NSDUH have relatively fewer methodological shifts or anomalies that may cause variations in the data over time. In the absence of those, differences in N-SSATS or NSDUH counts or estimates, when statistically significant and meaningful, may be expected to reflect actual changes. One limitation of NSDUH is that because it is a sample survey, trends in rare events and among subpopulations may be difficult to assess due to potentially large sampling error.

4.2.4 Unique Contributions of Each Data Source

Each of the three data sources makes a unique contribution toward our understanding of substance use treatment. TEDS is the only data source that provides information about both treatment admissions and discharges. NSDUH is the only source that provides the ability to link treatment or client characteristics with an extensive set of other relevant covariates; it is also the only source that has a measure of all substance use

treatment received in the past year, not just specialty treatment. NSDUH is also the only source that provides data concerning treatment need and percentages of those in need who received treatment. N-SSATS provides the best overall single-day treatment counts nationally, for individual States, and across time.

4.3. Next Steps

The analyses presented in this report are the first step in refining analyses to identify the best ways to utilize CBHSQ data systems to answer some basic questions about substance use treatment, such as how many persons receive treatment in a year, how large is the gap between treatment received and treatment needed, and how have the numbers of persons receiving and needing treatment changed over time. The discussion and conclusions in this report are also a step toward understanding how to answer questions about the data sources, such as why do these studies give conflicting results, and which estimate should be used to answer questions about substance use treatment.

Some specific questions raised by this analysis need to be explored further to achieve maximum benefit from studies utilizing these three data sets. Avenues of investigation should include the following:

- What number/proportion of the TEDS count of persons in treatment are homeless persons or persons who have been institutionalized long term, and what are the characteristics of these persons?
- Can N-SSATS and TEDS be linked at some level to quantify the extent and the nature of the undercoverage in TEDS?
- Can the N-SSATS past year admissions numbers be used to generate person-level past year treatment counts?
- Are there changes in definitions, questionnaires, and eligibility rules in these three studies that will facilitate joint analyses?
- Can admissions be estimated from NSDUH, without adding new questions?

- Are there ways of utilizing TEDS and N-SSATS to enhance the precision of NSDUH small area estimates?
- How can NSDUH and TEDS be used to enhance N-SSATS so that more informative projections of admissions and persons receiving treatment can be made?

Finally, it is important to recognize that the nature of these data sets and how they may be used in the future will not remain constant. The movement toward more integrated care, mental health parity, and health care reform will undoubtedly lead to changing data needs and data systems. The results presented here will be valuable to policymakers and designers of data systems as the substance use treatment system evolves within the broader health care context.

Acknowledgments

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End Notes

- 1 RTI International is a trade name of Research Triangle Institute.
- 2 Current treatment was assessed in NSDUH using two questions: (TX07) [IF TX02 = 1 OR DK/REF] Are you currently receiving treatment or counseling for your [TXFILL1]?; and (TX38) [IF TX25 = 1 -8 AND TX07 NE 1 OR BLANK] What was the outcome of the treatment or counseling you received at [FILL IN ANSWER FROM TX25]? [IF TX25 = DK/REF OR TX25 = 9 AND TX07 NE 1 OR BLANK] What was the outcome of the treatment or counseling you received? (when response = you are still in treatment).

- 3 For States that collect data on multiple races: (a) when a single race was designated, the specific race code was used; (b) if the State collects a primary or preferred race along with additional races, the code for the primary/preferred race was used; and (c) if the State uses a system such as an algorithm to select a single race when multiple races have been designated, the same system was used to determine the race code for TEDS. When two or more races were designated and neither (b) nor (c) applied, the TEDS code for *Two or more races* was used.
- 4 Percentages of employment status using the NSDUH data are computed among all persons aged 12 or older; persons aged 12 to 17 are reported in the “other” category.
- 5 The comparison of insurance coverage was restricted to differences in the percentages of those who were insured versus those who were uninsured due to differences between TEDS and NSDUH in the categories of insurance types provided.
- 6 Treatment at the time of the interview was assessed in NSDUH using two questions: (TX07) [IF TX02 = 1 OR DK/REF] Are you currently receiving treatment or counseling for your [TXFILL1]?; and (TX38) [IF TX25 = 1 -8 AND TX07 NE 1 OR BLANK] What was the outcome of the treatment or counseling you received at [FILL IN ANSWER FROM TX25]? [IF TX25 = DK/REF OR TX25 = 9 AND TX07 NE 1 OR BLANK] What was the outcome of the treatment or counseling you received? (when response = you are still in treatment).
- 7 Focus of treatment was assessed in NSDUH using a series of questions: e.g., for alcohol (TX26) [IF (AL01 = 1 OR ALREF = 1) AND TX01 = 1 AND TX07 NE 1 OR BLANK] The last time you entered treatment, did you receive treatment or counseling for your use of alcohol? [IF (AL01 = 1 OR ALREF = 1) AND TX01 = 1 AND TX07 = 1] Are you currently receiving treatment or counseling for your use of alcohol?; and for marijuana/hashish (TX27) [IF (MJ01 =1 OR MJREF = 1) AND TX01 =1 AND TX07 NE 1 OR BLANK] The last time you entered treatment, did you receive treatment or counseling for your use of marijuana or hashish? [IF (MJ01 = 1 OR MJREF = 1) AND TX01 = 1 AND TX07 = 1] Are you currently receiving treatment or counseling for your use of marijuana or hashish?
- 8 Specific State reporting requirements for the 2007 to 2009 TEDS are available in CBHSQ (2011a).



The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Appendix A: Description of the Data Sets

This appendix provides more details on the three sources of data for the estimates of receipt of substance use treatment that were presented in this report: NSDUH, TEDS, and N-SSATS. Specifically, this appendix briefly describes the following characteristics of each data source: (1) purpose of the data sets; (2) design; (3) data collection procedures; (4) data processing procedures, including procedures for handling missing or inconsistent data; and (5) content of the data sets.

The following publications for these studies were the principal sources of information presented in this appendix:

- NSDUH: the 2005-2010 reports on national findings (CBHSQ, 2007-2011);
- TEDS: the 2007-2009 highlights reports (CBHSQ, 2008-2010); and
- N-SSATS: the 2007-2009 reports on facilities (CBHSQ, 2008-2010).

These publications provide more detailed information about these studies. Other publications for these surveys are cited as part of descriptions of specific methods (e.g., sample design). Additional information about these surveys' methods can be obtained from their respective Web sites:

- NSDUH: http://www.samhsa.gov/data/Methodological_Reports.aspx
- TEDS: <http://www.samhsa.gov/data/DASIS.aspx?qr=t#TEDS>
- N-SSATS: <http://www.samhsa.gov/data/DASIS.aspx>

A.1 Purpose of the Data Sets

While NSDUH is focused on alcohol and drug use in the general U.S. civilian, noninstitutionalized population, TEDS compiles information on client admissions to substance use treatment, and N-SSATS collects information from public and private facilities that provide substance use treatment. This section describes in more detail the objectives and scope of these three data sets.

NSDUH

NSDUH is the primary source of statistical information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse in the general U.S. civilian, noninstitutionalized population aged 12 or older. In particular, NSDUH provides information about trends in the use of alcohol, tobacco, and illegal drugs in the population and trends within specific population subgroups. NSDUH yields estimates of substance use for all 50 States, the District of Columbia, and substate regions within each State. NSDUH also collects data on sociodemographic variables such as age, gender, pregnancy status, race/ethnicity, education, employment, and geographic area.

NSDUH also presents findings on mental health issues in the civilian, noninstitutionalized population. Specifically, NSDUH allows estimates to be made of the prevalence of mental illness and mental health service utilization, including the prevalence of mental disorders that co-occurred with substance use or with substance use disorders, and treatment for co-occurring mental disorders and substance use or substance use disorders.

TEDS

TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to and discharges from substance abuse treatment. TEDS is coordinated and managed by CBHSQ and is part of BHSIS, formerly known as DASIS, a cooperative program among SAMHSA and State substance abuse agencies to collect data on substance abuse services. The TEDS data collection effort was developed in response to the 1988 Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments (P.L. 100-690), which established a revised SAPTBG and mandated Federal data collection on clients receiving treatment for either alcohol or drug abuse.

The primary goal of TEDS is to monitor the characteristics of clients admitted to planned, continuing treatment regimens. Thus, TEDS excludes early intervention and crisis intervention programs that do not lead to enrollment in continued treatment. A majority of States report data on all admissions to all eligible facilities, although some report only admissions financed by public funds.

N-SSATS

N-SSATS was designed to collect data on the location, characteristics, and utilization of alcohol and drug treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.¹ CBHSQ plans and directs N-SSATS. N-SSATS, along with TEDS, is a component of DASIS, a cooperative program among SAMHSA and State substance abuse agencies to collect data on substance abuse services. The 2009 survey was the 32nd in this series of national surveys begun in the 1970s.

N-SSATS provides the mechanism for quantifying the dynamic character and composition of the U.S. substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to

- assist SAMHSA and State and local governments in assessing the nature and extent of services provided in State-supported and other substance abuse treatment facilities, and in forecasting substance abuse treatment resource requirements;
- update SAMHSA's I-SATS, which includes all known drug and alcohol abuse treatment facilities;
- analyze substance abuse treatment services trends and conduct comparative analyses for the Nation, regions, and States;

¹ The jurisdictions include American Samoa, the territory of Guam, the Federated States of Micronesia, the Republic of Palau, the Commonwealth of Puerto Rico, and the Virgin Islands of the United States.

- generate the *National Directory of Drug and Alcohol Abuse Treatment Programs*, a compendium of facilities approved by State substance abuse agencies for the provision of substance abuse treatment; and
- update the information in SAMHSA’s Substance Abuse Treatment Facility Locator (<http://findtreatment.samhsa.gov/>), a searchable database of facilities approved by State substance abuse agencies for the provision of substance abuse treatment.

TEDS and N-SSATS in the Context of BHSIS

TEDS and N-SSATS are two of the three components of SAMHSA’s BHSIS. Together, the components provide national- and State-level information on the numbers and characteristics of individuals admitted to alcohol and drug treatment programs and describe the facilities that deliver care to those individuals. BHSIS is the primary source of national data on substance use treatment. The core component of BHSIS is the I-SATS, a continuously updated comprehensive listing of all known public and private substance abuse treatment facilities. I-SATS is the list frame for N-SSATS. Facilities in I-SATS fall into two general categories and are distinguished by the relationship of the facility to its State substance abuse agency. These categories are described subsequently.

- Treatment facilities approved by State substance abuse agencies

The largest group of facilities (about 80 percent of all active I-SATS facilities) includes those that are licensed, certified, or otherwise approved by the SSA to provide substance abuse treatment. State DASIS representatives maintain this segment of I-SATS by reporting new facilities, closures, and address changes to SAMHSA. Some facilities are not licensed, certified, or otherwise approved by the State agency. Some private for-profit facilities fall into this category. This group also includes programs operated by Federal agencies, the VA, the DOD, and the IHS. I-SATS records for federally operated facilities are updated annually through lists provided by these agencies.

- Treatment facilities not approved by State substance abuse agencies

This group of facilities (about 20 percent of all active I-SATS facilities) represents the SAMHSA effort since the mid-1990s to make I-SATS as comprehensive as possible by including treatment facilities that State substance abuse agencies, for a variety of reasons, do not fund, license, or certify. Many of these facilities are private for-profit, small group practices, or hospital-based programs. Most of them are identified through periodic screening of alternative source databases. State substance abuse agencies are given the opportunity to review these facilities and to add them to the State agency-approved list, if appropriate.

TEDS includes facilities that are licensed or certified by the SSA to provide substance abuse treatment (or are administratively tracked for other reasons) and that are required by the States to provide TEDS client-level data. N-SSATS is an annual survey of the location, characteristics, services offered, and utilization of alcohol and drug abuse treatment facilities in I-SATS.

A.2 Design

Fundamental design differences characterize the NSDUH, TEDS, and N-SSATS data sets due to their differences in purpose and scope. The following descriptions provide more detail on the design characteristics of each data set.

NSDUH

The 2005 through 2010 NSDUHs are part of a coordinated 5-year sample design (extended through 2010) providing estimates for all 50 States plus the District of Columbia for the years 2005 through 2010. The respondent universe is the civilian, noninstitutionalized population aged 12 years old or older residing within the United States. The survey includes persons living in noninstitutionalized group quarters (e.g., shelters, rooming/boarded houses, college dormitories, migratory workers' camps, halfway houses) and civilians living on military bases.

Although this population includes almost 98 percent of the total U.S. population aged 12 or older, it excludes some important and unique subpopulations that may have very different substance use and treatment patterns. For example, the survey excludes active military personnel who have been shown to have significantly lower rates of illicit drug use. Also, persons living in institutional group quarters, such as prisons and residential substance use treatment centers, are not included in NSDUH, and they have been shown in other surveys to have higher rates of illicit drug use. Also excluded are other types of institutional group quarters such as nursing homes, mental institutions, and long-term hospitals. Also excluded from the survey are persons with no fixed household address, such as homeless persons not living in a shelter for the majority of the quarter in which the shelter is sampled; homeless persons are another population shown to have higher than average rates of illicit drug use.

For the 50-State design, 8 States were 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)² while at the same time maintaining efficiency for national estimates.

More information on the sample design can be found in the 2008 NSDUH sample design report by Morton, Chromy, Hirsch, and Martin (2009) on the SAMHSA Web site (available as a PDF at http://www.samhsa.gov/data/Methodological_Reports.aspx).

TEDS

TEDS is designed to monitor the demographic and substance abuse characteristics of clients admitted to substance use treatment. TEDS admissions do not represent individuals but rather admission-level data. For example, one individual admitted to treatment twice within a

² SAE is a hierarchical Bayes modeling technique used to make State-level estimates for approximately 20 measures related to substance use. For more details, see the State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health (Hughes, Sathe, & Spagnola, 2008; available as a PDF at <http://www.samhsa.gov/data/NSDUH.aspx>).

calendar year would be counted as two admissions. However, data from some States include person-level identifiers that allow linkage of treatment episode records for an individual. This report uses these data to provide person-level rather than treatment episode-level estimates.

The national TEDS data are analyzed and published annually on a calendar year basis, although States submit TEDS data to SAMHSA on an ongoing basis as it is received from the provider facilities. The cutoff for receipt of data for each TEDS report is approximately August 31 of the year following the data year. Data received after that time does not appear in the initial annual report. For example, the annual report for calendar year 2009 admissions is prepared after the cutoff of August 31, 2010. For inclusion in the initial annual report, States must submit complete 2009 data before August 31, 2010.

TEDS data is not submitted by all States and jurisdictions each year. In 2007, Alabama, Alaska, Georgia, Mississippi, and West Virginia did not submit TEDS data; in 2008, Alabama and Georgia did not submit TEDS data; and in 2009, Georgia and the District of Columbia did not submit TEDS data.

Although TEDS does not exclude facilities, the facilities that report TEDS data are primarily those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of drug and/or alcohol treatment services. The scope of facilities included is affected by differences in State licensure, certification, and accreditation practices, and disbursement of public funds. Although there is variation by State, the majority include only facilities receiving public funding. Therefore TEDS generally does not include data on private facilities, VA-operated facilities, DOD-operated military treatment facilities, hospital-based programs, and Federal prisons; some facilities operated by the IHS are included. A list of State reporting requirements, which is provided in the annual TEDS admissions reports, is presented in Table A.1.

Table A.1 State Data Systems Reporting Characteristics: TEDS 2007 to 2009

State or Jurisdiction	Facilities Reporting TEDS Data to the State SSA		Eligible Clients
	Facilities Required To Report to the State SSA ¹	Facilities Reporting Voluntarily to the State SSA	
Alabama	Facilities that receive State/public funding	None	All clients in facility
Alaska	Facilities that receive State/public funding	None	All clients in facility
Arizona	Facilities that receive State/public funding	None	State/public-funded clients only
Arkansas	Facilities that are licensed by State SSA	State Community Correction facilities Some private facilities	All clients in a licensed facility
California	Facilities that receive State funding All licensed narcotic treatment facilities	None	All clients in facility except DUI
Colorado	State-licensed facilities Methadone facilities Community-based juvenile and adult justice treatment programs, except institutionally-based	None	All clients receiving substance abuse treatment services in facility

Table A.1 State Data Systems Reporting Characteristics: TEDS 2007 to 2009 (continued)

State or Jurisdiction	Facilities Reporting TEDS Data to the State SSA		Eligible Clients
	Facilities Required To Report to the State SSA ¹	Facilities Reporting Voluntarily to the State SSA	
Connecticut	Facilities that receive State/public funding (including corrections) Facilities serving adults that are licensed by State Dept. of Public Health Some facilities treating youths < 18 General hospitals funded by State SSA	None	All clients in facility
Delaware	Facilities that receive State/public funding, excluding: - Child/youth services - Most Medicaid-funded services - Most criminal justice system services	None	State/public-funded clients only
District of Columbia	Facilities that receive State/public funding	None	State/public-funded clients only
Florida	Facilities that receive State/public funding	None	All clients in facility
Georgia	2007: Facilities that receive State/public funding 2008-2009: Facilities that receive SAPTBG, State, and Medicaid funding through State SSA (this includes Medicaid for foster children, aged, blind, and disabled individuals)	None	2007: State/public-funded clients only 2008-2009: SSA-funded clients with SA or co-occurring SA and MH disorders
Hawaii	Facilities that receive State/public funding	None	All clients in facility
Idaho	Facilities that receive State/public funding	None	State/public-funded clients only
Illinois	Facilities that receive funding through State SSA (this includes Medicaid-paid subacute addiction treatment services)	None	State/public-funded clients only
Indiana	Facilities that receive State/public funding	None	State/public-funded clients only
Iowa	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA Medicare-certified facilities	State prison Department of Human Services youth facility	All clients in facility
Kansas	Facilities that receive State/public funding Medicaid-certified facilities Department of Corrections fourth-time DUI facilities	None	All clients in facility
Kentucky	Facilities that receive State/public funding	None	All clients in facility
Louisiana	Facilities that receive State/public funding State programs	None	State/public-funded clients only

Table A.1 State Data Systems Reporting Characteristics: TEDS 2007 to 2009 (continued)

State or Jurisdiction	Facilities Reporting TEDS Data to the State SSA		Eligible Clients
	Facilities Required To Report to the State SSA ¹	Facilities Reporting Voluntarily to the State SSA	
Maine	Facilities that receive State/public funding Facilities licensed by the State must report all their substance abuse clients Facilities seeking Medicaid reimbursement for substance abuse services Clients who are being treated because of "Operating Under the Influence"	Some private substance abuse providers report their clients although not required by statute to do so	All clients in facility
Maryland	Facilities that are licensed/certified by the Health Department Office of Health Care Quality	None	All clients in facility
Massachusetts	Facilities that are licensed/certified by State SSA	None	All clients in facility
Michigan	Facilities that receive State/public funding Medicaid providers of substance abuse treatment	None	Clients whose services are supported by State/public funds through the Department of Community Health, including Medicaid
Minnesota	Providers serving publicly funded clients	None	All clients in facility
Mississippi	Facilities that receive State/public funding Facilities certified by Mental Health Department	None	All clients in facility
Missouri	Facilities that receive State/public funding	None	State/public-funded clients only
Montana	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA	None	All clients in facility except DUI clients
Nebraska	Facilities that receive SSA-administered State/public funding	None	State/public-funded clients only
Nevada	Facilities that receive State/public funding	None	All clients in facility
New Hampshire	Facilities that receive State/public funding	None	State/public-funded clients only
New Jersey	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA Facilities in State intoxicated driver program	Some private facilities and solo practitioners	All clients in facility
New Mexico	Facilities that receive SSA substance abuse funding	None	SSA-funded clients with SA or co-occurring SA and MH disorders
New York	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA	None	All clients in facility

Table A.1 State Data Systems Reporting Characteristics: TEDS 2007 to 2009 (continued)

State or Jurisdiction	Facilities Reporting TEDS Data to the State SSA		Eligible Clients
	Facilities Required To Report to the State SSA ¹	Facilities Reporting Voluntarily to the State SSA	
North Carolina	Facilities that receive State/public funding	None	All clients in facility
North Dakota	Eight State divisional service centers and other facilities receiving SAPTBG funds One State hospital	Some private facilities	All clients in State Hospital and Regional Human Service Centers Small privates report only SAPTBG-funded clients
Ohio	Facilities that receive State/public funding	None	State/public-funded clients only
Oklahoma	Facilities that receive State/public funding	None	State/public-funded clients only
Oregon	Facilities that receive State/public funding or are required because they provide DUI or methadone treatment	None	All clients in facility
Pennsylvania	Facilities that receive SAPTBG/State funds through the Department of Health; this includes some but not all Medicaid funds spent on substance abuse diagnoses	Some, but not all, county prisons, hospitals, and private providers and solo practitioners	State/public-funded clients only are required Data on all clients are requested and received from some facilities
Rhode Island	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA	VA Hospital reports voluntarily	All clients in facility
South Carolina	Facilities that receive State/public funding	None	All clients in facility
South Dakota	Facilities that receive State/public funding Facilities that are licensed/certified by State SSA Medicare-certified facilities Solo practitioners licensed/certified by State SSA	None	All clients in facility
Tennessee	Facilities that receive State/public funding	None	State/public-funded clients only
Texas	Facilities that receive State/public funding	None	State/public-funded clients only
Utah	Facilities that receive State/public funding	None	All clients in facility
Vermont	Facilities that receive State/public funding	None	All clients in facility
Virginia	Facilities that receive State/public funding	None	All clients in facility
Washington	Facilities that receive State/public funding Medicare-certified facilities	State-certified privately funded methadone treatment programs	State/public-funded clients only are required Data on all clients are requested and received from some facilities

Table A.1 State Data Systems Reporting Characteristics: TEDS 2007 to 2009 (continued)

State or Jurisdiction	Facilities Reporting TEDS Data to the State SSA		Eligible Clients
	Facilities Required To Report to the State SSA ¹	Facilities Reporting Voluntarily to the State SSA	
West Virginia	Facilities that receive State/public funding	None	All clients in facility
Wisconsin	Facilities that receive State/public funding	None	State/public-funded clients only
Wyoming	Facilities that receive State/public funding	None	All clients in a facility

DUI = driving under the influence; MH = mental health; SA = substance abuse; SAPTBG = Substance Abuse Prevention and Treatment Block Grant; SSA = Single State Authority; VA = U.S. Department of Veterans Affairs.

¹ "State/public funding" generally refers to funding by the State substance abuse agency but may also include funding by another public agency.

Source: State Substance Abuse Agencies, July 2010.

N-SSATS

Whereas NSDUH collects individual-level data and TEDS collects admission-level data, N-SSATS collects data from all alcohol and drug abuse treatment facilities. N-SSATS includes both public and private treatment facilities and is designed to collect data throughout the 50 States, the District of Columbia, and other U.S. jurisdictions. Treatment facilities that are licensed, certified, or otherwise approved by the SSA to provide substance abuse treatment make up the largest group of facilities. The survey also includes programs operated by Federal agencies: the VA, the DOD, and the IHS. Together, these facilities represent about 80 percent of the total. The remaining facilities included in N-SSATS are those that are not licensed or certified through the State substance abuse agencies or Federal agencies. These facilities are usually hospital-based or private for-profit facilities.

Some N-SSATS respondents provide information but are deemed to be out of the scope of the N-SSATS *Annual Report* and public use files. On average, 5 percent of responding facilities were excluded from the N-SSATS *Annual Report* and public use files each survey year from 2007 through 2009. The excluded facilities and reasons for exclusion fall into four categories:

- Halfway houses that do not provide substance abuse treatment. These facilities are included in the survey for listing in the *Directory* and the Treatment Facility Locator.
- Solo practitioners. I-SATS and N-SSATS are designed to include facilities rather than individuals. Solo practitioners are listed and surveyed only if the SSA explicitly requests that they be included in the survey. Those not identified for inclusion are excluded from the *Annual Report* and public use files and from subsequent surveys.
- Jails, prisons, or other organizations that exclusively treat incarcerated clients.
- Facilities whose response indicates that their client counts are included in the counts provided by another facility and that did not report facility characteristics are excluded from facility counts, although their client counts are included in those of the reporting facility.

An average of 13,616 facilities were included each survey year from 2007 through 2009 in the Annual Report and public use files.

N-SSATS is designed to collect data from each physical location where treatment services are provided. Accordingly, SAMHSA requests that State substance abuse agencies use the point of delivery of service (i.e., physical location) as the defining factor for a facility. Because of the different State administrative systems, however, there are some inconsistencies in implementation. For example, in some States, multiple treatment programs (e.g., detoxification, residential, and outpatient) at the same address and under the same management have separate State licenses. These are treated as separate by the SSA and are given separate I-SATS ID numbers. In other States, multiple sites are included as a single entity under a parent or administrative unit. In many of these cases, individual sites can report services data in N-SSATS, but client data are available only at a higher administrative level. Beginning in 1995, efforts have been made to identify facility networks and to eliminate duplicate reporting by networks. For most facilities, the reporting level remains consistent from year to year. However, beginning in 1998, an emphasis was placed on collecting minimum information from all physical locations, and this has resulted in an increase in the number of facilities.

A.3 Data Collection Methodology

There are fundamental differences in the data collection methodologies used across the three data sets because of their differing designs and objectives. NSDUH data collection involves in-person interviews with sample individuals; TEDS is a compilation of client-level admission data collected and submitted by the States as they are received from providers; and N-SSATS data collection involves questionnaires completed by surveyed facilities on hard copy, over the Internet, or by telephone. This section provides more detail on the data collection processes and procedures used for each data set.

NSDUH

The data collection method used in NSDUH involves in-person interviews with sample persons, incorporating procedures that would be likely to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. Confidentiality is stressed in all written and oral communications with potential respondents. Respondents' names are not collected with the data, and CAI methods are used to provide a private and confidential setting to complete the interview.

Introductory letters are sent to sampled addresses, followed by an interviewer visit. A 5-minute screening procedure using a handheld computer involves listing all household members along with their basic sociodemographic data. The computer uses the demographic data in a preprogrammed selection algorithm to select zero to two persons, depending on the composition of the household. The selection process is designed to provide the necessary sample sizes for the specified population age groupings.

In areas where a third or more of the households contain Spanish-speaking residents, the initial introductory letters written in English are mailed with a Spanish version on the back. All interviewers carry copies of this letter in Spanish. If the interviewer is not certified bilingual, he

or she uses preprinted Spanish cards to attempt to find someone in the household who speaks English and who can serve as the screening respondent or who can translate for the screening respondent. If no one is available, the interviewer schedules a time when a Spanish-speaking interviewer can come to the address.

In households where a language other than Spanish is encountered, another language card is used to attempt to find someone who speaks English to complete the screening. The NSDUH interview is available in English and Spanish, and both versions have the same content. If the sample person prefers to complete the interview in Spanish, a certified bilingual interviewer is sent to the address to conduct the interview. Because the interview is not translated into any other language, if a sample person does not speak English or Spanish, the interview is not conducted.

Interviewers attempt to conduct the NSDUH interview immediately after the screening with each sample person in the household. The interviewer requests the selected respondent to identify a private area in the home to conduct the interview away from other household members. The interview averages about an hour and includes a combination of CAPI in which the interviewer reads the questions and ACASI.

The NSDUH interview consists of core and noncore (i.e., supplemental) sections. A core set of questions critical for basic trend measurement of prevalence estimates remains in the survey every year and comprises the first part of the interview. Noncore questions, or modules, that can be revised, dropped, or added from year to year make up the remainder of the interview.

The core consists of initial demographic items (which are interviewer administered) and self-administered questions pertaining to the use of tobacco, alcohol, marijuana, cocaine, crack cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, and sedatives. Topics in the remaining noncore self-administered sections include (but are not limited to) injection drug use, perceived risks of substance use, substance dependence or abuse, arrests, treatment for substance use problems, pregnancy and health care issues, and mental health issues.

Noncore demographic questions (which are interviewer administered and follow the ACASI questions) address such topics as immigration, current school enrollment, employment and workplace issues, health insurance coverage, and income. It should be noted that some of the noncore portions of the interview have remained in the survey, relatively unchanged, from year to year (e.g., current health insurance coverage, employment). More detailed information on content of the survey instruments is provided in Section A.5 of this appendix.

The interview begins in CAPI mode with the field interviewer reading the questions from the computer screen and entering the respondent's replies into the computer. The interview then transitions to the ACASI mode for the sensitive questions. In this mode, the respondent can read the questions silently on the computer screen and/or listen to the questions read through headphones and enter his or her responses directly into the computer. At the conclusion of the ACASI section, the interview returns to the CAPI mode with the interviewer completing the questionnaire. Each respondent who completes a full interview is given a \$30.00 cash payment as a token of appreciation for his or her time.

TEDS

The process of collecting and submitting TEDS data involves a number of tasks on the part of the States.

Data Collection through State Data Systems

First, the data is collected through the State data systems. There may be some variation from State to State in terms of the types of data systems and related infrastructures in place. States are provided with TEDS *State Instruction Manuals* containing detailed instructions on collection of admission and discharge data. The manuals include definitions of data items, reporting guidelines, acceptable code values, descriptions of data crosschecks, and formatting information for all TEDS data elements. Coding instructions include guidelines that take into account potential variations from State to State in types of data systems used. The TEDS-A and TEDS-D Codebooks for 2007 through 2009 can be found at <http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/33261#method>.

State Crosswalks

Next, the States must translate or crosswalk the State data to the appropriate TEDS data fields, codes, and file format. Each State is responsible for translating data from the State's own data collection system to the data elements used by TEDS. A computer program must be written to extract data from the State system and construct the appropriate data files for TEDS submission.

A State Crosswalk Plan is a document containing the general instructions (or map) for translating data from the State's own data collection system to the data elements used by TEDS. Each State, working with Synectics, develops this plan and maintains the plan as changes to State data systems require. The State Crosswalk Plan guides development of the State's computer program that converts the State data items to the TEDS data items. It is the State's responsibility to develop the computer program to extract State data for submission to TEDS according to the specifications in the State TEDS Crosswalk. It is also the State's responsibility to update that program as needed when a change is made to the State data system to ensure that the State data items are accurately cross-walked/translated to the TEDS data item codes.

Submission of Data Files

Finally, the States submit the data files to SAMHSA; methods of submission include using the State TEDS Submission System (STSS), using diskettes or CDs, or using electronic transmission. States are expected to report TEDS data on a regular and timely basis as the data are received from providers and become available from the State data system. It is preferred that States report monthly but States not able to report on a monthly basis may report on a quarterly basis.

States are encouraged to submit all data to TEDS within 2 months of the client admission date to enable timely analysis and publication of the national TEDS data. Admissions from facilities that report late to the States may appear in a later data submission to SAMHSA. Thus,

the number of admissions reported for 2007 through 2009 may increase as submissions of 2007, 2008, and 2009 data continue to be submitted.

The TEDS data are analyzed and published annually on a calendar year basis. The cutoff for receipt of data for each report is approximately August 31 of the year following the data year. Data received after that time does not appear in the annual report. For example, the annual report for calendar year 2009 admissions is prepared after the cutoff of August 31, 2010. For inclusion in the report, States must submit complete 2009 data before August 31, 2010.

Additional information about data processing upon receipt of the TEDS data is provided in Section A.4 of this appendix.

Data Collection Notes

Several limitations to the TEDS data exist:

- The number and characteristics of TEDS client records depends, to some extent, on external factors, including the availability of public funds. In States with higher funding levels, a larger percentage of the substance-abusing population may be admitted to treatment, including the less severely impaired and the less economically disadvantaged.
- The primary, secondary, and tertiary substances of abuse reported to the TEDS are those substances that led to the treatment episode and are not necessarily a complete enumeration of all drugs used at the time of admission.
- The way an admission is defined may vary from State to State such that the absolute number of admissions is not a valid measure for comparing States.
- States continually review the quality of their data processing. As systematic errors are identified, revisions may be enacted in historical TEDS data files. While this system improves the data set over time, reported historical statistics may change slightly from year to year.
- States vary in the extent to which coercion plays a role in referral to treatment. This variation derives from criminal justice practices and differing concentrations of abuser subpopulations.
- Public funding constraints may direct States to selectively target special populations, for example, pregnant women or adolescents.
- TEDS consists of treatment admissions and therefore may include multiple admissions for the same client. Thus, any statistics derived from the data will represent admissions, not clients. It is possible for clients to have multiple initial admissions within a State and even within providers that have multiple treatment sites within the State. TEDS provides a national snapshot of what is seen at admission to treatment, but is currently not designed to follow individual clients through a sequence of treatment episodes.

- TEDS distinguishes between "transfer admissions" and "initial admissions." Transfer admissions include clients transferred for distinct services within an episode of treatment. Only initial admissions are included in the public-use file.
- Some States have no Opioid Treatment Programs (OTPs) that provide medication-assisted therapy using methadone and/or buprenorphine. See the TEDS Crosswalks (<http://www.dasis.samhsa.gov/dasis2/crosswalks.htm>) for information regarding data collected by each State.

N-SSATS

Data collection packets containing a hardcopy N-SSATS questionnaire are mailed to surveyed facilities on the survey reference date. Surveyed facilities are also offered the options of completing the surveys over the Internet or by telephone. Until 1996, State substance abuse agencies distributed and collected the survey forms. Beginning in 1996, data collection was centralized; since that time, SAMHSA has mailed facility survey forms directly to and collected forms directly from the facilities, and has conducted follow-up telephone interviews with facility directors or their designee.

Exclusions

In 1997, facilities offering only DUI/DWI programs were excluded; these facilities were reinstated in 1998. Facilities operated by the BOP were excluded from the 1997 Uniform Facility Data Set survey and subsequent surveys because SAMHSA conducted a separate survey of correctional facilities. (OAS, 2000). During that survey, it was discovered that jails, prisons, and other organizations treating incarcerated persons only were poorly enumerated on I-SATS. Beginning in 1999, these facilities were identified during the survey and excluded from analyses and public-use data files. I-SATS and N-SSATS are designed to include specialty substance abuse treatment facilities rather than individuals. Solo practitioners are listed on I-SATS and surveyed in N-SSATS only if the SSA explicitly requests that they be included. Beginning in 2000, halfway houses that did not provide substance abuse treatment were included on I-SATS and in N-SSATS so that they could be listed in the National Directory of Drug and Alcohol Abuse Treatment Programs and on the Treatment Facility Locator. These facilities are excluded from analyses and public-use data files.

Field Period and Reference Dates

The 2007 through 2009 N-SSATS surveys were conducted between March and October of each year, with a reference date of March 30 or March 31 of each year. The field period typically lasts about 6 months beginning on the reference date (i.e., from the last working day in March to the beginning of October). For example, the field period for the 2007 N-SSATS ran from March 30, 2007, through October 17, 2007, with a reference date of March 30, 2007.

Procedures

Six weeks before the N-SSATS survey is implemented, letters are mailed to all facilities to alert them to expect the survey; an additional purpose of the letters is to update records with new address information received from the Post Office. Subsequently, data collection packets are

mailed to each facility out on the survey reference date, containing the questionnaire, SAMHSA cover letter, State-specific letter of endorsement, information on completing the survey on the Internet, and a sheet of Frequently Asked Questions. During the data collection phase, contract personnel are made available to answer facilities' questions concerning the survey, as well as support in responding to questions for those facilities completing the questionnaire over the Internet. About 4 to 5 weeks after the initial questionnaire mailing, thank-you/reminder letters are sent to all facilities. Approximately 8 weeks after the initial questionnaire mailing, nonresponding facilities are sent a second questionnaire mailing. About 4 to 5 weeks after the second questionnaire mailing, nonrespondents receive a reminder telephone call. Those facilities that have not responded within 2 to 3 weeks of the reminder call are telephoned and asked to complete the survey by telephone.

Two primary data collection modes were employed: a paper questionnaire sent by mail and a secure Web-based questionnaire. Respondents could select either method to complete the survey. Six weeks before the survey reference date, letters were mailed to all facilities to alert them to expect the survey. The letters also served to update records with new address information received from the Post Office. On the reference date, data collection packets (including the questionnaire, SAMHSA cover letter, State-specific letter of endorsement, information on completing the survey on the Web, and a sheet of Frequently Asked Questions) were mailed to each facility. During the data collection phase, contract personnel were available to answer facilities' questions concerning the survey. Web-based support for facilities completing the questionnaire on the Web was also available. About 4 to 5 weeks after the initial questionnaire mailing, thank-you/reminder letters were sent to all facilities. Approximately 8 weeks after the initial questionnaire mailing, nonresponding facilities were mailed a second questionnaire packet. About 4 to 5 weeks after the second questionnaire mailing, nonrespondents received a reminder telephone call. Those facilities that had not responded within 2 to 3 weeks of the reminder call were telephoned and asked to complete the survey by CATI.

Facility Status and Response Rate

Questionnaires were mailed to those facilities believed to be actively providing substance abuse treatment services, an average of 17,107 facilities each survey year from 2007 through 2009. Of those facilities, approximately 11 percent each survey year were found to be ineligible for the survey because they had either closed or did not provide substance abuse or detoxification services on the reference date. Of the eligible facilities, an average of 94 percent completed the survey each survey year from 2007 through 2009.

Beginning in 1992, SAMHSA expanded efforts to obtain information from nonresponding facilities. A representative sample of nonrespondents was contacted and administered an abbreviated version of the survey instrument via telephone. In 1993 and later years, this effort was extended to all nonresponding facilities. In 1997, a series of measures was introduced to enhance the survey response rate. These included advance notification and improved methods for updating address and contact information, as well as intensive telephone follow-up.

Survey Response Mode

The proportion of facilities using the Web survey to respond to N-SSATS has increased steadily since introduction of the option in 2002. The percentage of facilities responding via the Web increased from 44 percent in 2007 to 58 percent in 2009. Mail response declined from 36 percent in 2007 to 29 percent in 2009. Telephone response, which represents follow-up of facilities that have not responded by mail or Web, also changed, decreasing from 21 percent in 2007 to 14 percent in 2009.

Data Considerations and Limitations

As with any data collection effort, certain procedural considerations and data limitations must be taken into account when interpreting data.

- N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for facility nonresponse (averaging 6 percent in each survey year from 2007 through 2009).
- N-SSATS is a point-prevalence survey. It provides information on the substance abuse treatment system and its clients on the reference date. Client counts do not represent annual totals. Rather, N-SSATS provides a “snapshot” of substance abuse treatment facilities and clients on an average day. As question wording and definitions may vary slightly from year to year, the individual questionnaires should be consulted in any analysis.
- The use of I-SATS as the list frame for N-SSATS imposes certain constraints related to the unit of response and the scope of facilities included. In addition, the expansion of I-SATS in recent years to provide a more complete enumeration of substance abuse treatment facilities means that year-to-year comparisons of the numbers of facilities reporting to N-SSATS must be interpreted with caution.

A.4 Data Processing

NSDUH

At the conclusion of the computer-assisted interview, interviewers securely transmit the completed encrypted data to RTI in Research Triangle Park, North Carolina, via home telephone lines. No personal identifying information is captured in the CAI record for the respondent. Computers at RTI direct the information to a raw data file (i.e., in which no editing of the data had been done) that consists of one record for each completed interview. Cases are retained only if respondents provided data on lifetime use of cigarettes and at least nine other substances in the core section of the questionnaire. Written responses to questions (e.g., names of other drugs that were used) are assigned numeric codes as part of the data processing procedures. Even though editing and consistency checks are done by the CAI program during the interview, additional, more complex edits and consistency checks are also completed during or after data collection processing. Additionally, statistical imputation is used to replace missing or ambiguous values after editing for some key variables. Analysis weights are created so that estimates will be representative of the target population.

Data Coding and Logical Editing

With the exception of industry and occupation data, coding of written answers that respondents or interviewers typed was performed at RTI for the 2005 through 2010 NSDUH. These written answers include mentions of drugs that respondents had used or other responses that did not fit a previous response option (subsequently referred to as "OTHER, Specify" data). Coding of the "OTHER, Specify" variables was accomplished through computer-assisted survey procedures and the use of a secure Web site that allowed for coding and review of the data. The computer-assisted procedures entailed a database check for a given "OTHER, Specify" variable that contained typed entries and the associated numeric codes. If an exact match was found between the typed response and an entry in the system, the computer-assisted procedures assigned the appropriate numeric code. Typed responses that did not match an existing entry were coded through the Web-based coding system. Data on the industries in which respondents worked and on respondents' occupations were assigned numeric industry and occupation codes by staff at the U.S. Census Bureau.

Therefore, the first important step in processing the raw NSDUH data was logical editing of the data. Logical editing involved using data from within a respondent's record to (1) reduce the amount of item nonresponse (i.e., missing data) in interview records, including identification of items that were legitimately skipped; (2) make related data elements consistent with each other; and (3) identify ambiguities or inconsistencies to be resolved through statistical imputation procedures (see Appendix B).

In 2005 through 2010 NSDUHs, statistical imputation was used to replace missing or ambiguous values after completion of data coding and logical editing. Analysis weights were created so that estimates would be representative of the target population.

Statistical Imputation

For some key variables that still had missing or ambiguous values after editing, statistical imputation was used to replace these values with appropriate response codes. For example, a response is ambiguous if the editing procedures assigned a respondent's most recent use of a drug to "use at some point in the lifetime," with no definite period within the lifetime. In this case, the imputation procedures assign a definite value for when the respondent last used the drug (e.g., in the past 30 days, more than 30 days ago but within the past 12 months, more than 12 months ago). Similarly, if a response is completely missing, the imputation procedures replace missing values with nonmissing ones.

In most cases, missing or ambiguous values are imputed in NSDUH using a methodology called predictive mean neighborhood (PMN), which was developed specifically for the 1999 survey and has been used in all subsequent survey years. The PMN method offers a rigorous and flexible method that was implemented to improve the quality of estimates and allow more variables to be imputed. Some of the key reasons for implementing this method include the following: (1) the ability to use covariates to determine donors is far greater than that offered in the hot deck, (2) the relative importance of covariates can be determined by standard estimating equation techniques, (3) the correlations across response variables can be accounted for by

making the imputation multivariate, and (4) sampling weights can be easily incorporated in the models.

The PMN method has some similarity with the predictive mean matching method of Rubin (1986) except that, for the donor records, Rubin used the observed variable value (not the predictive mean) to compute the distance function. Also, the well-known method of nearest neighbor imputation is similar to PMN, except that the distance function is in terms of the original predictor variables and often requires somewhat arbitrary scaling of discrete variables. PMN is a combination of a model-assisted imputation methodology and a random nearest neighbor hot-deck procedure. The hot-deck procedure is set up in such a way that imputed values are made consistent with preexisting nonmissing values for other variables. Whenever feasible, the imputation of variables using PMN is multivariate, in which imputation is accomplished on several response variables at once. Variables requiring imputation using PMN are the core demographic variables, core drug use variables (recency of use, frequency of use, and age at first use), income, health insurance, and noncore demographic variables for work status, immigrant status, and the household roster. A weighted regression imputation is used to impute some of the missing values in the nicotine dependence variables.

In the modeling stage of PMN, the model chosen depends on the nature of the response variable Y . In the 2005 through 2010 NSDUHs, the models included binomial logistic regression, multinomial logistic regression, Poisson regression, and ordinary linear regression, where the models incorporated the sampling design weights.

In general, hot-deck imputation replaces an item nonresponse (missing or ambiguous value) with a recorded response that is donated from a "similar" respondent who has nonmissing data. For random nearest neighbor hot-deck imputation, the missing or ambiguous value is replaced by a responding value from a donor randomly selected from a set of potential donors. Potential donors are those defined to be "close" to the unit with the missing or ambiguous value according to a predefined function called a distance metric. In the hot-deck stage of PMN, the set of candidate donors (the "neighborhood") consists of respondents with complete data who have a predicted mean close to that of the item nonrespondent. The predicted means are computed both for respondents with and without missing data, which differs from Rubin's method, where predicted means are not computed for the donor respondent (Rubin, 1986). In particular, the neighborhood consists of either the set of the closest 30 respondents or the set of respondents with a predicted mean (or means) within 5 percent of the predicted mean(s) of the item nonrespondent, whichever set is smaller. If no respondents are available who have a predicted mean (or means) within 5 percent of the item nonrespondent, the respondent with the predicted mean(s) closest to that of the item nonrespondent is selected as the donor.

In the univariate case (where only one variable is imputed using PMN), the neighborhood of potential donors is determined by calculating the relative distance between the predicted mean for an item nonrespondent and the predicted mean for each potential donor, and then choosing those means defined by the distance metric. The pool of donors is restricted further to satisfy logical constraints whenever necessary (e.g., age at first crack use must not be less than age at first cocaine use).

Whenever possible, missing or ambiguous values for more than one response variable are considered at a time. In this (multivariate) case, the distance metric is a Mahalanobis distance (Manly, 1986) rather than a relative Euclidean distance. Whether the imputation is univariate or multivariate, only missing or ambiguous values are replaced, and donors are restricted to be logically consistent with the response variables that are not missing. Furthermore, donors are restricted to satisfy "likeness constraints" whenever possible. That is, donors are required to have the same values for variables highly correlated with the response. If no donors are available who meet these conditions, these likeness constraints can be loosened. For example, donors for the age-at-first-use variable are required to be the same age as the recipients, if at all possible. Further details on the PMN methodology are provided in RTI International (2013) and in Singh, Grau, and Folsom (2001, 2002).

Although statistical imputation could not proceed separately within each State due to insufficient pools of donors, information about each respondent's State of residence was incorporated in the modeling and hot-deck steps. For most drugs, respondents were separated into three "State usage" categories as follows: respondents from States with high usage of a given drug were placed into one category, respondents from States with medium usage were placed into another, and the remainder were placed into a third category. This categorical "State rank" variable was used as one set of covariates in the imputation models. In addition, eligible donors for each item nonrespondent were restricted to be of the same State usage category (i.e., the same "State rank") as the nonrespondent.

Development of Analysis Weights

The general approach to developing and calibrating analysis weights involved developing design-based weights, d_k , as the product of the inverse of the selection probabilities at each selection stage. Unlike previous NSDUHs with three stages of selection (i.e., selection of segments, selection of household, and selection of persons), the 2005, 2006, and 2007 NSDUHs used a four-stage sample selection scheme in which an extra selection stage of census tracts was added before the selection of a segment. Thus, the design-based weights, d_k , for the 2006 and 2007 NSDUH incorporated an extra layer of sampling selection to reflect the sample design change. Adjustment factors, $a_k(\lambda)$, then were applied to the design-based weights to adjust for nonresponse, to poststratify to known population control totals, and to control for extreme weights when necessary. In view of the importance of State-level estimates with the 50-State design, it was necessary to control for a much larger number of known population totals. Several other modifications to the general weight adjustment strategy that had been used in past surveys also were implemented for the first time beginning with the 1999 CAI sample.

Weight adjustments were based on a generalization of Deville and Särndal's (1992) logit model. This generalized exponential model (GEM) (Folsom & Singh, 2000) incorporates unit-specific bounds, $(\ell_k, u_k), k \in s$, for the adjustment factor $a_k(\lambda)$ as follows:

$$a_k(\lambda) = \frac{\ell_k(u_k - c_k) + u_k(c_k - \ell_k)\exp(A_k x_k' \lambda)}{(u_k - c_k) + (c_k - \ell_k)\exp(A_k x_k' \lambda)},$$

where c_k are prespecified centering constants, such that $\ell_k < c_k < u_k$ and $A_k = (u_k - \ell_k) / (u_k - c_k)(c_k - \ell_k)$. The variables ℓ_k, c_k , and u_k are user-specified bounds, and λ is the column vector of p model parameters corresponding to the p covariates x . The λ -parameters are estimated by solving

$$\sum_s x_k d_k a_k(\lambda) - \tilde{T}_x = 0,$$

where \tilde{T}_x denotes control totals that could be either nonrandom, as is generally the case with poststratification, or random, as is generally the case for nonresponse adjustment.

The final weights $w_k = d_k a_k(\lambda)$ minimize the distance function $\Delta(w, d)$ defined as

$$\Delta(w, d) = \sum_{k \in s} \frac{d_k}{A_k} \left\{ (a_k - \ell_k) \log \frac{a_k - \ell_k}{c_k - \ell_k} + (u_k - a_k) \log \frac{u_k - a_k}{u_k - c_k} \right\}.$$

This general approach was used at several stages of the weight adjustment process, including (1) adjustment of household weights for nonresponse at the screener level, (2) poststratification of household weights to meet population controls for various demographic groups by State, (3) adjustment of household weights for extremes, (4) poststratification of selected person weights, (5) adjustment of responding person weights for nonresponse at the questionnaire level, (6) poststratification of responding person weights, and (7) adjustment of responding person weights for extremes.

Every effort was made to include as many relevant State-specific covariates (typically defined by demographic domains within States) as possible in the multivariate models used to calibrate the weights (nonresponse adjustment and poststratification steps). Because further subdivision of State samples by demographic covariates often produced small cell sample sizes, it was not possible to retain all State-specific covariates (even after meaningful collapsing of covariate categories) and still estimate the necessary model parameters with reasonable precision. Therefore, a hierarchical structure was used in grouping States with covariates defined at the national level, at the census division level within the Nation, at the State group within the census division, and, whenever possible, at the State level. In every case, the controls for the total population within a State and the five age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 or older) within a State were maintained except that, in the last step of poststratification of person weights, six age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 to 64, 65 or older) were used. Census control totals by age, race, gender, and Hispanicity were required for the civilian, noninstitutionalized population of each State. Beginning with the 2002 NSDUH, the Population Estimates Branch of the U.S. Census Bureau has produced the necessary population estimates in response to a special request based on the 2000 census.

Consistent with the surveys from 1999 onward, control of extreme weights through separate bounds for adjustment factors was incorporated into the GEM calibration processes for both nonresponse and poststratification. This is unlike the traditional method of winsorization in which extreme weights are truncated at prespecified levels and the trimmed portions of weights

are distributed to the nontruncated cases. In GEM, it is possible to set bounds around the prespecified levels for extreme weights, and then the calibration process provides an objective way of deciding the extent of adjustment (or truncation) within the specified bounds. A step was added to poststratify the household-level weights to obtain census-consistent estimates based on the household rosters from all screened households; these household roster-based estimates then provided the control totals needed to calibrate the respondent pair weights for subsequent planned analyses. An additional step poststratified the selected person sample to conform to the adjusted roster estimates. This additional step takes advantage of the inherent two-phase nature of the NSDUH design. The final step poststratified the respondent person sample to external census data (defined within the State whenever possible, as discussed above). For more detailed information, see the *2010 NSDUH Methodological Resource Book* (RTI International, 2008).

For certain populations of interest, multiple years of NSDUH data were combined to obtain annual averages. The person-level weights for estimates based on the annual averages were obtained by dividing the analysis weights for the multiple specific years by a factor of the number of years.

TEDS

In 2007, 2008, and 2009, TEDS records with partially complete data were retained. Where records included missing or invalid data for a specific variable, those records were excluded from tabulations of that variable. This section describes the processing of the TEDS data once the States have submitted the TEDS data files to SAMHSA. For a description of the data collection procedures conducted by the States, see Section A.3 of this appendix.

Upon receipt of the TEDS data files, Synectics verifies that the records meet the required standards, makes the appropriate updates to the TEDS database, and produces feedback reports summarizing the results of the data processing. The processing completed by Synectics includes the following:

- checking each record submitted to verify that all TEDS key fields are valid;
- cross-checking information within records to ensure consistency and accuracy;
- ensuring that each record in the TEDS database is unique;
- notifying States of errors in their data submissions and providing help to resolve State submission problems;
- ensuring appropriate security of State submissions;
- promptly returning the diskette or CD to the States (if so instructed); and
- providing States with TEDS Quarterly Feedback Reports at the end of each calendar quarter.

Processing Data Submitted through STSS

When data are submitted through the STSS, most processing and editing steps are done automatically, with immediate feedback of processing reports available to the State. Data files uploaded by the State to the STSS are tested with all TEDS edit procedures, and processing reports are automatically generated. States may correct errors and retest the file until the data are deemed ready for final processing and addition to the TEDS database. At that time, the State submits the file through the STSS to Synectics, who does the final processing.

The information that follows describes procedures that are performed automatically through the STSS or are performed by Synectics for non-STSS data submissions.

Processing Data Submitted by Diskette, CD, or Electronic Transmission

The most important data fields in processing a State TEDS submission are the System Transaction Type codes (Add, Delete, and Change) and the key fields (State Code, Provider Identifier, Client Identifier, Co-Dependent/Collateral, Client Transaction Type, Date of Admission, and Type of Service). The System Transaction Type code determines whether to add, delete, or correct a record in the database. The key fields combine to form a unique identifier for each record in the TEDS database. Records with an invalid key field are not included in the final data set or used in analyses.

The records in a submission are processed in the following order according to the transaction code: Deletes, followed by Changes, followed by Adds. (This same order is followed during the STSS validation procedures). Within this processing order, records are matched against the database and the indicated action is performed. An "Add" record with key fields identical to another "add" record in the submission or to a record in the TEDS database is considered to be a duplicate and is rejected unless there is a corresponding "delete" record. Rejected records are not added to the database.

In addition to checking for duplicates and invalid key fields, the edit program examines all other fields on the admission record to make sure each field has a valid code. If errors are detected, the records and the errors or inconsistencies are listed in the processing reports. Records with errors in nonkey fields are added to the database, even those that contain one or more fields with invalid codes.

After Synectics receives a non-STSS State submission, the contractor runs the edit program in a "test mode." In this mode, the edit is performed and duplicate records and records with errors are identified, but the records are not added to the TEDS database. A processing feedback report is produced and the results are reviewed. If the data file is "reasonably clean," the submission is run again with the program in "production mode," adding acceptable records to the database. A processing report is produced and sent to the State so that detected errors may be corrected. If the test run shows a significant number of records with errors in the Minimum or Supplemental Data Set and/or a significant number of records that were rejected, Synectics will notify the State by telephone or e-mail that the file will not be run for production. Synectics will work with the State to make the necessary corrections so the data may be resubmitted.

Processing Reports

The STSS generates processing reports automatically for files submitted through STSS. Synectics will provide States with feedback regarding each non-STSS data submission. For each submission, each State will receive the following:

- Acknowledgment letter confirming that Synectics has received and incorporated the State's data into TEDS.
- *Submission Processing Results Summary—Admissions*, showing the number of records submitted and accepted and rejected in the submission. This report also provides information on the number of records rejected by reason for rejection and provides summary statistics on any invalid data in the Minimum and Supplementary Data Set fields.

When applicable, the State will also receive one or more of the following reports:

- *Fatal and Warning Errors in TEDS Submission—Grouped by Reason*, displays records rejected in the processing because of problems found in key fields (fatal errors) and records with errors in nonkey fields that will be added to the database with the error. Records are displayed in groups according to the reason for the error.
- *Fatal and Warning Errors in TEDS Submission—Grouped by Field*, displays records rejected in the processing because of problems found in key fields (fatal errors) and records with errors in nonkey fields that will be added to the database with the error. Records are displayed in groups according to the field responsible for the error.

The *Submission Processing Results Summary—Admissions* and the *Fatal and Warning Errors in TEDS Submission* reports, along with other report options, are immediately available to the STSS user. These reports will be sent as e-mail attachments for data files not submitted through the STSS.

States are responsible for reviewing these reports, resolving the errors, and resubmitting corrected records.

Frequent Errors in TEDS Records

In order to help prevent potential errors and to make the submission process smoother, States are alerted to the following commonly occurring errors:

- Records in a submission that are duplicates of other records;
- Misuse of Detailed Codes;
- Age at First Use and Age of Client (Date of Birth) Discrepancies;
- Improper Use of Detailed Drug Codes;

- Client’s Status at Time of Admission; and
- Errors in the Provider ID.

Error Resolution and Correction of Client Records

The States review the submission processing reports so that they are aware of both systematic and individual errors detected during data processing. The *Submission Processing Results Summary Report* provides counts of the total number of errors found in the fields of the Minimum and Supplementary Data Sets. Examination of this report gives an overall evaluation of the quality of the submission in terms of records rejected because of errors in a key field and the number of accepted records with an error in a nonkey field. If State edits are working properly, the number of errors in any submission should be low (less than 5 percent). If a data field has a very large number of errors, it probably indicates a systematic error that, once resolved, will correct many of the records. Nonsystematic errors found in a submission require the examination of individual records to identify the error and discover the cause. Examination of the *Fatal and Warning Errors in TEDS Submission—Grouped by Reason* will assist States in determining the cause of the errors. This report shows each individual record by Client ID and other key fields, and contains a brief explanation of the erroneous field. Examination of this report should explain the reason for most errors. In those cases that are still in question, Synectics can assist the State in error resolution. Additional information on error correction is available in the *Treatment Episode Data Set (TEDS) State Instruction Manual Admission Data with National Outcomes Measures (NOMS)*, which is available at <http://www.dasis.samhsa.gov/dasis2/teds.htm>.

TEDS Master Files and Acceptable Admission Date

The TEDS Masterfile contains all of the accepted admission records submitted by the States (the files do not include records rejected during processing). The Masterfile consists of two components: an active file and an archived file. The TEDS Active Masterfile contains admissions data with date of admission in January 1, 2000, and later. Admission records older than that have been archived. Any data submitted with an admission date during the archive period will be rejected during the TEDS processing.

Resubmitting Data

States not using the STSS are notified of the status of their submission by a telephone call or e-mail from Synectics or by receipt of State feedback reports. Sometimes State submissions cannot be processed because the entire submission is unreadable. States will be notified by telephone of such major problems, and Synectics will work with the State to resolve them. States should resubmit corrected files in a timely manner. For situations in which a resubmission is necessary, States may send the data as a separate “special” resubmission, or they may include the resubmission with their next regular submission.

N-SSATS

Data Editing and Quality Assurance

The N-SSATS paper-and-pencil questionnaires allow respondents to leave some questions blank while still having the opportunity to respond to subsequent questions. In 2007 through 2009, all N-SSATS mail questionnaires were reviewed manually for consistency and for missing data. Calls were made to facilities to clarify questionable responses and to obtain missing data. If facilities could not be reached during the edit callbacks, responses that were clearly in error were replaced by imputation. After data entry, automated quality assurance reviews were conducted. The reviews incorporated the rules used in manual editing, plus consistency checks and checks for data outliers not readily identified by manual review. Item nonresponse was minimized through careful editing and extensive follow-up. The Web questionnaire was programmed to be self-editing; that is, respondents were prompted to complete missing responses and to confirm or correct inconsistent responses.

Item Nonresponse

Careful editing and extensive follow-up have minimized item nonresponse. Item nonresponse was generally low, averaging 3 percent across all items. It was 10 percent or more for only 13 items. Missing data for client count variables (i.e., the number of clients in hospital inpatient, residential [nonhospital], and outpatient treatment, and their subcategories) were imputed, as were total annual admissions. Facilities with missing values for nonimputed variables were excluded from the tabulations using those variables. As a result, the numbers of treatment facilities on which tables are based may vary somewhat from table to table. The total number of facilities is generally included on each table.

Appendix B provides information on the methodology used for imputation of missing N-SSATS data and outliers.

Appendix B: Statistical Methods and Measurement

This appendix describes and compares the statistical methods and measurement for the three sources of data for the estimates of receipt of substance abuse treatment that were presented in this report: NSDUH, TEDS, and N-SSATS.

Because of the multiple differences in scope of information gathered and methodology between the three data sets (described in Appendix A), there is variation in the complexity of their data processing procedures and statistical methods.

TEDS

Methodology for TEDS Estimates of Single-Day Treatment Counts

The following methods were used to produce single-day treatment counts and average counts of the number of persons who received treatment during calendar years 2007, 2008, and 2009.

Data Files

TEDS admissions and linked discharge records for data submitted through October 10, 2011, were used for these counts. Both counts used records reflecting admissions and those reflecting transfers from other substance use treatment services; records of codependents (persons who do not have a substance use disorder but who receive treatment because a loved one has a substance use disorder) were excluded.

Data Definitions and Recoding

Substances of Abuse. The substance treatment categories were assigned using the TEDS, based on data reported as primary, secondary, and tertiary problem substances. If alcohol was reported as the primary problem substance and no secondary or tertiary problem substance was recorded, the case was categorized as alcohol-only treatment. If alcohol was reported as the primary problem substance and a drug was reported as the secondary and/or tertiary problem substance, the case was categorized as primary alcohol with secondary drug treatment. Likewise, if a drug was reported as the primary problem substance and alcohol was not reported as the secondary or tertiary problem substance, the case was categorized as drug-only treatment. If a drug was reported as the primary problem substance and alcohol was reported as either the secondary or tertiary problem substance, the case was categorized as primary drug with secondary alcohol treatment.

The numbers of admissions on March 30, 2007; March 31, 2008; and March 31, 2009, were calculated as described previously, and then averaged over the 3 years. The primary substances of abuse included the following:

- Marijuana: TEDS category 4=*Marijuana/hashish*
- Prescription drugs: TEDS categories 7=*Other opiates and synthetics* (i.e., other than heroin and methadone); 12=*Other stimulants* (i.e., other than methamphetamine and amphetamine); 13-14=*Benzodiazepines* and *Other non-benzodiazepine tranquilizers*; and 15-16=*Barbiturates* and *Other non-barbiturate sedatives or hypnotics*
- Methamphetamine: TEDS category 10=*Methamphetamine*
- Inhalants: TEDS category 17=*Inhalants*
- Hallucinogens: TEDS category 9=*Other hallucinogens* (i.e., other than phencyclidine [PCP])
- Alcohol: TEDS category 2=*Alcohol*

Modality (Type of Service). For the report variable “Modality,” the eight TEDS service type categories were combined:

- Hospital inpatient: Hospital detoxification; hospital residential/rehabilitation
- Outpatient rehabilitation: Outpatient; intensive outpatient; ambulatory outpatient
- Residential rehabilitation: Free-standing residential detoxification; short-term residential/rehabilitation; long-term residential/rehabilitation

Estimation Methodology

Estimates of the numbers of clients in treatment on a single day comprised two parts. The time period of this report covers a period of significant improvement in discharge data reporting.

1. Linked records represent clients who had been both admitted and discharged. The number of clients who were admitted on or before the reference date and discharged on or after the reference date was calculated.
2. Admissions records with no linked discharge should indicate that a client has been admitted and not yet discharged. However, because the discharge system was not fully operative in all States for the dates required, it can be assumed that a number of the admissions had in fact been discharged. Therefore, a probability of having been discharged by each reference date was computed for each record.
 - a. Admission and linked records were compared to identify unlinked readmission records. A frequency distribution of length of stay (LOS) in treatment was computed by service type using all linked records. (LOS is highly correlated with service type.) Service types were
 - Opioid Treatment Programs (OTP) detox
 - Non-OTP detox
 - Hospital residential

- Short-term residential
- Long-term residential
- OTP intensive outpatient
- OTP outpatient
- OTP ambulatory detox
- Non-OTP intensive outpatient
- Non-OTP outpatient
- Non-OTP ambulatory detox

LOS was computed as date of last contact minus date of admission plus 1.

- b. The probability of being in treatment on the reference date was calculated as 1 minus the cumulative frequency (i.e., if 0.34 (34 percent). If clients had been discharged by day 10, then a record with date of admission 10 days before the reference date had a $1.00 - 0.34 = 0.66$ (66 percent) chance of being in treatment on the reference date.
- c. The probability of being in treatment for each reference date was attached to each admission record. Probabilities of being in treatment were summed for each reference date. Thus, if 100 clients were admitted 10 days before the reference date, each would have a probability of 0.66, yielding a total of 66 clients likely to be in treatment on the reference date.
- d. Data from 2000 to 2009 were used to check the plausibility that estimated counts based on these procedures were accurate.

N-SSATS

Methodology of Imputation of Missing Data and Outliers

Client count variables (i.e., the number of clients in hospital inpatient, nonhospital residential, and outpatient treatment, and their subcategories) and total annual admissions were candidates for imputation. In 2007 and 2008, a total of 92 facilities in each year were missing 1-day client census counts for one or more types of service. In 2009, a total of 15 facilities were missing 1-day client census counts for one or more types of service. A facility was given an imputed value for a type of service if it reported that it provided the service but had not provided client counts for that service type. For example, if a facility reported that it provided hospital inpatient services and outpatient services, but not nonhospital residential services, client values were imputed for the hospital inpatient and outpatient variables only.

Outliers were identified as cases where the number of clients reported exceeded the 75th percentile of the distribution of client counts for all cases of one of the main service types. The

2007, 2008, and 2009 values were each compared with the respective average of previous years' data. If the difference exceeded 1.8 times the previous year's value in either direction, the value was imputed.

When available, client values from up to 5 previous years were used to impute the missing client counts on the 2007, 2008, and 2009 N-SSATS. In all other cases, the average client value, stratified by State and facility operation, was used to impute the missing client counts. If a facility were unique in its State and facility operation category, values were imputed using average values for the State only. Missing client counts were imputed for each type of service (i.e., hospital inpatient detoxification, hospital inpatient treatment, nonhospital residential detoxification, etc.) and summed to the larger service type totals (total hospital inpatient clients, total nonhospital residential clients, and total outpatient clients), and finally to total clients.

Appendix C: Estimate and Confidence Interval Tables for Chapters 2 and 3

Table C.2.1 Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in the United States: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average (All States)				NSDUH 2005 to 2010 Average (TEDS States Only ¹)				TEDS ² 2007 to 2009 Average	
	Number (95% CI)		Percentage (95% CI)		Number (95% CI)		Percentage (95% CI)		Number	Percentage
Total Modality	2,464,150	(2,336,545-2,598,650)	100.0	(NA)	2,357,118	(2,230,925-2,490,372)	100.0	(NA)	1,928,578	100.0
Hospital Inpatient Residential	774,093	(717,561-832,956)	31.4	(29.1-33.8)	738,366	(683,035-796,048)	31.3	(29.0-33.8)	61,382	3.2
Rehabilitation—Inpatient	1,004,459	(943,901-1,066,177)	40.8	(38.3-43.3)	956,002	(896,748-1,016,446)	40.6	(38.0-43.1)	543,456	28.2
Outpatient	1,999,029	(1,946,842-2,047,078)	81.1	(79.0-83.1)	1,916,780	(1,865,867-1,963,529)	81.3	(79.2-83.3)	1,507,988	78.2
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	1,673,268	(1,612,645-1,731,535)	67.9	(65.4-70.3)	1,608,483	(1,548,797-1,665,730)	68.2	(65.7-70.7)	NA	NA
	1,032,262	(970,415-1,095,160)	41.9	(39.4-44.4)	978,815	(918,237-1,040,499)	41.5	(39.0-44.1)	NA	NA
Substance										
Marijuana	764,690	(712,629-818,777)	31.0	(28.9-33.2)	727,542	(676,554-780,588)	30.9	(28.7-33.1)	766,433	39.7
Cocaine (including crack)	636,416	(582,894-693,043)	25.8	(23.7-28.1)	603,954	(551,842-659,192)	25.6	(23.4-28.0)	488,826	25.3
Heroin	341,168	(295,184-393,017)	13.8	(12.0-15.9)	329,798	(284,515-380,964)	14.0	(12.1-16.2)	293,395	15.2
Prescription Drugs	657,661	(608,386-709,401)	26.7	(24.7-28.8)	620,335	(572,908-670,213)	26.3	(24.3-28.4)	240,288	12.5
Methamphetamine	NA		NA		NA		NA		213,176	11.1
Inhalants	149,737	(125,109-178,843)	6.1	(5.1-7.3)	141,049	(117,242-169,325)	6.0	(5.0-7.2)	3,574	0.2
Hallucinogens	271,434	(239,619-306,889)	11.0	(9.7-12.5)	257,338	(226,090-292,312)	10.9	(9.6-12.4)	12,139	0.6
Alcohol	1,695,291	(1,638,653-1,749,738)	68.8	(66.5-71.0)	1,632,830	(1,577,951-1,685,488)	69.3	(66.9-71.5)	1,146,597	59.5
Route of Administration										
Injection	178,090	(148,707-212,739)	7.3	(6.1-8.7)	169,501	(141,004-203,224)	7.3	(6.0-8.7)	238,459	12.4
Age										
12 to 17	158,143	(143,811-173,796)	6.4	(5.8-7.1)	150,083	(136,210-165,265)	6.4	(5.8-7.0)	170,289	8.8
18 to 24	462,044	(431,746-493,952)	18.8	(17.5-20.0)	439,308	(409,767-470,464)	18.6	(17.4-20.0)	372,992	19.3
25 to 34	576,308	(526,266-629,563)	23.4	(21.4-25.5)	552,228	(503,174-604,505)	23.4	(21.3-25.6)	504,865	26.2
35 to 44	556,134	(504,025-611,948)	22.6	(20.5-24.8)	531,826	(480,747-586,636)	22.6	(20.4-24.9)	446,508	23.2
45 or Older	711,521	(645,450-781,449)	28.9	(26.2-31.7)	683,673	(618,226-753,049)	29.0	(26.2-31.9)	433,924	22.5

Table C.2.1 Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in the United States: NSDUH 2005 to 2010 and TEDS 2007 to 2009 (continued)

	NSDUH 2005 to 2010 Average (All States)				NSDUH 2005 to 2010 Average (TEDS States Only ¹)				TEDS ² 2007 to 2009 Average	
	Number (95% CI)		Percentage (95% CI)		Number (95% CI)		Percentage (95% CI)		Number	Percentage
Race/Ethnicity										
Not Hispanic or Latino	2,153,846	(2,104,459-2,197,311)	87.4	(85.4-89.2)	2,047,365	(1,998,418-2,090,523)	86.9	(84.8-88.7)	1,601,402	85.3
White	1,636,071	(1,571,302-1,698,431)	66.4	(63.8-68.9)	1,569,932	(1,506,777-1,630,658)	66.6	(63.9-69.2)	1,135,068	60.4
Black/African American	422,623	(371,984-478,580)	17.2	(15.1-19.4)	386,811	(337,899-441,257)	16.4	(14.3-18.7)	368,823	19.6
American Indian/Alaska Native	29,939	(21,804-41,059)	1.2	(0.9-1.7)	27,490	(19,595-38,515)	1.2	(0.8-1.6)	39,924	2.1
Asian/Pacific Islander	24,320	(14,499-40,683)	1.0	(0.6-1.7)	22,721	(13,173-39,072)	1.0	(0.6-1.7)	21,267	1.1
Two or More Races	40,892	(29,041-57,463)	1.7	(1.2-2.3)	40,410	(28,580-57,017)	1.7	(1.2-2.4)	11,031	0.6
Other	NA		NA		NA		NA		25,285	1.3
Hispanic or Latino	310,304	(266,839-359,691)	12.6	(10.8-14.6)	309,753	(266,594-358,700)	13.1	(11.3-15.2)	276,702	14.7
Gender										
Male	1,640,333	(1,581,404-1,697,236)	66.6	(64.2-68.9)	1,573,132	(1,515,045-1,629,138)	66.7	(64.3-69.1)	1,292,491	67.0
Female	823,817	(766,914-882,746)	33.4	(31.1-35.8)	783,985	(727,980-842,073)	33.3	(30.9-35.7)	635,540	33.0
Years of Education										
0 to 8 Years	138,804	(115,522-166,444)	5.6	(4.7-6.8)	133,869	(111,027-161,073)	5.7	(4.7-6.8)	180,424	9.5
9 to 11 Years	670,605	(616,389-727,711)	27.2	(25.0-29.5)	633,850	(581,585-688,989)	26.9	(24.7-29.2)	541,507	28.6
12 (High School/GED)	816,660	(759,160-876,277)	33.1	(30.8-35.6)	779,985	(723,609-838,499)	33.1	(30.7-35.6)	752,030	39.8
More than 12	838,081	(775,417-903,102)	34.0	(31.5-36.6)	809,414	(747,831-873,316)	34.3	(31.7-37.1)	417,619	22.1

* Low precisions; no estimate reported.

NA = not available.

¹ TEDs States exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years (2007-2009).

² See Appendix B for information concerning how TEDS admissions data were adjusted to be person-level data.

Table C.2.1AL Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment at Any Location in the Past Year in the United States: NSDUH 2005 to 2010

	NSDUH 2005 to 2010 Average (All States)				NSDUH 2005 to 2010 Average (TEDS States Only ¹)			
	Number (95% CI)		Percentage (95% CI)		Number (95% CI)		Percentage (95% CI)	
Total	4,062,843	(3,901,488-4,230,757)	100.0	(NA)	3,889,756	(3,732,045-4,054,015)	100.0	(NA)
Modality								
Hospital Inpatient	774,093	(713,157-838,933)	19.1	(17.6-20.6)	738,366	(678,187-802,552)	19.0	(17.4-20.6)
Residential Rehabilitation— Inpatient	1,004,459	(936,827-1,075,294)	24.7	(23.1-26.5)	956,002	(889,915-1,025,319)	24.6	(22.9-26.4)
Outpatient	1,999,029	(1,918,180-2,079,981)	49.2	(47.2-51.2)	1,916,780	(1,836,981-1,996,674)	49.3	(47.2-51.3)
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	1,673,268	(1,592,592-1,755,126)	41.2	(39.2-43.2)	1,608,483	(1,528,654-1,689,498)	41.4	(39.3-43.4)
	1,032,262	(964,029-1,103,604)	25.4	(23.7-27.2)	978,815	(911,778-1,049,044)	25.2	(23.4-27.0)
Substance								
Marijuana	1,075,829	(1,015,367-1,138,546)	26.5	(25.0-28.0)	1,022,197	(962,487-1,084,240)	26.3	(24.7-27.9)
Cocaine (including crack)	782,136	(720,415-847,802)	19.3	(17.7-20.9)	741,993	(682,208-805,702)	19.1	(17.5-20.7)
Heroin	398,011	(346,348-456,433)	9.8	(8.5-11.2)	386,491	(335,392-444,402)	9.9	(8.6-11.4)
Prescription Drugs	829,629	(769,277-893,430)	20.4	(18.9-22.0)	789,473	(731,471-850,836)	20.3	(18.8-21.9)
Methamphetamine	NA		NA		NA		NA	
Inhalants	210,565	(177,794-248,991)	5.2	(4.4-6.1)	201,459	(170,337-237,905)	5.2	(4.4-6.1)
Hallucinogens	362,935	(322,743-407,586)	8.9	(7.9-10.0)	347,833	(307,979-392,280)	8.9	(7.9-10.1)
Alcohol	2,607,725	(2,532,596-2,681,178)	64.2	(62.3-66.0)	2,507,755	(2,434,410-2,579,393)	64.5	(62.6-66.3)
Route of Administration								
Injection	207,589	(175,011-245,845)	5.1	(4.3-6.1)	197,800	(166,685-234,355)	5.1	(4.3-6.1)
Age								
12 to 17	324,763	(302,954-347,996)	8.0	(7.5-8.6)	308,631	(287,431-331,250)	7.9	(7.4-8.5)
18 to 24	826,199	(785,231-868,738)	20.3	(19.3-21.4)	794,147	(754,596-835,218)	20.4	(19.4-21.5)
25 to 34	895,344	(830,321-963,941)	22.0	(20.4-23.7)	864,838	(800,847-932,399)	22.2	(20.6-24.0)
35 to 44	879,887	(813,458-950,153)	21.7	(20.0-23.4)	819,699	(755,903-887,354)	21.1	(19.4-22.8)
45 or Older	1,136,651	(1,051,851-1,225,506)	28.0	(25.9-30.2)	1,102,441	(1,018,414-1,190,528)	28.3	(26.2-30.6)

Table C.2.1AL Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment at Any Location in the Past Year in the United States: NSDUH 2005 to 2010 (continued)

	NSDUH 2005 to 2010 Average (All States)			NSDUH 2005 to 2010 Average (TEDS States Only ¹)		
	Number (95% CI)		Percentage (95% CI)	Number (95% CI)		Percentage (95% CI)
Race/Ethnicity						
Not Hispanic or Latino	3,484,002	(3,415,408-3,546,427)	85.8 (84.1-87.3)	3,318,307	(3,250,736-3,379,854)	85.3 (83.6-86.9)
White	2,718,528	(2,635,127-2,799,392)	66.9 (64.9-68.9)	2,616,805	(2,534,842-2,696,145)	67.3 (65.2-69.3)
Black/African American	610,258	(550,305-675,486)	15.0 (13.5-16.6)	553,887	(496,105-617,176)	14.2 (12.8-15.9)
American Indian/Alaska Native	52,882	(40,139-69,600)	1.3 (1.0-1.7)	47,892	(35,617-64,325)	1.2 (0.9-1.7)
Asian/Pacific Islander	42,835	(30,212-60,652)	1.1 (0.7-1.5)	41,128	(28,702-58,851)	1.1 (0.7-1.5)
Two or More Races	59,500	(45,779-77,254)	1.5 (1.1-1.9)	58,595	(44,892-76,398)	1.5 (1.2-2.0)
Other	NA		NA	NA		NA
Hispanic or Latino	578,842	(516,416-647,436)	14.2 (12.7-15.9)	571,449	(509,902-639,020)	14.7 (13.1-16.4)
Gender						
Male	2,757,238	(2,685,608-2,826,858)	67.9 (66.1-69.6)	2,642,971	(2,572,570-2,711,334)	67.9 (66.1-69.7)
Female	1,305,605	(1,235,985-1,377,236)	32.1 (30.4-33.9)	1,246,784	(1,178,422-1,317,186)	32.1 (30.3-33.9)
Years of Education						
0 to 8 Years	267,965	(233,343-307,312)	6.6 (5.7-7.6)	257,366	(223,210-296,326)	6.6 (5.7-7.6)
9 to 11 Years	1,056,425	(990,351-1,125,293)	26.0 (24.4-27.7)	997,768	(933,601-1,064,757)	25.7 (24.0-27.4)
12 (High School/GED)	1,293,156	(1,222,102-1,366,354)	31.8 (30.1-33.6)	1,239,086	(1,169,770-1,310,531)	31.9 (30.1-33.7)
More than 12	1,445,297	(1,365,615-1,526,996)	35.6 (33.6-37.6)	1,395,536	(1,317,781-1,475,247)	35.9 (33.9-37.9)

* Low precisions; no estimate reported.

NA = not available.

¹ TEDs States exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years (2007-2009).

Table C.2.1NH Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs Excluding Persons Receiving Treatment Solely from Hospital-Based Programs in the Past Year in the United States: NSDUH 2005 to 2010

	NSDUH 2005 to 2010 Average (All States)				NSDUH 2005 to 2010 Average (TEDS States Only ¹)			
	Number (95% CI)		Percentage (95% CI)		Number (95% CI)		Percentage (95% CI)	
Total	2,329,327	(2,205,220-2,460,348)	100.0	(NA)	2,227,200	(2,105,179-2,356,223)	100.0	(NA)
Modality								
Residential Rehabilitation—								
Inpatient	1,004,459	(946,176-1,063,571)	43.1	(40.6-45.7)	956,002	(899,203-1,013,650)	42.9	(40.4-45.5)
Outpatient	1,999,029	(1,956,193-2,037,680)	85.8	(84.0-87.5)	1,916,780	(1,874,835-1,954,458)	86.1	(84.2-87.8)
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	1,673,268	(1,617,351-1,726,430)	71.8	(69.4-74.1)	1,608,483	(1,553,897-1,660,258)	72.2	(69.8-74.5)
Facility—Outpatient	1,032,262	(972,246-1,092,998)	44.3	(41.7-46.9)	978,815	(919,747-1,038,662)	43.9	(41.3-46.6)
Substance								
Marijuana	737,198	(687,065-789,232)	31.6	(29.5-33.9)	701,534	(652,502-752,489)	31.5	(29.3-33.8)
Cocaine (including crack)	609,513	(558,547-663,387)	26.2	(24.0-28.5)	577,424	(528,052-629,702)	25.9	(23.7-28.3)
Heroin	322,623	(278,560-372,391)	13.9	(12.0-16.0)	311,890	(268,572-360,907)	14.0	(12.1-16.2)
Prescription Drugs	633,240	(585,481-683,368)	27.2	(25.1-29.3)	599,023	(553,118-647,264)	26.9	(24.8-29.1)
Methamphetamine	NA		NA		NA		NA	
Inhalants	145,398	(121,631-173,445)	6.2	(5.2-7.4)	136,741	(113,838-163,895)	6.1	(5.1-7.4)
Hallucinogens	261,816	(231,301-295,789)	11.2	(9.9-12.7)	247,720	(217,893-281,059)	11.1	(9.8-12.6)
Alcohol	1,599,275	(1,545,414-1,651,059)	68.7	(66.3-70.9)	1,538,275	(1,485,921-1,588,521)	69.1	(66.7-71.3)
Route of Administration								
Injection	164,666	(137,773-196,333)	7.1	(6.0-8.5)	156,678	(130,734-187,307)	7.1	(5.9-8.5)
Age								
12 to 17	145,276	(131,797-160,033)	6.2	(5.7-6.9)	138,634	(125,589-152,935)	6.2	(5.6-6.9)
18 to 24	437,325	(407,517-468,781)	18.8	(17.5-20.1)	417,180	(388,151-447,852)	18.7	(17.4-20.1)
25 to 34	559,354	(510,754-611,025)	24.0	(21.9-26.2)	536,170	(488,600-586,808)	24.1	(21.9-26.3)
35 to 44	538,483	(487,094-593,548)	23.1	(20.9-25.5)	514,175	(463,925-568,115)	23.1	(20.8-25.5)
45 or Older	648,888	(585,948-715,814)	27.9	(25.2-30.7)	621,041	(559,099-687,018)	27.9	(25.1-30.8)

Table C.2.1NH Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs Excluding Persons Receiving Treatment Solely from Hospital-Based Programs in the Past Year in the United States: NSDUH 2005 to 2010 (continued)

	NSDUH 2005 to 2010 Average (All States)				NSDUH 2005 to 2010 Average (TEDS States Only ¹)			
	Number (95% CI)		Percentage (95% CI)		Number (95% CI)		Percentage (95% CI)	
Race/Ethnicity								
Not Hispanic or Latino	2,045,502	(1,998,589-2,086,570)	87.8	(85.8-89.6)	1,943,927	(1,897,251-1,984,844)	87.3	(85.2-89.1)
White	1,555,494	(1,493,771-1,614,838)	66.8	(64.1-69.3)	1,492,639	(1,432,418-1,550,453)	67.0	(64.3-69.6)
Black/African American	401,174	(351,973-455,669)	17.2	(15.1-19.6)	365,836	(318,369-418,828)	16.4	(14.3-18.8)
American Indian/Alaska Native	26,697	(19,411-36,673)	1.1	(0.8-1.6)	24,248	(17,219-34,101)	1.1	(0.8-1.5)
Asian/Pacific Islander	22,410	(12,942-38,687)	1.0	(0.6-1.7)	21,932	(12,521-38,294)	1.0	(0.6-1.7)
Two or More Races	39,727	(28,005-56,236)	1.7	(1.2-2.4)	39,272	(27,572-55,810)	1.8	(1.2-2.5)
Other	NA		NA		NA		NA	
Hispanic or Latino	283,825	(242,757-330,738)	12.2	(10.4-14.2)	283,273	(242,356-329,950)	12.7	(10.9-14.8)
Gender								
Male	1,547,122	(1,490,533-1,601,757)	66.4	(64.0-68.8)	1,481,409	(1,425,719-1,535,107)	66.5	(64.0-68.9)
Female	782,205	(727,570-838,794)	33.6	(31.2-36.0)	745,792	(692,093-801,481)	33.5	(31.1-36.0)
Years of Education								
0 to 8 Years	124,535	(103,651-149,344)	5.3	(4.4-6.4)	120,412	(99,848-144,924)	5.4	(4.5-6.5)
9 to 11 Years	637,582	(585,425-692,541)	27.4	(25.1-29.7)	601,457	(551,082-654,639)	27.0	(24.7-29.4)
12 (High School/GED)	767,158	(711,634-824,806)	32.9	(30.6-35.4)	732,236	(678,112-788,482)	32.9	(30.4-35.4)
More than 12	800,052	(738,853-863,568)	34.3	(31.7-37.1)	773,094	(712,999-835,459)	34.7	(32.0-37.5)

* Low precisions; no estimate reported.

NA = not available.

¹ TEDs States exclude Alabama, Alaska, the District of Columbia, and Georgia, which submitted no or incomplete data for one or more of the 3 years (2007-2009).

Table C.2.1.1 Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in California: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average				TEDS 2007 to 2009 Average	
	Number (95% CI)		Percentage (95% CI)		Number	Percentage
Total	270,380	(217,949-335,282)	100.0	(NA)	231,884	100.0
Modality						
Hospital Inpatient	61,393	(41,213-87,673)	22.7	(15.2-32.4)	0	0.0
Residential Rehabilitation—						
Inpatient	116,577	(90,542-144,100)	43.1	(33.5-53.3)	59,748	25.8
Outpatient	196,215	(168,891-218,445)	72.6	(62.5-80.8)	185,277	79.9
Outpatient Rehabilitation	159,760	(131,689-185,799)	59.1	(48.7-68.7)	NA	NA
Mental Health Center or						
Facility—Outpatient	90,693	(65,806-119,494)	33.5	(24.3-44.2)	NA	NA
Substance						
Marijuana	72,698	(52,370-97,391)	26.9	(19.4-36.0)	78,099	33.7
Cocaine (including crack)	59,888	(41,478-83,489)	22.1	(15.3-30.9)	57,900	25.0
Heroin	32,835	(17,791-57,695)	12.1	(6.6-21.3)	43,253	18.7
Prescription Drugs	87,986	(66,965-111,973)	32.5	(24.8-41.4)	14,982	6.5
Methamphetamine	NA		NA		84,423	36.4
Inhalants	23,816	(13,139-41,761)	8.8	(4.9-15.4)	301	0.1
Hallucinogens	33,893	(20,385-54,403)	12.5	(7.5-20.1)	432	0.2
Alcohol	196,818	(171,581-217,592)	72.8	(63.5-80.5)	92,013	39.7
Route of Administration						
Injection	13,667	(6,153-29,329)	5.1	(2.3-10.9)	44,650	19.3
Age						
12 to 17	16,250	(10,796-24,201)	6.0	(4.0-9.0)	30,827	13.3
18 to 24	40,712	(30,753-53,180)	15.1	(11.4-19.7)	34,071	14.7
25 to 34	66,279	(46,070-91,728)	24.5	(17.0-33.9)	54,786	23.6
35 to 44	72,362	(51,846-97,379)	26.8	(19.2-36.0)	53,469	23.1
45 or Older	*	*_*	*	*_*	58,731	25.3
Race/Ethnicity						
Not Hispanic or Latino	173,609	(148,221-196,355)	64.2	(54.8-72.6)	150,186	64.8
White	136,540	(109,796-163,179)	50.5	(40.6-60.4)	95,197	41.1
Black/African American	28,515	(13,897-55,203)	10.5	(5.1-20.4)	36,508	15.7
American Indian/Alaska						
Native	559	(170-1,837)	0.2	(0.1-0.7)	3,340	1.4
Asian/Pacific Islander	6,487	(2,279-17,945)	2.4	(0.8-6.6)	5,796	2.5
Two or More Races	1,507	(544-4,144)	0.6	(0.2-1.5)	3,586	1.5
Other	NA		NA		5,759	2.5
Hispanic or Latino	96,771	(74,025-122,159)	35.8	(27.4-45.2)	81,692	35.2
Gender						
Male	197,816	(170,815-219,668)	73.2	(63.2-81.2)	147,382	63.6
Female	72,565	(50,712-99,565)	26.8	(18.8-36.8)	84,395	36.4
Years of Education						
0 to 8 Years	18,488	(8,694-37,727)	6.8	(3.2-14.0)	21,044	9.2
9 to 11 Years	67,198	(46,831-92,747)	24.9	(17.3-34.3)	80,007	34.8
12 (High School/GED)	93,892	(68,923-122,410)	34.7	(25.5-45.3)	89,471	38.9
More than 12	90,802	(64,254-121,835)	33.6	(23.8-45.1)	39,292	17.1

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.2 Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Florida: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average				TEDS 2007 to 2009 Average	
	Number (95% CI)		Percentage (95% CI)		Number	Percentage
Total	138,035	(111,991-170,067)	100.0	(NA)	67,305	100.0
Modality						
Hospital Inpatient	41,357	(28,561-56,906)	30.0	(20.7-41.2)	NA	NA
Residential Rehabilitation— Inpatient	75,006	(59,768-89,678)	54.3	(43.3-65.0)	17,147	25.5
Outpatient	96,878	(81,200-109,739)	70.2	(58.8-79.5)	54,981	81.7
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	76,541	(61,604-90,797)	55.5	(44.6-65.8)	NA	NA
54,583	(40,486-70,062)	39.5	(29.3-50.8)	NA	NA	
Substance						
Marijuana	46,947	(35,357-60,113)	34.0	(25.6-43.5)	32,122	47.7
Cocaine (including crack)	42,730	(31,047-56,489)	31.0	(22.5-40.9)	19,667	29.2
Heroin	15,499	(8,451-27,193)	11.2	(6.1-19.7)	2,526	3.8
Prescription Drugs	39,401	(29,164-51,531)	28.5	(21.1-37.3)	13,601	20.2
Methamphetamine	NA		NA		1,500	2.2
Inhalants	12,791	(7,076-22,336)	9.3	(5.1-16.2)	113	0.2
Hallucinogens	21,136	(13,657-31,667)	15.3	(9.9-22.9)	313	0.5
Alcohol	92,517	(77,046-105,710)	67.0	(55.8-76.6)	31,404	46.7
Route of Administration						
Injection	7,125	(2,951-16,479)	5.2	(2.1-12.0)	3,519	5.2
Age						
12 to 17	6,109	(3,862-9,572)	4.4	(2.8-6.9)	14,337	21.3
18 to 24	23,714	(17,737-31,184)	17.2	(12.8-22.6)	12,925	19.2
25 to 34	24,882	(16,695-35,895)	18.0	(12.1-26.0)	15,795	23.5
35 to 44	31,524	(21,361-44,672)	22.8	(15.5-32.4)	12,422	18.5
45 or Older	*	*_*	*	*_*	11,826	17.6
Race/Ethnicity						
Not Hispanic or Latino	122,051	(111,735-128,661)	88.4	(80.9-93.2)	58,916	87.5
White	95,793	(80,380-108,594)	69.4	(58.2-78.7)	43,424	64.5
Black/African American	*	*_*	*	*_*	14,035	20.9
American Indian/Alaska Native	378	(85-1,658)	0.3	(0.1-1.2)	242	0.4
Asian/Pacific Islander	71	(10-510)	0.1	(0.0-0.4)	285	0.4
Two or More Races	1,656	(533-5,061)	1.2	(0.4-3.7)	927	1.4
Other	NA		NA		2	0.0
Hispanic or Latino	15,983	(9,374-26,300)	11.6	(6.8-19.1)	8,387	12.5
Gender						
Male	90,529	(75,256-103,778)	65.6	(54.5-75.2)	42,432	63.0
Female	47,506	(34,257-62,779)	34.4	(24.8-45.5)	24,873	37.0
Years of Education						
0 to 8 Years	7,844	(3,055-19,084)	5.7	(2.2-13.8)	8,231	12.4
9 to 11 Years	23,275	(15,793-33,336)	16.9	(11.4-24.2)	20,733	31.4
12 (High School/GED)	58,930	(43,879-75,029)	42.7	(31.8-54.4)	22,765	34.4
More than 12	47,986	(34,938-62,932)	34.8	(25.3-45.6)	14,403	21.8

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.3 Numbers and Percentage Distributions and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Illinois: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average		TEDS 2007 to 2009 Average	
	Number (95% CI)	Percentage (95% CI)	Number	Percentage
Total	95,950 (79,400-115,911)	100.0 (NA)	69,483	100.0
Modality				
Hospital Inpatient	29,032 (22,048-37,116)	30.3 (23.0-38.7)	9	0.0
Residential Rehabilitation— Inpatient	35,672 (27,374-44,841)	37.2 (28.5-46.7)	22,214	32.0
Outpatient	78,661 (70,560-84,593)	82.0 (73.5-88.2)	55,424	79.8
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	64,105 (54,443-72,487)	66.8 (56.7-75.5)	NA	NA
	35,930 (27,412-45,345)	37.4 (28.6-47.3)	NA	NA
Substance				
Marijuana	21,963 (15,414-30,250)	22.9 (16.1-31.5)	28,155	40.5
Cocaine (including crack)	20,703 (13,927-29,586)	21.6 (14.5-30.8)	21,292	30.6
Heroin	14,848 (8,522-24,552)	15.5 (8.9-25.6)	16,750	24.1
Prescription Drugs	16,345 (11,162-23,275)	17.0 (11.6-24.3)	3,915	5.6
Methamphetamine	NA	NA	2,035	2.9
Inhalants	876 (331-2,296)	0.9 (0.3-2.4)	98	0.1
Hallucinogens	2,826 (1,187-6,571)	2.9 (1.2-6.8)	237	0.3
Alcohol	64,788 (55,811-72,598)	67.5 (58.2-75.7)	40,392	58.1
Route of Administration				
Injection	4,508 (1,771-10,976)	4.7 (1.9-11.5)	5,280	7.6
Age				
12 to 17	6,154 (4,354-8,627)	6.4 (4.5-9.0)	7,871	11.3
18 to 24	18,503 (14,150-23,805)	19.3 (14.7-24.8)	12,383	17.8
25 to 34	23,161 (16,823-30,951)	24.1 (17.5-32.3)	15,749	22.7
35 to 44	23,386 (15,962-32,845)	24.4 (16.6-34.2)	16,892	24.3
45 or Older	* * *	* * *	16,588	23.9
Race/Ethnicity				
Not Hispanic or Latino	86,282 (80,207-90,181)	89.9 (83.6-94.0)	62,942	90.6
White	61,176 (51,735-69,627)	63.8 (53.9-72.6)	33,319	48.0
Black/African American	23,029 (15,755-32,308)	24.0 (16.4-33.7)	27,723	39.9
American Indian/Alaska Native	367 (76-1,738)	0.4 (0.1-1.8)	377	0.5
Asian/Pacific Islander	666 (128-3,384)	0.7 (0.1-3.5)	285	0.4
Two or More Races	1,044 (511-2,120)	1.1 (0.5-2.2)	NA	NA
Other	NA	NA	1,238	1.8
Hispanic or Latino	9,668 (5,769-15,743)	10.1 (6.0-16.4)	6,509	9.4
Gender				
Male	58,839 (50,155-66,833)	61.3 (52.3-69.7)	46,007	66.2
Female	37,110 (29,117-45,795)	38.7 (30.3-47.7)	23,476	33.8
Years of Education				
0 to 8 Years	6,679 (3,384-12,742)	7.0 (3.5-13.3)	5,628	8.1
9 to 11 Years	26,043 (18,417-35,384)	27.1 (19.2-36.9)	24,046	34.6
12 (High School/GED)	32,604 (24,500-41,820)	34.0 (25.5-43.6)	27,429	39.5
More than 12	30,624 (22,600-39,946)	31.9 (23.6-41.6)	12,379	17.8

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.4 Numbers and Percentage Distributions of and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Michigan: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average		TEDS 2007 to 2009 Average	
	Number (95% CI)	Percentage (95% CI)	Number	Percentage
Total	102,203	(85,273-122,445)	57,956	100.0
Modality				
Hospital Inpatient	31,536	(23,372-41,066)	0	0.0
Residential Rehabilitation— Inpatient	42,576	(34,371-51,260)	16,068	27.7
Outpatient	83,182	(75,861-88,827)	47,111	81.3
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	69,051	(60,311-76,738)	NA	NA
	36,636	(29,150-44,864)	NA	NA
Substance				
Marijuana	30,961	(25,233-37,357)	24,265	41.9
Cocaine (including crack)	21,637	(15,780-28,940)	15,536	26.8
Heroin	17,563	(11,109-26,669)	8,961	15.5
Prescription Drugs	19,520	(14,391-25,936)	8,716	15.0
Methamphetamine	NA		889	1.5
Inhalants	4,288	(2,276-7,937)	72	0.1
Hallucinogens	8,916	(5,482-14,186)	194	0.3
Alcohol	72,224	(64,280-79,101)	36,489	63.0
Route of Administration				
Injection	7,862	(4,428-13,587)	6,638	11.5
Age				
12 to 17	5,887	(4,163-8,265)	3,287	5.7
18 to 24	21,204	(17,033-26,084)	12,815	22.1
25 to 34	26,745	(20,068-34,704)	15,445	26.6
35 to 44	25,258	(17,898-34,411)	13,085	22.6
45 or Older	23,109	(15,205-33,536)	13,324	23.0
Race/Ethnicity				
Not Hispanic or Latino	99,141	(96,658-100,531)	56,001	96.6
White	75,827	(66,506-83,402)	38,392	66.2
Black/African American	21,134	(13,706-31,169)	15,138	26.1
American Indian/Alaska Native	371	(97-1,412)	713	1.2
Asian/Pacific Islander	62	(9-453)	124	0.2
Two or More Races	1,746	(718-4,185)	492	0.8
Other	NA		1,141	2.0
Hispanic or Latino	3,063	(1,672-5,546)	1,955	3.4
Gender				
Male	64,931	(57,228-72,012)	38,052	65.7
Female	37,272	(30,192-44,976)	19,905	34.3
Years of Education				
0 to 8 Years	3,670	(1,937-6,846)	2,583	4.5
9 to 11 Years	21,674	(16,380-28,118)	16,703	28.8
12 (High School/GED)	48,091	(39,563-56,790)	27,088	46.7
More than 12	28,769	(21,383-37,522)	11,581	20.0

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.5 Numbers and Percentage Distributions of and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in New York: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average		TEDS 2007 to 2009 Average			
	Number (95% CI)		Percentage (95% CI)			
Total	207,852	(168,643-256,032)	100.0	(NA)	245,898	100.0
Modality						
Hospital Inpatient	82,690	(62,528-104,671)	39.8	(30.1-50.4)	32,967	13.4
Residential Rehabilitation— Inpatient	79,602	(60,152-101,038)	38.3	(28.9-48.6)	69,899	28.4
Outpatient	179,942	(159,857-192,432)	86.6	(76.9-92.6)	192,140	78.1
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	162,380	(141,452-178,099)	78.1	(68.1-85.7)	NA	NA
	98,199	(77,642-119,216)	47.2	(37.4-57.4)	NA	NA
Substance						
Marijuana	68,063	(50,104-88,834)	32.7	(24.1-42.7)	105,248	42.8
Cocaine (including crack)	71,082	(51,600-93,517)	34.2	(24.8-45.0)	74,947	30.5
Heroin	*	*_*	*	*_*	56,745	23.1
Prescription Drugs	30,547	(20,378-44,584)	14.7	(9.8-21.4)	25,250	10.3
Methamphetamine	NA		NA		966	0.4
Inhalants	7,101	(2,573-18,866)	3.4	(1.2-9.1)	164	0.1
Hallucinogens	25,154	(14,132-42,869)	12.1	(6.8-20.6)	834	0.3
Alcohol	151,346	(134,531-165,518)	72.8	(64.7-79.6)	158,708	64.5
Route of Administration						
Injection	*	*_*	*	*_*	27,753	11.3
Age						
12 to 17	10,505	(7,199-15,214)	5.1	(3.5-7.3)	13,321	5.4
18 to 24	26,549	(19,071-36,392)	12.8	(9.2-17.5)	38,614	15.7
25 to 34	44,941	(32,024-61,253)	21.6	(15.4-29.5)	55,911	22.7
35 to 44	53,897	(37,661-74,084)	25.9	(18.1-35.6)	65,813	26.8
45 or Older	71,960	(51,656-95,373)	34.6	(24.9-45.9)	72,239	29.4
Race/Ethnicity						
Not Hispanic or Latino	*	*_*	*	*_*	191,765	78.0
White	95,182	(75,706-115,296)	45.8	(36.4-55.5)	110,148	44.8
Black/African American	49,915	(34,151-70,022)	24.0	(16.4-33.7)	73,898	30.1
American Indian/Alaska Native	*	*_*	*	*_*	1,500	0.6
Asian/Pacific Islander	3,367	(826-13,232)	1.6	(0.4-6.4)	1,530	0.6
Two or More Races	3,455	(1,354-8,679)	1.7	(0.7-4.2)	NA	NA
Other	NA		NA		4,688	1.9
Hispanic or Latino	*	*_*	*	*_*	54,131	22.0
Gender						
Male	157,938	(138,414-173,341)	76.0	(66.6-83.4)	179,552	73.0
Female	49,914	(34,511-69,438)	24.0	(16.6-33.4)	66,344	27.0
Years of Education						
0 to 8 Years	10,605	(4,046-26,418)	5.1	(1.9-12.7)	18,692	7.6
9 to 11 Years	68,177	(50,307-88,816)	32.8	(24.2-42.7)	74,000	30.1
12 (High School/GED)	52,695	(38,415-70,087)	25.4	(18.5-33.7)	91,380	37.2
More than 12	76,375	(58,179-96,589)	36.7	(28.0-46.5)	61,812	25.1

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.6 Numbers and Percentage Distributions of and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Ohio: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average		TEDS 2007 to 2009 Average	
	Number (95% CI)	Percentage (95% CI)	Number	Percentage
Total	96,729 (80,240-116,564)	100.0 (NA)	105,443	100.0
Modality				
Hospital Inpatient	32,877 (24,613-42,287)	34.0 (25.4-43.7)	564	0.5
Residential Rehabilitation— Inpatient	43,643 (35,474-52,092)	45.1 (36.7-53.9)	10,177	9.7
Outpatient	80,818 (74,155-85,804)	83.6 (76.7-88.7)	99,827	94.7
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	69,303 (61,543-75,930)	71.6 (63.6-78.5)	NA	NA
46,136 (37,329-55,093)	47.7 (38.6-57.0)	NA	NA	
Substance				
Marijuana	30,456 (23,255-38,712)	31.5 (24.0-40.0)	48,674	46.2
Cocaine (including crack)	18,171 (11,644-27,187)	18.8 (12.0-28.1)	27,719	26.3
Heroin	10,365 (6,019-17,253)	10.7 (6.2-17.8)	10,085	9.6
Prescription Drugs	22,759 (16,349-30,721)	23.5 (16.9-31.8)	11,877	11.3
Methamphetamine	NA	NA	1,083	1.0
Inhalants	5,090 (2,528-9,973)	5.3 (2.6-10.3)	171	0.2
Hallucinogens	8,780 (4,852-15,357)	9.1 (5.0-15.9)	515	0.5
Alcohol	72,771 (65,140-79,059)	75.2 (67.3-81.7)	65,335	62.0
Route of Administration				
Injection	4,761 (2,453-9,030)	5.0 (2.6-9.4)	8,573	8.1
Age				
12 to 17	6,659 (4,848-9,079)	6.9 (5.0-9.4)	11,141	10.6
18 to 24	20,046 (15,473-25,547)	20.7 (16.0-26.4)	23,488	22.3
25 to 34	24,734 (17,984-32,958)	25.6 (18.6-34.1)	29,493	28.0
35 to 44	21,756 (15,425-29,736)	22.5 (15.9-30.7)	21,723	20.6
45 or Older	23,533 (15,289-34,348)	24.3 (15.8-35.5)	19,598	18.6
Race/Ethnicity				
Not Hispanic or Latino	92,651 (87,774-94,926)	95.8 (90.7-98.1)	76,064	98.2
White	75,876 (67,354-82,451)	78.4 (69.6-85.2)	57,191	73.8
Black/African American	13,314 (8,506-20,217)	13.8 (8.8-20.9)	17,589	22.7
American Indian/Alaska Native	* *_*	* *_*	213	0.3
Asian/Pacific Islander	* *_*	* *_*	136	0.2
Two or More Races	623 (280-1,379)	0.6 (0.3-1.4)	40	0.1
Other	NA	NA	894	1.2
Hispanic or Latino	4,078 (1,802-8,954)	4.2 (1.9-9.3)	1,388	1.8
Gender				
Male	66,490 (59,249-72,894)	68.7 (61.3-75.4)	67,304	63.8
Female	30,239 (23,835-37,479)	31.3 (24.6-38.7)	38,138	36.2
Years of Education				
0 to 8 Years	6,666 (3,672-11,791)	6.9 (3.8-12.2)	7,915	7.5
9 to 11 Years	26,408 (18,942-35,475)	27.3 (19.6-36.7)	32,537	31.0
12 (High School/GED)	32,451 (24,935-40,942)	33.5 (25.8-42.3)	42,048	40.0
More than 12	31,203 (23,724-39,757)	32.3 (24.5-41.1)	22,606	21.5

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.7 Numbers and Percentage Distributions of and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Pennsylvania: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average		TEDS 2007 to 2009 Average	
	Number (95% CI)	Percentage (95% CI)	Number	Percentage
Total	108,068 (89,934-129,814)	100.0 (NA)	46,990	100.0
Modality				
Hospital Inpatient	39,888 (30,364-50,460)	36.9 (28.1-46.7)	864	1.8
Residential Rehabilitation— Inpatient	45,613 (36,358-55,404)	42.2 (33.6-51.3)	16,198	34.5
Outpatient	98,705 (90,299-103,343)	91.3 (83.6-95.6)	38,358	81.6
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	85,424 (75,355-93,013)	79.0 (69.7-86.1)	NA	NA
	44,414 (35,599-53,791)	41.1 (32.9-49.8)	NA	NA
Substance				
Marijuana	31,431 (23,583-40,635)	29.1 (21.8-37.6)	16,116	34.3
Cocaine (including crack)	28,519 (20,944-37,651)	26.4 (19.4-34.8)	10,843	23.1
Heroin	28,647 (22,020-36,424)	26.5 (20.4-33.7)	7,401	15.8
Prescription Drugs	29,220 (21,171-38,958)	27.0 (19.6-36.0)	7,557	16.1
Methamphetamine	NA	NA	293	0.6
Inhalants	6,328 (3,439-11,382)	5.9 (3.2-10.5)	90	0.2
Hallucinogens	10,424 (6,706-15,879)	9.6 (6.2-14.7)	335	0.7
Alcohol	69,157 (60,219-77,279)	64.0 (55.7-71.5)	25,865	55.0
Route of Administration				
Injection	12,611 (8,276-18,786)	11.8 (7.8-17.6)	5,643	12.0
Age				
12 to 17	6,575 (4,864-8,836)	6.1 (4.5-8.2)	4,916	10.5
18 to 24	24,755 (19,574-30,830)	22.9 (18.1-28.5)	11,515	24.5
25 to 34	20,803 (14,547-28,917)	19.2 (13.5-26.8)	12,020	25.6
35 to 44	20,598 (13,022-31,137)	19.1 (12.0-28.8)	9,766	20.8
45 or Older	35,337 (25,626-46,646)	32.7 (23.7-43.2)	8,773	18.7
Race/Ethnicity				
Not Hispanic or Latino	104,362 (99,900-106,426)	96.6 (92.4-98.5)	36,000	92.8
White	88,838 (81,002-94,777)	82.2 (75.0-87.7)	28,974	74.7
Black/African American	11,439 (6,617-19,113)	10.6 (6.1-17.7)	6,329	16.3
American Indian/Alaska Native	210 (30-1,483)	0.2 (0.0-1.4)	126	0.3
Asian/Pacific Islander	* **	* **	83	0.2
Two or More Races	3,486 (1,383-8,532)	3.2 (1.3-7.9)	NA	NA
Other	NA	NA	488	1.3
Hispanic or Latino	3,706 (1,642-8,168)	3.4 (1.5-7.6)	2,795	7.2
Gender				
Male	63,230 (52,741-73,051)	58.5 (48.8-67.6)	31,938	68.0
Female	44,838 (35,017-55,327)	41.5 (32.4-51.2)	15,052	32.0
Years of Education				
0 to 8 Years	7,237 (3,494-14,434)	6.7 (3.2-13.4)	23,719	57.1
9 to 11 Years	27,763 (20,546-36,460)	25.7 (19.0-33.7)	5,257	12.7
12 (High School/GED)	37,151 (28,052-47,451)	34.4 (26.0-43.9)	9,520	22.9
More than 12	35,917 (27,146-45,915)	33.2 (25.1-42.5)	3,016	7.3

* Low precisions; no estimate reported.

NA = not available.

Table C.2.1.8 Numbers and Percentage Distributions of and Confidence Intervals of Numbers and Percentage Distributions of Treatment and Demographic Characteristics among Persons Who Received Substance Use Treatment from Specialty Treatment Programs in the Past Year in Texas: NSDUH 2005 to 2010 and TEDS 2007 to 2009

	NSDUH 2005 to 2010 Average			TEDS 2007 to 2009 Average		
	Number (95% CI)		Percentage (95% CI)		Number	Percentage
Total	84,936	(65,807-109,593)	100.0	(NA)	41,930	100.0
Modality						
Hospital Inpatient	32,372	(23,776-41,945)	38.1	(28.0-49.4)	1	0.0
Residential Rehabilitation— Inpatient	42,993	(33,079-52,850)	50.6	(38.9-62.2)	16,796	40.1
Outpatient	64,137	(54,523-71,462)	75.5	(64.2-84.1)	28,841	68.8
Outpatient Rehabilitation Mental Health Center or Facility—Outpatient	58,752	(48,979-66,849)	69.2	(57.7-78.7)	NA	NA
	*	*_*	*	*_*	NA	NA
Substance						
Marijuana	36,841	(27,989-46,221)	43.4	(33.0-54.4)	18,947	45.2
Cocaine (including crack)	37,937	(28,829-47,486)	44.7	(33.9-55.9)	14,208	33.9
Heroin	*	*_*	*	*_*	4,345	10.4
Prescription Drugs	*	*_*	*	*_*	6,526	15.6
Methamphetamine	NA		NA		5,774	13.8
Inhalants	8,079	(3,892-15,889)	9.5	(4.6-18.7)	103	0.2
Hallucinogens	15,619	(9,699-23,998)	18.4	(11.4-28.3)	167	0.4
Alcohol	56,751	(47,801-64,468)	66.8	(56.3-75.9)	20,150	48.1
Route of Administration						
Injection	3,176	(1,267-7,700)	3.8	(1.5-9.1)	6,102	14.6
Age						
12 to 17	11,045	(7,191-16,524)	13.0	(8.5-19.5)	6,476	15.4
18 to 24	21,180	(14,656-29,394)	24.9	(17.3-34.6)	8,038	19.2
25 to 34	26,640	(18,414-36,524)	31.4	(21.7-43.0)	12,096	28.8
35 to 44	*	*_*	*	*_*	8,477	20.2
45 or Older	*	*_*	*	*_*	6,843	16.3
Race/Ethnicity						
Not Hispanic or Latino	*	*_*	*	*_*	26,252	62.9
White	40,555	(31,400-49,891)	47.7	(37.0-58.7)	18,883	45.2
Black/African American	*	*_*	*	*_*	6,937	16.6
American Indian/Alaska Native	*	*_*	*	*_*	268	0.6
Asian/Pacific Islander	*	*_*	*	*_*	164	0.4
Two or More Races	522	(157-1,715)	0.6	(0.2-2.0)	NA	NA
Other	NA		NA		NA	NA
Hispanic or Latino	*	*_*	*	*_*	15,508	37.1
Gender						
Male	53,940	(43,859-62,797)	63.5	(51.6-73.9)	25,158	60.0
Female	30,995	(22,139-41,077)	36.5	(26.1-48.4)	16,771	40.0
Years of Education						
0 to 8 Years	7,440	(3,942-13,523)	8.8	(4.6-15.9)	5,309	12.7
9 to 11 Years	32,918	(23,733-43,151)	38.8	(27.9-50.8)	12,542	30.0
12 (High School/GED)	*	*_*	*	*_*	15,798	37.8
More than 12	*	*_*	*	*_*	8,167	19.5

* Low precisions; no estimate reported.

NA = not available.

Table C.2.2 Single-Day Treatment Counts for Alcohol or Drug Specialty Treatment¹ and Confidence Intervals for Estimates of Hospitals Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2008 to 2010 Combined (October 1 Counts),¹ NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH October 1 2008 to 2010 Number (95% CI)		NSDUH Average Day 2007 to 2009 ^{2,3} Number (95% CI)		TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	1,434,851	(1,278,112-1,610,688)	1,196,460	(1,066,843-1,341,740)	532,109	1,153,617	1,139,670
Census Regions							
Northeast	278,998	(212,738-365,732)	258,055	(204,829-325,015)	158,461	285,374	280,460
Midwest	308,811	(246,380-386,949)	250,503	(202,868-309,260)	146,006	232,093	230,012
South	442,619	(360,482-543,359)	342,547	(274,530-427,337)	76,031	312,156	307,163
West	404,423	(317,497-514,938)	345,355	(272,608-437,367)	151,610	323,994	322,034
Eight Largest States							
California	201,700	(133,352-304,722)	152,925	(100,457-232,583)	68,868	139,043	138,179
Florida	75,198	(45,902-123,044)	85,986	(53,239-138,693)	15,646	51,470	50,566
Illinois	71,469	(44,539-114,507)	44,802	(28,032-71,538)	13,794	44,902	44,536
Michigan	57,947	(41,724-80,416)	46,804	(31,818-68,788)	12,552	42,676	42,539
New York	110,008	(66,014-182,993)	100,975	(68,315-149,107)	80,054	117,075	115,100
Ohio	50,830	(33,095-77,990)	36,628	(24,087-55,658)	25,825	36,847	36,418
Pennsylvania	53,555	(35,397-80,956)	69,628	(47,989-100,928)	20,791	47,438	46,977
Texas	66,942	(43,044-104,038)	14,796	(7,643-28,634)	7,972	40,171	39,351

* Low precisions; no estimate reported.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. NSDUH “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43. “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and those for whom the substance for which they were treated is unknown are included.

² NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

³ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.3 Single-Day Treatment Counts for Alcohol-Only¹ Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH Average Day 2007 to 2009 ^{2,3,4} Number (95% CI)		TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	438,665	(354,848-542,237)	102,587	216,832	213,888
Census Regions					
Northeast	62,203	(39,206-98,660)	29,575	40,791	39,797
Midwest	119,873	(85,141-168,729)	33,600	51,728	51,276
South	115,758	(75,675-177,030)	14,860	49,639	48,617
West	140,831	(91,146-217,499)	24,552	74,674	74,198
Eight Largest States					
California	66,572	(31,492-140,547)	6,318	26,723	26,542
Florida	44,493	(21,906-90,230)	2,186	8,257	8,007
Illinois	11,406	(5,730-22,691)	2,599	10,225	10,137
Michigan	19,371	(12,153-30,860)	3,042	10,290	10,265
New York	20,683	(8,702-49,108)	13,131	14,976	14,614
Ohio	19,160	(9,980-36,751)	5,086	7,220	7,133
Pennsylvania	19,886	(9,614-41,091)	5,521	7,016	6,935
Texas	*	*-*	901	5,552	5,405

* Low precisions; no estimate reported.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ “Alcohol-only” refers to treatment for only alcohol. Individuals in treatment for both alcohol and drugs are excluded.

² Single-day treatment counts are based on the day of interview for NSDUH Average Day and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. NSDUH “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

³ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

⁴ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.4 Single-Day Treatment Counts for Drug-Only¹ Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH Average Day 2007 to 2009 ^{2,3,4} Number (95% CI)	TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	314,806 (261,637-378,764)	217,502	414,845	411,654
Census Regions				
Northeast	97,849 (67,687-141,410)	69,718	119,474	118,266
Midwest	58,025 (40,557-83,005)	47,552	70,447	69,944
South	96,577 (71,220-130,950)	31,364	128,149	127,076
West	62,355 (40,565-95,831)	68,868	96,774	96,368
Eight Largest States				
California	12,431 (5,587-27,650)	43,397	50,213	50,025
Florida	20,276 (9,042-45,427)	7,968	20,407	20,176
Illinois	20,963 (10,179-43,125)	5,733	16,527	16,381
Michigan	13,789 (6,657-28,537)	4,691	14,111	14,082
New York	41,299 (20,561-82,846)	32,482	47,811	47,363
Ohio	2,825 (1,032-7,736)	7,139	8,731	8,651
Pennsylvania	29,081 (16,239-52,028)	9,451	19,470	19,350
Texas	7,298 (2,503-21,263)	4,285	15,212	15,079

* Low precision; no estimate reported.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ “Drug-only” refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.

² Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year.

“Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility.

Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

³ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

⁴ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.5 Single-Day Treatment Counts for Alcohol and Drug¹ Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH Average Day 2007 to 2009 ^{2,3,4} Number (95% CI)	TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	397,732 (333,100-474,879)	198,971	521,940	514,128
Census Regions				
Northeast	95,774 (66,769-137,339)	58,799	125,109	122,397
Midwest	63,211 (44,017-90,760)	61,125	109,918	108,793
South	120,097 (86,271-167,162)	26,589	134,368	131,470
West	118,650 (83,717-168,117)	52,359	152,545	151,468
Eight Largest States				
California	62,306 (36,309-106,851)	18,946	62,106	61,612
Florida	20,697 (7,506-56,981)	4,759	22,805	22,382
Illinois	10,257 (3,264-32,181)	5,450	18,149	18,018
Michigan	12,358 (6,473-23,578)	4,797	18,275	18,192
New York	37,728 (22,958-61,964)	34,431	54,287	53,123
Ohio	14,343 (7,164-28,694)	11,086	20,896	20,634
Pennsylvania	19,697 (10,850-35,733)	5,819	20,953	20,691
Texas	4,414 (2,000-9,741)	2,786	19,407	18,867

* Low precision; no estimate reported.

NA = not available.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ “Alcohol and drug” refers to treatment received for both alcohol and at least one other drug at the time of admission. Individuals in treatment for alcohol only or drugs only are excluded.

² Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

³ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

⁴ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.6 Single-Day Treatment Counts for Primary Alcohol with Secondary Drug¹ Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH Average Day 2007 to 2009 ^{2,3,4} Number (95% CI)	TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	165,571 (125,368-218,657)	86,898	NA	NA
Census Regions				
Northeast	29,702 (17,237-51,170)	25,999	NA	NA
Midwest	22,992 (13,365-39,551)	28,262	NA	NA
South	48,171 (27,795-83,470)	11,281	NA	NA
West	64,707 (39,526-105,899)	21,357	NA	NA
Eight Largest States				
California	32,873 (14,906-72,444)	6,137	NA	NA
Florida	942 (202-4,405)	1,676	NA	NA
Illinois	* **	2,165	NA	NA
Michigan	5,865 (2,385-14,418)	2,211	NA	NA
New York	13,487 (6,648-27,349)	14,990	NA	NA
Ohio	9,785 (3,892-24,579)	5,360	NA	NA
Pennsylvania	6,558 (2,581-16,654)	2,879	NA	NA
Texas	1,724 (412-7,206)	857	NA	NA

* Low precision; no estimate reported.

NA = not available.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ “Primary alcohol” refers to alcohol as the main substance of abuse at the time of admission. Individuals in treatment for alcohol only are included.

² Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

³ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

⁴ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.7 Single-Day Treatment Counts for Primary Drug with Secondary Alcohol¹ Specialty Treatment and Confidence Intervals for Estimates of Single-Day Treatment Counts Overall and by Census Regions and for the Eight Largest States: NSDUH 2007 to 2009 Combined (Average-Day Counts), TEDS 2007 to 2009 Combined, and N-SSATS 2007 to 2009 Combined

Single-Day Treatment Counts	NSDUH Average Day 2007 to 2009 ^{2,3,4} Number (95% CI)	TEDS March 30 or March 31 2007 to 2009	N-SSATS – All Facilities March 30 or March 31 2007 to 2009	N-SSATS – Hospitals Excluded March 30 or March 31 2007 to 2009
Total United States	228,813 (180,823-289,525)	111,973	NA	NA
Census Regions				
Northeast	62,724 (39,192-100,356)	32,800	NA	NA
Midwest	40,219 (25,051-64,560)	32,863	NA	NA
South	71,926 (47,048-109,944)	15,308	NA	NA
West	53,943 (33,305-87,352)	31,002	NA	NA
Eight Largest States				
California	29,433 (14,255-60,741)	12,809	NA	NA
Florida	19,754 (6,874-56,680)	3,083	NA	NA
Illinois	9,889 (3,023-32,302)	3,285	NA	NA
Michigan	6,493 (2,581-16,325)	2,586	NA	NA
New York	21,043 (10,759-41,130)	19,441	NA	NA
Ohio	4,558 (1,831-11,340)	5,726	NA	NA
Pennsylvania	13,139 (6,105-28,252)	2,940	NA	NA
Texas	2,691 (1,070-6,766)	1,929	NA	NA

* Low precision; no estimate reported.

NA = not available.

NOTE 1: Not all States report to TEDS. Counts for NSDUH and N-SSATS do not exclude data from States not reporting to TEDS for a given year.

NOTE 2: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies. TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ “Primary drug” refers to a substance, other than alcohol, that is the main substance of abuse at the time of admission. Individuals in treatment for drugs only are included.

² Single-day treatment counts are based on a reference date of October 1 for NSDUH and March 30 or March 31 for N-SSATS and TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS and TEDS data are based on the data file from the previous year. “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

³ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

⁴ Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

Table C.2.8 Alcohol and Drug Single-Day Specialty Treatment Counts, by State: NSDUH 2008 to 2010 Combined (October 1 Counts)

Region/State	Single-Day Treatment Counts 2008 to 2010 NSDUH (October 1) ¹	
	Alcohol or Drug Treatment ² (95% CI)	
Total United States	1,434,851	(1,278,112-1,610,688)
Region		
Northeast	278,998	(212,738-365,732)
Midwest	308,811	(246,380-386,949)
South	442,619	(360,482-543,359)
West	404,423	(317,497-514,938)
State		
Alabama	10,174	(2,877-35,807)
Alaska	3,233	(1,777-5,869)
Arizona	24,100	(12,106-47,869)
Arkansas	12,534	(6,967-22,508)
California	201,700	(133,352-304,722)
Colorado	8,122	(5,235-12,597)
Connecticut	18,141	(8,425-38,914)
Delaware	4,275	(2,321-7,857)
District of Columbia	6,595	(2,851-15,107)
Florida	75,198	(45,902-123,044)
Georgia	38,037	(16,266-88,614)
Hawaii	8,947	(3,687-21,557)
Idaho	7,268	(3,058-17,190)
Illinois	71,469	(44,539-114,507)
Indiana	35,512	(16,882-74,411)
Iowa	11,354	(5,117-25,120)
Kansas	3,737	(1,048-13,289)
Kentucky	24,995	(11,541-53,897)
Louisiana	11,082	(4,975-24,635)
Maine	5,197	(2,271-11,855)
Maryland	21,663	(6,923-67,338)
Massachusetts	30,053	(13,584-66,253)
Michigan	57,947	(41,724-80,416)
Minnesota	6,997	(1,507-32,333)
Mississippi	4,241	(1,168-15,354)
Missouri	6,651	(1,722-25,619)
Montana	9,976	(5,345-18,528)
Nebraska	8,816	(4,202-18,432)
Nevada	21,791	(9,937-47,472)
New Hampshire	4,030	(1,662-9,742)
New Jersey	48,740	(22,777-103,868)
New Mexico	12,422	(8,179-18,841)
New York	110,008	(66,014-182,993)
North Carolina	53,620	(22,841-125,187)
North Dakota	2,493	(1,027-6,025)
Ohio	50,830	(33,095-77,990)

Table C.2.8 Alcohol and Drug Single-Day Specialty Treatment Counts, by State: NSDUH 2008 to 2010 Combined (October 1 Counts) (continued)

Region/State	Single-Day Treatment Counts 2008 to 2010 NSDUH (October 1) ¹	
	Alcohol or Drug Treatment ² (95% CI)	
State (continued)		
Oklahoma	15,785	(7,429-33,437)
Oregon	22,825	(11,847-43,838)
Pennsylvania	53,555	(35,397-80,956)
Rhode Island	5,650	(2,808-11,333)
South Carolina	36,396	(20,764-63,595)
South Dakota	2,892	(1,535-5,440)
Tennessee	14,280	(5,910-34,426)
Texas	66,942	(43,044-104,038)
Utah	20,646	(9,339-45,352)
Vermont	3,623	(1,857-7,045)
Virginia	34,037	(13,620-84,653)
Washington	61,301	(32,739-114,261)
West Virginia	12,763	(5,350-30,245)
Wisconsin	50,112	(20,235-122,943)
Wyoming	2,093	(1,063-4,112)

* Low precision; no estimate reported.

¹ Single-day treatment counts are based on a reference date of October 1 for NSDUH. “Treatment” includes treatment received at a hospital, drug rehabilitation facility, or mental health facility. Nonspecialty treatment data are excluded from total counts. NSDUH October 1 single-day treatment counts are derived from TX43.

² “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and those for whom the substance for which they were treated is unknown are included.

Table C.2.9 Alcohol and Drug Single-Day Specialty Treatment Counts (Average Day), by State: NSDUH 2007 to 2009 Combined

Region/State	Single-Day Treatment Counts 2007 to 2009 NSDUH (Average Day) ^{1,2}					
	Alcohol or Drug Treatment ³	Alcohol-Only Treatment ⁴	Drug-Only Treatment ⁴	Primary Alcohol with Secondary Drug Treatment ⁵	Primary Drug with Secondary Alcohol Treatment ⁵	Unknown Substance for Which Treatment Was Received
Total United States	1,196,460	438,665	314,806	165,571	228,813	45,257
Region						
Northeast	258,055	62,203	97,849	29,702	62,724	2,229
Midwest	250,503	119,873	58,025	22,992	40,219	9,394
South	342,547	115,758	96,577	48,171	71,926	10,115
West	345,355	140,831	62,355	64,707	53,943	23,518
State						
Alabama	19,472	5,273	6,345	4,453	3,401	0
Alaska	4,454	2,782	292	733	621	26
Arizona	36,508	16,379	2,423	10,553	2,792	4,362
Arkansas	9,908	3,718	1,079	857	2,358	1,896
California	152,925	66,572	12,431	32,873	29,433	11,616
Colorado	15,481	9,441	1,426	2,948	1,626	40
Connecticut	23,901	13,531	7,430	*	2,940	0
Delaware	6,997	1,873	4,233	430	189	271
District of Columbia	7,276	529	2,821	61	3,648	217
Florida	85,986	44,493	20,276	942	19,754	520
Georgia	13,657	1,981	1,925	7,038	2,713	0
Hawaii	3,526	1,039	2,169	318	*	0
Idaho	7,021	2,429	1,678	134	2,254	526
Illinois	44,802	11,406	20,963	*	9,889	2,177
Indiana	36,762	15,015	7,169	4,372	7,367	2,838
Iowa	7,155	4,596	2,125	182	253	0
Kansas	6,561	3,144	*	*	2,247	1,117
Kentucky	20,374	7,028	9,073	1,173	2,659	440
Louisiana	14,833	464	10,303	*	4,065	0
Maine	5,692	1,532	1,917	285	1,958	0
Maryland	31,574	20,365	5,119	415	4,694	981
Massachusetts	13,505	1,010	4,190	5,639	2,517	0
Michigan	46,804	19,371	13,789	5,865	6,493	1,286
Minnesota	14,101	9,636	2,964	428	1,073	0
Mississippi	3,144	*	1,473	*	1,671	0
Missouri	16,492	10,109	2,786	712	2,885	0
Montana	3,187	1,254	503	245	1,186	0
Nebraska	7,923	1,272	3,263	349	1,460	1,579
Nevada	16,373	274	10,002	1,531	4,566	0
New Hampshire	7,206	2,194	1,574	521	2,916	0
New Jersey	26,385	1,616	6,009	2,172	16,587	0
New Mexico	8,172	1,320	4,232	1,381	1,240	0
New York	100,975	20,683	41,299	13,487	21,043	1,266
North Carolina	10,758	548	7,554	1,979	678	0
North Dakota	1,395	858	188	155	95	99

Table C.2.9 Alcohol and Drug Single-Day Specialty Treatment Counts (Average Day), by State: NSDUH 2007 to 2009 Combined (continued)

Region/State	Single-Day Treatment Counts 2007 to 2009 NSDUH (Average Day) ^{1,2}					
	Alcohol or Drug Treatment ³	Alcohol-Only Treatment ⁴	Drug-Only Treatment ⁴	Primary Alcohol with Secondary Drug Treatment ⁵	Primary Drug with Secondary Alcohol Treatment ⁵	Unknown Substance for Which Treatment Was Received
State (continued)						
Ohio	36,628	19,160	2,825	9,785	4,558	299
Oklahoma	16,062	2,777	3,294	7,232	2,759	0
Oregon	41,771	16,674	14,897	1,478	4,478	4,244
Pennsylvania	69,628	19,886	29,081	6,558	13,139	964
Rhode Island	7,924	881	4,583	958	1,502	0
South Carolina	14,965	4,689	5,060	2,861	2,356	0
South Dakota	2,211	727	446	775	262	0
Tennessee	27,553	3,173	4,308	5,883	12,916	1,273
Texas	14,796	*	7,298	1,724	2,691	2,245
Utah	8,664	743	2,399	3,911	640	970
Vermont	2,840	870	1,766	81	122	0
Virginia	37,955	14,707	4,611	12,976	3,391	2,270
Washington	44,516	20,927	9,524	8,072	4,259	1,735
West Virginia	7,238	3,303	1,806	146	1,984	0
Wisconsin	29,669	24,578	1,455	*	3,636	0
Wyoming	2,756	997	382	527	850	0

* Low precision; no estimate reported.

¹ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

² Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

³ “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and those for whom the substance for which they were treated is unknown are included.

⁴ “Alcohol-only” refers to treatment for only alcohol. “Drug-only” refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.

⁵ “Primary alcohol” refers to alcohol as the main substance of abuse at the time of admission (individuals in treatment for alcohol only are included). “Primary drug” refers to a substance, other than alcohol, that is the main substance of abuse at the time of admission (individuals in treatment for drugs only are included).

Table C.2.9CI 95% Confidence Intervals for Estimates of Alcohol and Drug Single-Day Specialty Treatment Counts (Average Day), by State: NSDUH 2007 to 2009 Combined

Region/State	Single-Day Treatment Counts 2007 to 2009 NSDUH (Average Day) ^{1,2}					
	Alcohol or Drug Treatment ³	Alcohol-Only Treatment ⁴	Drug-Only Treatment ⁴	Primary Alcohol with Secondary Drug Treatment ⁵	Primary Drug with Secondary Alcohol Treatment ⁵	Unknown Substance for Which Treatment Was Received
Total US Region	(1,066,843-1,341,740)	(354,848-542,237)	(261,637-378,764)	(125,368-218,657)	(180,823-289,525)	(29,579-69,242)
Northeast	(204,829-325,015)	(39,206-98,660)	(67,687-141,410)	(17,237-51,170)	(39,192-100,356)	(791-6,279)
Midwest	(202,868-309,260)	(85,141-168,729)	(40,557-83,005)	(13,365-39,551)	(25,051-64,560)	(4,104-21,503)
South	(274,530-427,337)	(75,675-177,030)	(71,220-130,950)	(27,795-83,470)	(47,048-109,944)	(4,919-20,800)
West	(272,608-437,367)	(91,146-217,499)	(40,565-95,831)	(39,526-105,899)	(33,305-87,352)	(12,060-45,856)
State						
Alabama	(9,868-38,331)	(1,254-22,100)	(2,341-17,172)	(608-32,400)	(875-13,192)	(0-0)
Alaska	(2,302-8,585)	(1,147-6,720)	(74-1,152)	(192-2,790)	(216-1,784)	(3-191)
Arizona	(21,321-62,383)	(4,753-56,137)	(874-6,712)	(2,778-39,917)	(817-9,533)	(1,341-14,172)
Arkansas	(4,494-21,783)	(1,132-12,183)	(374-3,114)	(114-6,442)	(386-14,353)	(247-14,468)
California	(100,457-232,583)	(31,492-140,547)	(5,587-27,650)	(14,906-72,444)	(14,255-60,741)	(3,739-36,062)
Colorado	(8,028-29,805)	(3,842-23,152)	(432-4,707)	(414-20,925)	(220-12,004)	(5-298)
Connecticut	(9,591-59,130)	(4,065-44,705)	(2,885-19,088)	*-*	(1,012-8,528)	(0-0)
Delaware	(3,225-15,090)	(601-5,813)	(1,348-13,178)	(58-3,187)	(34-1,049)	(78-937)
District of Columbia	(4,576-11,535)	(71-3,902)	(1,150-6,888)	(12-301)	(1,761-7,529)	(29-1,627)
Florida	(53,239-138,693)	(21,906-90,230)	(9,042-45,427)	(202-4,405)	(6,874-56,680)	(73-3,716)
Georgia	(4,359-42,674)	(264-14,824)	(255-14,498)	(1,049-47,039)	(367-20,002)	(0-0)
Hawaii	(1,427-8,690)	(298-3,614)	(579-8,092)	(43-2,330)	*-*	(0-0)
Idaho	(3,863-12,735)	(692-8,498)	(634-4,437)	(18-1,012)	(722-7,015)	(71-3,903)
Illinois	(28,032-71,538)	(5,730-22,691)	(10,179-43,125)	*-*	(3,023-32,302)	(407-11,630)
Indiana	(19,797-68,075)	(5,201-43,193)	(2,541-20,196)	(1,030-18,529)	(1,850-29,240)	(376-21,336)
Iowa	(3,079-16,593)	(1,434-14,682)	(576-7,822)	(24-1,368)	(33-1,921)	(0-0)
Kansas	(3,025-14,204)	(867-11,373)	*-*	*-*	(718-7,021)	(263-4,741)
Kentucky	(8,493-48,646)	(1,025-47,723)	(3,564-23,047)	(159-8,656)	(856-8,248)	(60-3,249)
Louisiana	(6,265-34,999)	(64-3,356)	(3,544-29,847)	*-*	(857-19,213)	(0-0)
Maine	(3,013-10,732)	(397-5,896)	(860-4,270)	(69-1,181)	(524-7,289)	(0-0)
Maryland	(18,626-53,418)	(10,214-40,515)	(1,843-14,196)	(56-3,091)	(875-25,081)	(228-4,210)
Massachusetts	(4,562-39,852)	(140-7,284)	(581-30,101)	(774-40,876)	(340-18,566)	(0-0)
Michigan	(31,818-68,788)	(12,153-30,860)	(6,657-28,537)	(2,385-14,418)	(2,581-16,325)	(178-9,258)
Minnesota	(5,258-37,684)	(2,369-38,992)	(1,111-7,900)	(58-3,152)	(257-4,480)	(0-0)
Mississippi	(758-12,993)	*-*	(198-10,943)	*-*	(224-12,411)	(0-0)
Missouri	(7,407-36,639)	(2,966-34,330)	(867-8,941)	(97-5,249)	(1,158-7,183)	(0-0)
Montana	(1,892-5,363)	(461-3,402)	(138-1,825)	(82-729)	(505-2,778)	(0-0)
Nebraska	(3,606-17,345)	(514-3,142)	(986-10,757)	(47-2,586)	(199-10,656)	(286-8,688)

Table C.2.9CI 95% Confidence Intervals for Estimates of Alcohol and Drug Single-Day Specialty Treatment Counts (Average Day), by State: NSDUH 2007 to 2009 Combined (continued)

Region/State	Single-Day Treatment Counts 2007 to 2009 NSDUH (Average Day) ^{1,2}					
	Alcohol or Drug Treatment ³	Alcohol-Only Treatment ⁴	Drug-Only Treatment ⁴	Primary Alcohol with Secondary Drug Treatment ⁵	Primary Drug with Secondary Alcohol Treatment ⁵	Unknown Substance for Which Treatment Was Received
State (continued)						
Nevada	(8,316-32,116)	(59-1,277)	(3,742-26,603)	(353-6,634)	(1,560-13,330)	(0-0)
New Hampshire	(4,091-12,663)	(673-7,139)	(520-4,754)	(70-3,877)	(1,070-7,924)	(0-0)
New Jersey	(10,159-68,282)	(363-7,186)	(1,720-20,971)	(525-8,977)	(4,027-67,948)	(0-0)
New Mexico	(3,449-19,283)	(475-3,662)	(991-17,944)	(302-6,294)	(283-5,431)	(0-0)
New York	(68,315-149,107)	(8,702-49,108)	(20,561-82,846)	(6,648-27,349)	(10,759-41,130)	(312-5,125)
North Carolina	(4,333-26,678)	(73-4,127)	(2,274-25,052)	(469-8,341)	(91-5,021)	(0-0)
North Dakota	(498-3,893)	(173-4,239)	(58-609)	(71-338)	(13-704)	(13-732)
Ohio	(24,087-55,658)	(9,980-36,751)	(1,032-7,736)	(3,892-24,579)	(1,831-11,340)	(55-1,629)
Oklahoma	(7,662-33,564)	(750-10,262)	(858-12,608)	(1,760-29,545)	(767-9,908)	(0-0)
Oregon	(21,397-81,046)	(5,722-48,269)	(3,981-55,216)	(529-4,131)	(1,688-11,863)	(1,066-16,837)
Pennsylvania	(47,989-100,928)	(9,614-41,091)	(16,239-52,028)	(2,581-16,654)	(6,105-28,252)	(203-4,564)
Rhode Island	(3,689-16,928)	(236-3,286)	(1,847-11,322)	(146-6,228)	(402-5,591)	(0-0)
South Carolina	(7,096-31,487)	(618-35,305)	(1,296-19,694)	(384-21,235)	(313-17,641)	(0-0)
South Dakota	(1,041-4,686)	(233-2,271)	(121-1,637)	(135-4,444)	(62-1,113)	(0-0)
Tennessee	(10,963-68,907)	(423-23,728)	(880-21,042)	(805-42,716)	(3,645-45,553)	(292-5,541)
Texas	(7,643-28,634)	*-*	(2,503-21,263)	(412-7,206)	(1,070-6,766)	(315-15,978)
Utah	(4,534-16,525)	(106-5,181)	(743-7,733)	(890-17,103)	(153-2,670)	(132-7,127)
Vermont	(1,510-5,331)	(192-3,923)	(900-3,460)	(15-455)	(16-915)	(0-0)
Virginia	(12,741-112,184)	(1,995-107,051)	(1,170-18,150)	(4,661-36,044)	(1,135-10,124)	(447-11,516)
Washington	(22,388-88,160)	(7,337-59,414)	(3,309-27,349)	(2,370-27,422)	(955-18,950)	(229-13,108)
West Virginia	(3,698-14,135)	(1,050-10,358)	(486-6,691)	(20-1,087)	(493-7,963)	(0-0)
Wisconsin	(10,950-79,842)	(7,724-77,598)	(315-6,708)	*-*	(484-27,215)	(0-0)
Wyoming	(1,495-5,068)	(321-3,086)	(110-1,321)	(142-1,954)	(441-1,637)	(0-0)

* Low precision; no estimate reported.

¹ NSDUH average-day single-day counts are derived from the single-day question (TX07) and from the question on outcome of last treatment (TX38 where the response option is still in treatment).

² Data are subset to the following categories from TX25: (1) hospital as an outpatient, (2) inpatient at a residential drug or alcohol rehabilitation facility, (3) outpatient at a residential drug or alcohol rehabilitation facility, and (4) outpatient at a mental health center or facility.

³ "Alcohol or drug treatment" refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and those for whom the substance for which they were treated is unknown are included.

⁴ "Alcohol-only" refers to treatment for only alcohol. "Drug-only" refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.

⁵ "Primary alcohol" refers to alcohol as the main substance of abuse at the time of admission (individuals in treatment for alcohol only are excluded). "Primary drug" refers to a substance, other than alcohol, that is the main substance of abuse at the time of admission (individuals in treatment for drugs only are excluded).

Table C.2.10 Alcohol and Drug Single-Day Specialty Treatment Counts, by State: TEDS 2007 to 2009 Combined

Region/State	Single-Day Treatment Counts 2007 to 2009 TEDS—(March 30 or March 31) ¹					
	Alcohol or Drug Treatment ²	Alcohol-Only Treatment ³	Drug-Only Treatment ³	Primary Alcohol with Secondary Drug Treatment ⁴	Primary Drug with Secondary Alcohol Treatment ⁴	No Substance Use at Admission Reported
Total United States Region	532,109	102,587	217,502	86,898	111,973	13,148
Northeast	158,461	29,575	69,718	25,999	32,800	370
Midwest	146,006	33,600	47,552	28,262	32,863	3,730
South	76,031	14,860	31,364	11,281	15,308	3,218
West	151,610	24,552	68,868	21,357	31,002	5,831
State						
Alabama	NA	NA	NA	NA	NA	NA
Alaska	NA	NA	NA	NA	NA	NA
Arizona	14,710	2,159	4,546	1,360	1,608	5,037
Arkansas	5,186	975	2,239	729	1,196	48
California	68,868	6,318	43,397	6,137	12,809	207
Colorado	11,211	2,526	4,181	1,877	2,628	0
Connecticut	10,661	1,214	5,956	1,243	2,090	158
Delaware	2,290	170	904	288	787	140
District of Columbia	NA	NA	NA	NA	NA	NA
Florida	15,646	2,186	7,968	1,676	3,083	140
Georgia	NA	NA	NA	NA	NA	734
Hawaii	2,133	295	718	363	724	33
Idaho	2,043	509	899	226	407	2
Illinois	13,794	2,599	5,733	2,165	3,285	12
Indiana	18,724	4,027	5,960	4,203	4,317	218
Iowa	8,470	2,290	1,874	1,853	2,442	11
Kansas	6,923	1,317	1,633	1,710	2,263	0
Kentucky	6,366	1,061	2,638	1,153	1,345	169
Louisiana	5,463	770	2,338	911	1,358	85
Maine	4,610	919	2,364	679	644	4
Maryland	20,375	4,166	9,332	2,641	4,234	2
Massachusetts	14,802	3,801	5,633	2,612	2,673	83
Michigan	12,552	3,042	4,691	2,211	2,586	22
Minnesota	8,525	2,628	1,914	1,999	1,900	84
Mississippi	3,418	587	1,114	569	638	510
Missouri	11,260	2,149	4,383	1,566	2,528	633
Montana	2,371	528	291	894	658	0
Nebraska	2,529	743	550	662	468	106
Nevada	2,833	570	1,233	406	623	1
New Hampshire	1,666	490	426	349	315	86

Table C.2.10 Alcohol and Drug Single-Day Specialty Treatment Counts, by State: TEDS 2007 to 2009 Combined (continued)

Region/State	Single-Day Treatment Counts 2007 to 2009 TEDS—(March 30 or March 31) ¹					
	Alcohol or Drug Treatment ²	Alcohol-Only Treatment ³	Drug-Only Treatment ³	Primary Alcohol with Secondary Drug Treatment ⁴	Primary Drug with Secondary Alcohol Treatment ⁴	No Substance Use at Admission Reported
State (continued)						
New Jersey	19,413	3,224	10,305	2,257	3,623	4
New Mexico	1,338	383	546	156	94	159
New York	80,054	13,131	32,482	14,990	19,441	9
North Carolina	3,695	473	1,543	810	813	56
North Dakota	982	310	197	240	235	0
Ohio	25,825	5,086	7,139	5,360	5,726	2,515
Oklahoma	5,808	990	2,614	1,035	1,089	81
Oregon	17,611	5,839	4,501	3,555	3,716	0
Pennsylvania	20,791	5,521	9,451	2,879	2,940	0
Rhode Island	3,788	542	2,232	405	584	26
South Carolina	7,283	2,550	2,417	1,283	1,024	9
South Dakota	3,049	1,045	427	1,036	488	54
Tennessee	1,436	282	713	214	224	3
Texas	7,972	901	4,285	857	1,929	0
Utah	5,662	853	2,635	772	1,399	2
Vermont	2,676	731	870	584	491	0
Virginia	11,282	1,798	2,970	2,276	2,858	1,380
Washington	20,703	3,819	5,433	5,100	5,963	388
West Virginia	4,027	1,586	1,766	372	301	1
Wisconsin	9,157	4,728	1,577	1,726	1,053	74
Wyoming	2,125	752	488	510	373	1

* Low precision; no estimate reported.

NOTE 1: Reporting for Alabama, Alaska, the District of Columbia, and Georgia was incomplete for 2007 to 2009.

NOTE 2: TEDS collects data primarily from publicly funded facilities and does not include data from federally operated facilities.

¹ Single-day treatment counts are based on a reference date of March 30 or March 31 for TEDS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, TEDS data are based on the data file from the previous year.

² “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, both alcohol and drugs, and with no substance use at admission reported are included.

³ “Alcohol-only” refers to treatment for only alcohol. “Drug-only” refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.

⁴ “Primary alcohol” refers to alcohol as the main substance of abuse at the time of admission (individuals in treatment for alcohol only are excluded). “Primary drug” refers to a substance, other than alcohol, that is the main substance of abuse at the time of admission (individuals in treatment for drugs only are excluded).

Table C.2.11 Alcohol and Drug Single-Day Specialty Treatment Counts (All Facilities), by State: N-SSATS 2007 to 2009 Combined

Region/State	Single-Day Treatment Counts 2007 to 2009 N-SSATS—All Facilities (March 30 or March 31) ¹			
	Alcohol-Only Treatment ²	Drug-Only Treatment ²	Alcohol or Drug Treatment ³	Alcohol and Drug Treatment ⁴
Total United States	216,832	414,845	1,153,617	521,940
Region				
Northeast	40,791	119,474	285,374	125,109
Midwest	51,728	70,447	232,093	109,918
South	49,639	128,149	312,156	134,368
West	74,674	96,774	323,994	152,545
State				
Alabama	1,353	8,583	14,895	4,959
Alaska	1,015	454	3,103	1,634
Arizona	7,960	9,181	29,445	12,304
Arkansas	508	1,362	3,676	1,806
California	26,723	50,213	139,043	62,106
Colorado	13,628	6,968	35,410	14,814
Connecticut	3,006	12,961	24,941	8,974
Delaware	624	1,345	4,024	2,055
District of Columbia	639	2,431	4,881	1,810
Florida	8,257	20,407	51,470	22,805
Georgia	2,797	8,041	18,115	7,277
Hawaii	642	1,421	4,226	2,163
Idaho	805	823	3,871	2,243
Illinois	10,225	16,527	44,902	18,149
Indiana	5,838	10,765	29,598	12,996
Iowa	1,933	1,548	7,500	4,019
Kansas	2,261	2,507	10,526	5,759
Kentucky	4,454	5,648	20,413	10,312
Louisiana	1,518	4,907	12,553	6,128
Maine	1,765	3,739	9,840	4,336
Maryland	5,294	17,476	37,732	14,962
Massachusetts	7,020	13,953	38,445	17,473
Michigan	10,290	14,111	42,676	18,275
Minnesota	3,390	3,850	13,859	6,619
Mississippi	1,217	1,495	5,852	3,140
Missouri	2,958	6,628	19,329	9,744
Montana	865	568	3,359	1,926
Nebraska	1,178	973	5,081	2,930
Nevada	1,990	2,882	9,406	4,534
New Hampshire	698	1,916	4,826	2,212

Table C.2.11 Alcohol and Drug Single-Day Specialty Treatment Counts (All Facilities), by State: N-SSATS 2007 to 2009 Combined (continued)

Region/State	Single-Day Treatment Counts 2007 to 2009 N-SSATS—All Facilities (March 30 or March 31) ¹			
	Alcohol-Only Treatment ²	Drug-Only Treatment ²	Alcohol or Drug Treatment ³	Alcohol and Drug Treatment ⁴
State (continued)				
New Jersey	3,933	15,015	30,339	11,391
New Mexico	3,198	4,098	14,599	7,304
New York	14,976	47,811	117,075	54,287
North Carolina	4,971	11,475	28,498	12,052
North Dakota	578	286	2,308	1,444
Ohio	7,220	8,731	36,847	20,896
Oklahoma	2,398	4,189	12,579	5,993
Oregon	5,104	6,447	23,205	11,654
Pennsylvania	7,016	19,470	47,438	20,953
Rhode Island	1,440	3,402	8,115	3,272
South Carolina	3,047	6,106	14,874	5,720
South Dakota	897	303	2,845	1,645
Tennessee	1,833	7,000	13,135	4,301
Texas	5,552	15,212	40,171	19,407
Utah	1,744	4,064	12,191	6,383
Vermont	936	1,208	4,355	2,210
Virginia	4,042	7,012	20,627	9,573
Washington	9,959	9,106	42,998	23,933
West Virginia	1,134	5,460	8,661	2,068
Wisconsin	4,960	4,220	16,621	7,441
Wyoming	1,042	548	3,136	1,546

* Low precision; no estimate reported.

NA = not available.

NOTE: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies.

¹ Single-day treatment counts are based on a reference date of March 30 or March 31 for N-SSATS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS data are based on the data file from the previous year.

² “Alcohol-only” refers to treatment for only alcohol. “Drug-only” refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.

³ “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, and both alcohol and drugs are included.

⁴ “Alcohol and drug” treatment refers to alcohol and at least one drug as main substance of abuse at the time of admission (individuals in treatment for alcohol only or drugs only are excluded).

**Table C.2.12 Alcohol and Drug Single-Day Specialty Treatment Counts, by State:
N-SSATS 2007 to 2009 Combined, Hospitals Excluded**

Region/State	Single-Day Treatment Counts 2007 to 2009 N-SSATS—Hospitals Excluded (March 30 or March 31) ¹			
	Alcohol-Only Treatment ²	Drug-Only Treatment ²	Alcohol or Drug Treatment ³	Alcohol and Drug Treatment ⁴
Total United States	213,888	411,654	1,139,670	514,128
Region				
Northeast	39,797	118,266	280,460	122,397
Midwest	51,276	69,944	230,012	108,793
South	48,617	127,076	307,163	131,470
West	74,198	96,368	322,034	151,468
State				
Alabama	1,320	8,557	14,699	4,822
Alaska	1,009	454	3,093	1,631
Arizona	7,878	9,101	29,060	12,081
Arkansas	504	1,358	3,635	1,774
California	26,542	50,025	138,179	61,612
Colorado	13,601	6,956	35,322	14,765
Connecticut	2,925	12,828	24,534	8,781
Delaware	618	1,340	3,998	2,040
District of Columbia	631	2,417	4,830	1,782
Florida	8,007	20,176	50,566	22,382
Georgia	2,718	7,973	17,777	7,086
Hawaii	641	1,421	4,225	2,163
Idaho	792	820	3,831	2,220
Illinois	10,137	16,381	44,536	18,018
Indiana	5,755	10,696	29,185	12,734
Iowa	1,923	1,542	7,468	4,004
Kansas	2,261	2,507	10,524	5,757
Kentucky	4,386	5,566	20,036	10,084
Louisiana	1,481	4,868	12,255	5,906
Maine	1,747	3,721	9,731	4,263
Maryland	5,245	17,384	37,446	14,817
Massachusetts	6,829	13,688	37,554	17,038
Michigan	10,265	14,082	42,539	18,192
Minnesota	3,349	3,834	13,742	6,560
Mississippi	1,181	1,416	5,592	2,995
Missouri	2,940	6,512	19,146	9,694
Montana	846	550	3,257	1,861
Nebraska	1,174	969	5,058	2,915
Nevada	1,979	2,873	9,361	4,510
New Hampshire	675	1,911	4,792	2,205

**Table C.2.12 Alcohol and Drug Single-Day Specialty Treatment Counts, by State:
N-SSATS 2007 to 2009 Combined, Hospitals Excluded (continued)**

Region/State	Single-Day Treatment Counts 2007 to 2009 N-SSATS—Hospitals Excluded (March 30 or March 31) ¹			
	Alcohol-Only Treatment ²	Drug-Only Treatment ²	Alcohol or Drug Treatment ³	Alcohol and Drug Treatment ⁴
State (continued)				
New Jersey	3,736	14,844	29,472	10,892
New Mexico	3,179	4,081	14,533	7,273
New York	14,614	47,363	115,100	53,123
North Carolina	4,884	11,362	28,022	11,776
North Dakota	567	280	2,258	1,411
Ohio	7,133	8,651	36,418	20,634
Oklahoma	2,371	4,164	12,479	5,945
Oregon	5,081	6,431	23,134	11,622
Pennsylvania	6,935	19,350	46,977	20,691
Rhode Island	1,422	3,386	8,061	3,252
South Carolina	3,003	6,055	14,608	5,550
South Dakota	876	297	2,737	1,564
Tennessee	1,780	6,953	12,871	4,139
Texas	5,405	15,079	39,351	18,867
Utah	1,729	4,049	12,135	6,357
Vermont	913	1,175	4,240	2,152
Virginia	3,958	6,961	20,382	9,463
Washington	9,905	9,065	42,827	23,856
West Virginia	1,125	5,448	8,615	2,042
Wisconsin	4,896	4,195	16,401	7,310
Wyoming	1,017	543	3,077	1,517

* Low precision; no estimate reported.

NA = not available.

NOTE: N-SSATS collects information from public and private facilities and includes facilities operated by Federal agencies.

- ¹ Single-day treatment counts are based on a reference date of March 30 or March 31 for N-SSATS. Because the reference date for NSDUH is October 1 of the prior year in other tables, for consistency across tables, N-SSATS data are based on the data file from the previous year. Data from hospitals are excluded.
- ² “Alcohol-only” refers to treatment for only alcohol. “Drug-only” refers to treatment for only drugs. Individuals in treatment for both drugs and alcohol are excluded.
- ³ “Alcohol or drug treatment” refers to treatment for either alcohol or drugs. Individuals in treatment for alcohol only, drugs only, and both alcohol and drugs are included.
- ⁴ “Primary alcohol” refers to alcohol as the main substance of abuse at the time of admission (individuals in treatment for alcohol only are included). “Primary drug” refers to a substance, other than alcohol, that is the main substance of abuse at the time of admission (individuals in treatment for drugs only are included).

Table C.2.13 Substance Use Treatment Annual Admissions, by State: N-SSATS 2007 to 2009 and TEDS 2007 to 2009

Region/State	Annual Admissions							
	N-SSATS ¹				TEDS			
	2007	2008	2009	Average	2007	2008	2009	Average
Total United States²	3,561,249	3,501,429	3,388,214	3,483,632	1,908,360	1,989,703	1,962,281	1,953,448
Region²								
Northeast	866,936	844,623	816,054	842,538	471,231	470,851	481,195	474,426
Midwest	864,322	859,041	832,660	852,008	617,247	629,301	614,696	620,415
South	903,846	898,677	851,628	884,717	364,685	424,533	425,094	404,771
West	926,145	899,088	887,869	904,367	455,197	465,018	441,296	453,837
State								
Arizona	84,122	93,644	81,967	86,578	21,160	20,971	19,217	20,449
Arkansas	15,825	15,659	14,404	15,296	15,012	28,518	24,607	22,712
California	409,490	384,456	374,331	389,426	202,725	202,473	181,799	195,666
Colorado	105,838	95,528	97,222	99,529	79,384	85,776	88,014	84,391
Connecticut	75,445	70,770	62,649	69,621	44,757	47,177	46,067	46,000
Delaware	11,023	12,751	10,072	11,282	8,424	7,935	7,784	8,048
Florida	200,668	194,113	177,832	190,871	52,657	80,962	79,343	70,987
Hawaii	10,473	10,321	14,338	11,711	6,969	7,374	7,245	7,196
Idaho	11,092	12,097	13,937	12,375	3,697	6,200	6,562	5,486
Illinois	162,908	169,079	159,908	163,965	71,067	76,433	71,262	72,921
Indiana	74,835	79,666	72,427	75,643	29,021	19,084	18,004	22,036
Iowa	35,776	35,216	34,764	35,252	26,927	26,261	30,711	27,966
Kansas	35,520	34,372	35,245	35,046	15,016	16,777	19,123	16,972
Kentucky	63,528	69,877	65,328	66,244	24,076	22,148	21,474	22,566
Louisiana	47,858	42,975	41,866	44,233	24,427	25,289	28,084	25,933
Maine	23,900	25,450	24,387	24,579	15,977	15,624	14,592	15,398
Maryland	84,458	85,370	85,285	85,038	67,404	65,656	62,820	65,293
Massachusetts	157,547	143,613	144,492	148,551	91,916	83,267	84,948	86,710
Michigan	153,853	148,290	140,976	147,706	66,934	65,363	64,259	65,519
Minnesota	76,338	72,273	74,954	74,522	49,537	49,861	51,991	50,463
Mississippi	25,059	20,921	18,360	21,447	8,241	8,742	8,022	8,335
Missouri	73,485	65,231	68,278	68,998	47,254	49,243	52,503	49,667
Montana	16,216	14,331	14,529	15,025	9,681	7,474	7,353	8,169
Nebraska	30,329	22,872	22,771	25,324	16,509	16,252	16,001	16,254
Nevada	25,022	29,513	24,439	26,325	9,852	9,372	9,908	9,711
New Hampshire	11,628	10,983	11,497	11,369	5,641	6,214	6,348	6,068
New Jersey	80,479	83,779	84,469	82,909	60,471	65,574	69,155	65,067
New Mexico	47,089	36,214	48,098	43,800	11,967	11,515	9,960	11,147
New York	324,570	326,976	315,611	322,386	308,588	314,573	313,568	312,243
North Carolina	88,199	94,930	102,795	95,308	23,339	38,391	53,620	38,450
North Dakota	12,029	12,039	13,929	12,666	2,421	2,519	2,439	2,460
Ohio	124,125	122,050	116,160	120,778	100,951	104,889	110,771	105,537
Oklahoma	37,171	31,811	36,410	35,131	16,461	16,974	16,930	16,788
Oregon	71,458	75,154	62,607	69,740	52,370	53,126	50,268	51,921
Pennsylvania	158,532	169,899	160,796	163,076	70,400	76,955	62,094	69,816
Rhode Island	17,566	15,438	15,975	16,326	11,359	11,404	10,784	11,182
South Carolina	49,779	49,862	51,069	50,237	26,329	27,184	27,874	27,129
South Dakota	15,455	15,340	14,220	15,005	15,774	15,064	15,002	15,280
Tennessee	52,819	55,578	37,440	48,612	10,295	9,906	10,242	10,148
Texas	137,961	135,141	128,632	133,911	44,578	45,771	46,180	45,510

Table C.2.13 Substance Use Treatment Annual Admissions, by State: N-SSATS 2007 to 2009 and TEDS 2007 to 2009 (continued)

Region/State	Annual Admissions							
	N-SSATS ¹				TEDS			
	2007	2008	2009	Average	2007	2008	2009	Average
State (continued)								
Utah	36,316	37,746	37,781	37,281	14,180	14,561	14,882	14,541
Vermont	14,655	12,133	12,786	13,191	8,138	8,513	7,140	7,930
Virginia	72,071	70,674	62,179	68,308	31,488	33,751	30,023	31,754
Washington	99,166	98,708	108,417	102,097	38,073	39,726	39,862	39,220
West Virginia	17,427	19,015	19,956	18,799	11,954	13,306	8,091	11,117
Wisconsin	72,283	68,195	62,423	67,634	29,820	29,105	29,129	29,351
Wyoming	9,863	11,376	10,203	10,481	5,139	6,450	6,226	5,938

* Low precision; no estimate reported.

¹ N-SSATS annual admission counts reflect past year admissions reported on the last working day of March in the given year.

² Both TEDS and N-SSATS total and regional counts exclude Alabama, Alaska, the District of Columbia, and Georgia, which had incomplete TEDS reporting.

Table C.3.1 Number of Persons Aged 12 or Older Who Needed Treatment for an Illicit Drug or Alcohol Problem in the Past Year and Number Who Received Specialty Treatment in the Past Year (NSDUH 2008-2010 Average), Number Who Received Treatment in the Past Year (TEDS 2007-2009 Average), and Percentage Who Needed Treatment but Did Not Receive Specialty Treatment (NSDUH 2008-2010 Averages in Numerator and Denominator; TEDS 2007-2009 Average in Numerator and NSDUH 2008-2010 Average in Denominator), by State

State	Needed Treatment (NSDUH)	Received Specialty Treatment (NSDUH)		Received Treatment (TEDS)	Percentage Who Needed but Did Not Receive Specialty Treatment (NSDUH numerator)	Percentage Who Needed but Did Not Receive Treatment (TEDS numerator)
		Number	(95% CI)			
TOTAL	23,349,410	2,504,756	(2,327,260-2,695,644)	1,928,578	89.3	91.7
Alabama	309,405	39,669	(22,140-70,822)	NA	87.2	NA
Alaska	61,252	10,699	(7,584-15,059)	NA	82.5	NA
Arizona	545,866	59,897	(38,643-92,635)	33,319	89.0	93.9
Arkansas	176,939	18,193	(10,753-30,711)	15,922	89.7	91.0
California	3,030,951	249,134	(184,605-335,966)	231,884	91.8	92.3
Colorado	431,203	32,767	(19,087-56,117)	70,061	92.4	83.8
Connecticut	300,019	40,885	(27,316-61,053)	36,123	86.4	88.0
Delaware	67,244	11,771	(7,463-18,503)	7,453	82.5	88.9
District of Columbia	65,445	10,924	(7,038-16,886)	NA	83.3	NA
Florida	1,364,860	151,979	(106,418-216,773)	67,305	88.9	95.1
Georgia	576,774	46,244	(25,207-84,650)	NA	92.0	NA
Hawaii	116,179	7,600	(4,599-12,536)	8,201	93.5	92.9
Idaho	127,473	18,156	(11,614-28,297)	7,379	85.8	94.2
Illinois	969,671	94,855	(71,006-126,619)	69,483	90.2	92.8
Indiana	476,373	65,797	(44,053-98,072)	31,935	86.2	93.3
Iowa	230,973	18,700	(11,494-30,368)	33,263	91.9	85.6
Kansas	212,605	20,094	(13,983-28,842)	23,354	90.5	89.0
Kentucky	278,503	38,083	(22,433-64,451)	18,215	86.3	93.5
Louisiana	285,554	14,704	(8,126-26,568)	25,875	94.9	90.9
Maine	86,597	9,139	(5,965-13,983)	15,330	89.4	82.3
Maryland	393,354	55,980	(32,625-95,712)	65,657	85.8	83.3
Massachusetts	599,763	70,925	(43,879-114,293)	64,212	88.2	89.3
Michigan	818,312	119,216	(92,732-153,124)	57,956	85.4	92.9
Minnesota	471,298	49,102	(29,571-81,293)	46,907	89.6	90.0
Mississippi	162,640	9,133	(4,749-17,536)	9,774	94.4	94.0
Missouri	420,259	51,896	(32,991-81,452)	49,768	87.7	88.2

Table C.3.1 Number of Persons Aged 12 or Older Who Needed Treatment for an Illicit Drug or Alcohol Problem in the Past Year and Number Who Received Specialty Treatment in the Past Year (NSDUH 2008-2010 Average), Number Who Received Treatment in the Past Year (TEDS 2007-2009 Average), and Percentage Who Needed Treatment but Did Not Receive Specialty Treatment (NSDUH 2008-2010 Averages in Numerator and Denominator; TEDS 2007-2009 Average in Numerator and NSDUH 2008-2010 Average in Denominator), by State (continued)

State	Needed Treatment (NSDUH)	Received Specialty Treatment (NSDUH)		Received Treatment (TEDS)	Percentage Who Needed but Did Not Receive Specialty Treatment (NSDUH numerator)	Percentage Who Needed but Did Not Receive Treatment (TEDS numerator)
		Number	(95% CI)			
Montana	94,371	12,284	(8,374-17,977)	8,891	87.0	90.6
Nebraska	143,709	10,855	(5,821-20,181)	13,428	92.4	90.7
Nevada	254,807	30,852	(17,283-54,797)	12,166	87.9	95.2
New Hampshire	115,540	13,188	(8,633-20,104)	6,252	88.6	94.6
New Jersey	591,094	55,380	(30,746-99,479)	87,880	90.6	85.1
New Mexico	171,126	16,248	(11,357-23,215)	8,964	90.5	94.8
New York	1,592,684	199,350	(146,927-270,167)	245,898	87.5	84.6
North Carolina	594,986	69,300	(40,337-118,731)	33,285	88.4	94.4
North Dakota	48,314	4,187	(2,297-7,609)	3,334	91.3	93.1
Ohio	896,518	93,027	(71,957-120,190)	105,443	89.6	88.2
Oklahoma	291,919	32,774	(21,233-50,479)	20,203	88.8	93.1
Oregon	380,614	67,452	(45,904-98,798)	66,029	82.3	82.7
Pennsylvania	963,583	119,627	(92,614-154,403)	46,990	87.6	95.1
Rhode Island	111,993	15,941	(10,671-23,743)	11,809	85.8	89.5
South Carolina	401,640	45,182	(28,022-72,644)	31,929	88.8	92.1
South Dakota	71,782	6,287	(4,399-8,973)	12,724	91.2	82.3
Tennessee	420,987	29,096	(14,980-56,367)	11,096	93.1	97.4
Texas	1,662,813	85,456	(61,773-118,165)	41,930	94.9	97.5
Utah	151,162	26,550	(19,441-36,215)	17,136	82.4	88.7
Vermont	52,753	6,605	(4,500-9,677)	9,305	87.5	82.4
Virginia	623,305	76,198	(38,861-148,570)	36,925	87.8	94.1
Washington	499,336	82,471	(54,480-124,517)	60,606	83.5	87.9
West Virginia	128,160	24,063	(13,318-43,230)	13,456	*	89.5
Wisconsin	467,391	61,104	(37,332-99,691)	26,371	86.9	94.4
Wyoming	39,311	5,735	(3,545-9,250)	7,152	85.4	81.8

* Low precision; this estimate would ordinarily be suppressed.

NOTE: For NSDUH, respondents were classified as needing treatment for an illicit drug problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs; (2) abuse of illicit drugs; or (3) received treatment for illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine use items added in 2005 and 2006.