CHNA Steering Committee
FY 2019

Name	Title	Affiliation	Address
Butler, Joelle	Media and Communications Coordinator	Meritus Medical Center	11110 Medical Campus Road, Suite 10, Hagerstown, MD 21742
Brown, Douglas	Clinical Coordinator, Physician Assistant Program	Frostburg State University	32 West Washington Street, Hagerstown, MD 21740
Delauter, Susan	Benefits & Wellness Administrator	City of Hagerstown	1 East Franklin Street Hagerstown, MD 21740
Gaviria, Diana	Medical Director	Maryland Department of Health	1302 Pennsylvania Avenue Hagertown, MD 21742
Goldman, Michele	Executive Director	Community Free Clinic	249 Mill Street Hagerstown, MD 21740
Hershey, Erin	Meritus Board of Directors	Meritus Heath	11110 Medical Campus Road Suite 129 Hagerstown, MD 21742
Lopp, Susan	Administrative Director	John R. Marsh Cancer Center	11110 Medical Campus Road Suite 129 Hagerstown, MD 21742
MacRae, Rod	Director of Health Planning and Strategic Initiatives	Washington County Health Department	1302 Pennsylvania Avenue Hagertown, MD 21742
Miller, Curt	Director of Public Relations	Brook Lane Health Services	13121 Brook Lane PO Box 1945 Hagerstown, MD 21742
Noyes, Jon	Executive Director of Strategic Planning	Meritus Medical Center	11110 Medical Campus Road, Suite 229, Hagerstown, MD 21742
Powderly, Kathy	Executive Director	Hagerstown Area Religious Council	P.O. Box 1158, Hagerstown, MD 21741
Rock, Rick	President	Washington County Mental Health Authority	339 E. Antietam Street Suite 5 Hagerstown, MD 21740

CHNA Steering Committee
FY 2019

Rogers, Guinn	President/CEO	United Way of Washington Co.	83 West Washington Street, Suite 101
Sell, Brad	President/ CEO	Community Foundation of Washington County	37 S. Potomac Street Hagerstown, MD 21740
Spotts, Douglas	VP and Chief Population Health Officer	Meritus Health System	11110 Medical Campus Road, Suite 229, Hagerstown, MD 21742
Steiner, Shelley	Director of Community Business Partnerships	Hospice of Washington County	747 Northern Avenue Hagerstown, MD 21742
Terl, Cynthia	Community Engagement Director	Wells House, Inc.	425 E. Patrick Street, Frederick, MD 21701
Thursfield, Fred	Executive Director, Meritus Health Foundation	Meritus Medical Center	11116 Medical Campus Road, Suite 3977, Hagerstown, MD 21742
Twigg, Allen	Executive Director	Behavioral & Community Health, Meritus Medical Center	11116 Medical Campus Road, Suite 2974, Hagerstown, MD 21742
Walter, Susan	CEO	Tri-state Community Health Center	109 Rayloc Drive Hancock, MD 21750

HEALTHY WASHINGTON COUNTY
September 2018

LAST NAME	FIRST NAME	AGENCY
BARNES	Kelli	Walmart
BILL	Lucy	Mobile Crisis SW, Turning Point, Way Station Inc.
BENNETT	Laura	Washington County Health Department
BISCARR	Margaret	PepsiCo
BLIGH	Sharon	Consumer Goods Forum
BOWDISH, PhD	Lawrence	U.S. Chamber of Commerce Foundation
BRILL	Jeanette	Meritus Medical Center
BRUNS	Andy	Herald-Mail Media
BUTLER	Joelle	Meritus Medical Center
CLARK	Melissa	AHEC West
CLINE	Jeff	Board of County Commissioners
CLIPPINGER	Cherie	Family Healthcare of Hagerstown
CRAWFORD	Stacey	Community Foundation of Washington County
CRIST	Fallon	The Mental Health Center
DASCH	Melissa	Turning Point, Way Station Inc.
DeHAVEN	Shelby	HEAL of Washington County
DELAUTER	Susan	City of Hagerstown
DeLEONIBUS	David	CORE Life
DePINTO	Cheryl	Population Health Improvement, MDH
DeSHONG	Sheila	Tri-State Community Health Center
EARLE	Cindy	Meritus Medical Center
FANJOY	Keith	San Mar Childrens Home
FORTUNATO	Kim	Campbell Soup
FREY	Paul	Chamber of Commerce
GAVIRIA	Dr. Diana	Washington County Health Department
GUSMAN	Emily	Hagerstown Police
HELMICK	Meagan	UNMC
HERMAN	Julie	Brook Lane Health Services
HERSHBERGER	Jan	Meritus Medical Center
HOLTZ	Kimberly	The Mental Health Center

HEALTHY WASHINGTON COUNTY
September 2018

LAST NAME	FIRST NAME	AGENCY
HOWELLS	Janice	Washington County Public Schools
JEAN-BAPTISTE	Nefertiti	Connector Entity
KEEFER	Patience	Walmart
KELLY	Andrea	Pepsi Co.
KERCHEVAL	Jim	Greater Hagerstown Committee
LOPP	Susan	Meritus Medical Center
MacRAE	Rod	Washington County Health Department
McCLELLAN	Rita	Campbell Soup
McCOY	Lisa	University of Maryland Extension
McPHERSON	Mary	Washington County Health Department
MARGEVICH	Maureen	Washington County Public Schools
MAUST	Jennifer	Meritus Medical Center
MESSER	Theresa	Johns Hopkins HealthCare
MILLER	Curtis	Brook Lane Health Services
MINOTTI	Melissa	Johns Hopkins School of Public Health
MURDAUGH	Kim	Family Healthcare of Hagerstown
OLACK	Amy	Washington County Commission on Aging
PERSON	Hannah	Washington County Health Department
REYNOLDS	Janine	The Mental Health Center
RILEY	Amy	City of Hagerstown/Parks and Rec
ROBERSON	Adam	Community Free Clinic
ROCK	Marshall (Rick)	Washington County Mental Health Authority
ROGERS	Guinn	United Way of Washington County
SEAVER	James	Tri-State Community Health Center
SMITH	Mollie	Brothers Who Care/MOTA
SNIDER	Nikki	Washington County Department of Social Services
STAUBS	Christie	Maryland Physicians Care
STEINER	Shelley	Hospice of Washington County
STERLING	Victoria	Washington County Health Department

HEALTHY WASHINGTON COUNTY
September 2018

LAST NAME	FIRST NAME	AGENCY
STEWART	David	Connector Entity
STEWART	Susan	AHEC West
STONER	Earl	Washington County Health Department
TERL	Cynthia	Wells House
THOMPSON	Deb	Meritus Medical Center
TWIGG	Allen	Meritus Medical Center
WALTER	Susan	Tri-State Community Health Center
WELDON	Mark	United Way of Washington County
ZIMMERMAN	Wendy	Meritus Medical Center

HEALTHY WASHINGTON COUNTY
September 2018

LAST NAME	FIRST NAME	AGENCY

Maryland State Health Improvement Proces

Network of Care

Focus Area
Healthy Beginnings

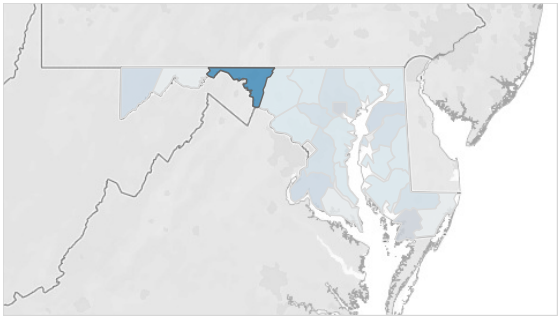
Indicator
Babies with Low Birth Weight

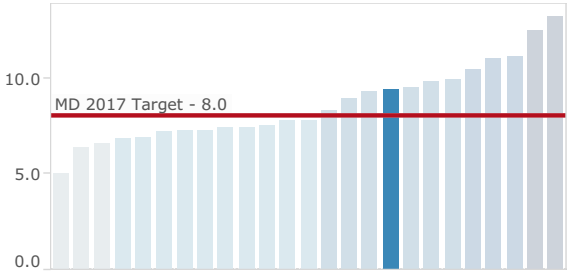
If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

Jurisdiction Value
5.0 — 13.2

Jurisdictions

Maryland	8.9
Allegany	6.6
Anne Arundel	7.8
Baltimore City	12.4
Baltimore Cou..	9.5
Calvert	7.8
Caroline	7.4
Carroll	6.8
Cecil	7.4
Charles	11.1
Dorchester	7.3
Frederick	6.9
Garrett	11.0
Harford	7.2
Howard	8.3
Kent	10.4
Montgomery	7.5
Prince Georges	9.8
Queen Annes	9.3
Saint Marys	6.4
Somerset	13.2
Talbot	7.3
Washington	9.4
Wicomico	9.9
Worcester	5.0





Jurisdictions (hover for details)

This indicator shows the percentage of live births that are a low birth weight (2500 grams or less). Babies born with a low birth weight are at increased risk for serious health consequences including disabilities and death. Low birth weight babies weigh less than 2,500 grams (5.5 pounds). Maryland's low birth weight percentage is higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2017

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

Focus Area	Indicator	Jurisdictions	Value	Change	Goal me..
Healthy Beginnings	Infant Death Rate	Washington	9.8	2.7	No
	Babies with Low Birth Weight	Washington	9.4	0.0	No
	Sudden Unexpected Infant Death Ra..	Washington	1.7	-2.6	No
	Teen Birth Rate	Washington	26.1	0.3	No
	Early Prenatal Care	Washington	70.2	0.0	Yes
	Students Entering Kindergarten Rea..	Washington	37.0	4.0	N/A
	High School Graduation Rate	Washington	91.1	-0.1	No
	Children Receiving Blood Lead Scree..	Washington	51.3	0.9	No
Healthy Living	Adults Who Currently Smoke	Washington	18.3	-3.7	No
	Adolescents Who Use Tobacco Produ..	Washington	20.9	-2.8	No
	HIV Incidence Rate	Washington	7.9	3.2	Yes
	Chlamydia Infection Rate	Washington	362.8	-7.4	Yes
	Life Expectancy	Washington	77.5	0.0	No
	Increase Physical Activity	Washington	45.5	-3.6	No
	Adolescents Who Have Obesity	Washington	14.1	-0.2	No
	Adults Who Are Not Overweight Or ..	Washington	31.5	-0.1	No
Healthy Communities	Child Maltreatment Rate	Washington	7.8	-2.7	N/A
	Suicide Rate	Washington	14.7	0.6	No
	Domestic Violence	Washington	148.4	-34.1	Yes
	Children With Elevated Blood Lead L..	Washington	0.2	-0.1	Yes
	Fall-Related Death Rate	Washington	10.2	Null	No
	Pedestrian Injury Rate On Public Ro..	Washington	38.5	5.9	No
	Affordable Housing	Washington	77.0	0.9	Yes
Access to Health Care	Adolescents Who Received A Wellne..	Washington	53.0	-3.1	No
	Children Receiving Dental Care In T..	Washington	58.3	-0.3	No
	Persons With A Usual Primary Care ..	Washington	83.3	-3.7	No
	Uninsured ED Visits	Washington	6.6	-0.7	Yes
Quality Preventive Care	Emergency Department Visit Rate D..	Washington	297.1	109.2	No
	Emergency Department Visit Rate D..	Washington	318.1	135.7	No
	Drug-Induced Death Rate	Washington	37.2	5.9	No
	Emergency Department Visits Relat..	Washington	5410.8	-374.5	No
	Hospitalization Rate Related To Alzh..	Washington	544.0	384.4	No
	Annual Season Influenza Vaccinations	Washington	32.3	3.3	No
	Emergency Department Visit Rate D..	Washington	66.0	18.2	No
	Age-Adjusted Mortality Rate From H..	Washington	193.5	-9.0	No
	Emergency Department Visits for Ad..	Washington	2307.2	474.2	No
	Emergency Department Visit Rate F..	Washington	511.1	-377.0	Yes
	Cancer Mortality Rate	Washington	165.2	-9.1	No

Washington County **DEMOGRAPHIC AND SOCIO-ECONOMIC OUTLOOK**

	Historical					Projected					
	1970	1980	1990	2000	2010 *	2015	2020	2025	2030	2035	2040
Population Characteristics:											
Total Population	103,829	113,086	121,393	131,923	147,430	151,200	160,300	169,950	178,890	186,610	193,450
Male	51,136	56,252	61,248	67,410	74,877	76,790	81,200	85,820	90,070	93,750	97,020
Female	52,693	56,834	60,145	64,513	72,553	74,400	79,100	84,130	88,820	92,860	96,430
Non-Hispanic White **	N/A	107,067	112,365	117,696	122,748	121,660	124,580	128,400	132,070	135,190	138,010
All Other **	N/A	6,019	9,028	14,227	24,682	29,530	35,720	41,550	46,820	51,420	55,440
Selected Age Groups:											
0-4	8,695	6,733	8,226	8,108	9,002	8,170	9,680	10,610	11,350	11,640	11,940
5-19	29,315	27,191	22,809	25,826	28,311	28,820	29,610	30,730	32,060	34,980	36,630
20-44	33,427	41,515	49,278	48,948	48,185	47,430	49,790	53,690	57,190	59,370	62,420
45-64	22,233	24,146	24,346	30,351	40,828	43,010	43,790	42,980	41,750	41,230	42,080
65+	10,159	13,501	16,734	18,690	21,104	23,780	27,430	31,940	36,540	39,390	40,390
Total	103,829	113,086	121,393	131,923	147,430	151,200	160,300	169,950	178,890	186,610	193,450
Total Household Population	99,981	108,017	113,345	122,503	139,005	142,255	150,774	159,809	168,102	175,193	181,531
Total Households	32,463	39,957	44,762	49,726	55,675	57,250	60,975	65,050	68,600	71,250	73,600
Average Household Size	3.08	2.70	2.53	2.46	2.50	2.48	2.47	2.46	2.45	2.46	2.47
Labor Force:											
Total Population 16+	73,240	87,562	96,806	104,251	117,590	121,760	129,460	137,460	143,550	149,240	154,760
In Labor Force	42,079	52,385	59,369	63,714	75,610	77,150	80,910	84,620	87,290	89,850	93,110
% in Labor Force *	57.5	59.8	61.3	61.1	64.3	63.4	62.5	61.6	60.8	60.2	60.2
Male Population 16+	36,550	43,174	48,682	53,057	59,640	61,710	65,520	69,390	72,310	75,010	77,610
In Labor Force	27,680	31,348	32,996	33,836	39,520	40,370	42,180	44,060	45,520	46,900	48,590
% in Labor Force *	75.7	72.6	67.8	63.8	66.3	65.4	64.4	63.5	63.0	62.5	62.6
Female Population 16+	36,690	44,388	48,124	51,194	57,950	60,050	63,940	68,070	71,240	74,230	77,150
In Labor Force	14,399	21,037	26,373	29,878	36,090	36,780	38,730	40,560	41,770	42,950	44,520
% in Labor Force *	39.2	47.4	54.8	58.4	62.3	61.2	60.6	59.6	58.6	57.9	57.7
Jobs by Place of Work :	44,839	52,159	66,698	74,880	77,353	83,200	88,100	92,200	94,200	96,000	97,700
Personal Income :											
Total (million of constant 2009$)	$1,773.6	$2,375.8	$3,003.2	$4,030.6	$5,241.0	$5,678.9	$6,665.9	$7,506.0	$8,234.4	$8,918.5	$9,607.5
Per Capita (constant 2009$)	$17,067	$21,024	$24,626	$30,523	$35,474	$37,559	$41,584	$44,166	$46,028	$47,795	$49,664

** For 2010 to 2040 non-hispanic white population is equal to "non-hispanic white alone", and all other population is equal to "all other races", alone and two or more races.

* Labor force participation rates for 2010 are estimates based on the 2008-2012 American Community Survey. These participation rates are applied to the Census 2010 population by age/sex to yield labor force estimates.

SOURCE: Projections prepared by the Maryland Department of Planning, July 2014. Population and houshold data from 1970 thru 2010 are from the U.S. Census Bureau, as is the labor force data from 1970 thru 2000. Labor force participation rate data for 2010 is an estimate by the Maryland Department of Planning based on 2008-2012 American Community Survey data. 1990 race and sex population is from modified age, race, sex data (MARS) and 2000 race and sex population from modified race data, both from the U.S. Census Bureau. Historical jobs, total personal income and per capita personal income data are from the U.S. Bureau of Economic Analysis.

Projections are rounded, therefore numbers may not add to totals.

Healthy Washington County
FY2019 Community Health Needs Assessment

Community health leaders need your help to better understand the health of our community. This survey will be used to identify needs and make improvements in health services for people living in our community.

We respect your privacy. Your individual answers will not identify you. Your answers will be combined anonymously with all the information that is received.

Thank you for participating. Your feedback is very important.

Please enter your zip code:

_____

1. In general, how would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. Please select all health concerns that you face. (choose ALL that apply)

☐ Alzheimer's/Dementia
☐ Alcohol overuse
☐ Asthma
☐ Cancer
☐ COPD
☐ Dental
☐ Diabetes or Pre-diabetes
☐ Drug abuse
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Joint or back pain
☐ Mental health (ADHD, Depression, Bi-polar)
☐ Overweight
☐ Sleep problems
☐ Smoking
☐ Smokeless tobacco
☐ I do not have any health challenges
☐ Other (please specify)_____

3. Overall, how would you rate the health status of the community?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

4. Where do you go for routine health care?

☐ Doctor's Office
☐ Health Department
☐ Emergency Room
☐ Community Free Clinic
☐ Urgent Care
☐ Tri-State Community Health Center
☐ Family HealthCare of Hagerstown
☐ V.A. Medical Center
☐ Other Clinic
☐ I do not receive routine health care
☐ I would not seek health care
☐ Other (please specify)_____

5. If you experience an immediate medical need, where would you go?

☐ Emergency Room
☐ Urgent Care
☐ Doctor's Office
☐ Health Department
☐ Other Clinic
☐ I would not seek health care
☐ Other (please specify)_____

6. Are there any issues that stop you from getting care when you need it? (check ALL that apply)

☐ Cost
☐ No insurance
☐ Don't have a family doctor
☐ Don't know how to find a doctor
☐ The doctor I need is not taking new patients
☐ Language barriers
☐ Cultural/religious beliefs
☐ Other (please specify)_____
☐ Can't afford the co-pay or deductible
☐ Can't get an appointment
☐ Doctor office not open evening or weekends
☐ Transportation
☐ Fear of doctors
☐ None

7. In the past 12 months, have you gone without medicine, or not taken medicine as prescribed because you could not afford it?

☐ Yes ☐ No ☐ I don't take medicine

8. What is MOST needed to improve the health of your family? (check up to THREE)

☐ Job opportunities
☐ Education
☐ Help to pay for medicine
☐ Mental health services
☐ Free health screenings
☐ Safe places to walk/play
☐ Wellness services
☐ Specialty doctors
☐ Dental services
☐ Transportation
☐ Birth control
☐ Recreation facilities
☐ Affordable housing
☐ Substance abuse treatment
☐ Quit tobacco use
☐ Financial assistance
☐ I'm not sure
☐ Other (please specify) _____

9. What types of health screenings and/or services are needed to keep you and your family healthy? (check up to SIX)

☐ Blood pressure
☐ Blood sugar
☐ Cancer
☐ Cholesterol (fats in blood)
☐ Dental
☐ Diabetes
☐ Diet/Nutrition
☐ Drug and alcohol abuse
☐ Eating disorders
☐ Weight-loss help
☐ Prenatal care
☐ Family Planning
☐ Flu shot
☐ Heart disease/Stroke
☐ Hearing
☐ HIV/AIDS
☐ Vision
☐ Memory loss
☐ Exercise/physical activity
☐ Mental health/depression
☐ Quit smoking
☐ Sexually transmitted diseases
☐ Suicide prevention
☐ Vaccination/immunizations
☐ Routine wellness checkups
☐ Falls prevention for the elderly

☐ Other (please specify) _____

10. Have you ever been told by a doctor or other health professional that you have diabetes?

☐ Yes (If "YES" go to question 11.)
☐ No (If "NO" go to question 12.)

11. If YES for diabetes, how are you managing your symptoms? (check ALL that apply)

☐ Medication
☐ Exercise
☐ Endocrinologist
☐ Support group
☐ I am not managing my symptoms
☐ Diet
☐ Family doctor
☐ Diabetes education program (past or present)
☐ I had gestational diabetes during pregnancy
☐ None of the above

☐ Other (please specify) _____

12. Are you interested in learning how to prevent diabetes?

☐ Yes
☐ No

13. What health issues do you need more information about? (please check up to SIX)

☐ Alcohol abuse
☐ Allergies
☐ Birth control
☐ Blood pressure
☐ Cancer
☐ Cholesterol
☐ Dementia
☐ Dental health
☐ Diabetes
☐ Diet/nutrition
☐ Prenatal care
☐ Drug abuse
☐ Eating disorders
☐ Quit smoking
☐ Falls prevention
☐ Heart disease
☐ HIV/AIDS and STDs
☐ Hospice or palliative care
☐ Injury prevention
☐ Living Will/Advanced Directives
☐ Medication
☐ Mental health/depression
☐ Organ donation
☐ Exercise/physical activity
☐ Suicide prevention
☐ Vaccination/immunizations
☐ Disease outbreak prevention

☐ Other (please specify) _____

14. Where do you get MOST of your health information? (check ALL that apply)

☐ Doctor/health professional	☐ Hospital	☐ Radio
☐ Facebook or Twitter	☐ Internet	☐ Church group
☐ Other social media	☐ Library	☐ School or college
☐ Family or friends	☐ Worksite	☐ TV
☐ Health Department	☐ Pharmacy	☐ Newspaper/magazine

☐ Other (please specify) _____

15. In general, how would you rate your overall mental or emotional health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

16. During the past month how many days have you often been bothered by feeling down, depressed or hopeless?

☐ 0 - less than 1 day ☐ 1-5 days ☐ 6-10 days ☐ more than 10 days

17. In the past month have you often been bothered with little interest or pleasure in doing things?

☐ Yes

☐ No

18. Have you ever needed mental health and couldn't get it?

☐ Yes

☐ No

☐ Have not needed care

☐ Prefer not to answer

19. Have you ever needed substance use treatment and couldn't get it?

☐ Yes

☐ No

☐ Have not needed care

☐ Prefer not to answer

20. In the last 12 months did you receive dental care?

☐ Yes (if "YES" go to question 22.)

☐ No (if "NO" go to question 21.)

21. If NO, why have you not received dental care?

☐ No insurance

☐ Cost

☐ Don't know how to find a dentist

☐ Fear of dentists

☐ The dentist I need is not taking new patients

☐ Language barriers

☐ Can't afford the co-pay or deductible

☐ Transportation

☐ I didn't need dental care in the past 12 months

☐ Other (please specify) _____

22. Please choose ALL statements below that apply to you.

☐ I eat at least **5** servings of fruits and vegetables each day

☐ I eat fast food more than once a week

☐ I smoke cigarettes

☐ I use electronic cigarettes

☐ I use smokeless tobacco

☐ I receive a flu shot each year

☐ I use medical marijuana

☐ None of the above applies to me

☐ I have more than **2** alcoholic drinks (if female) or **3** (if male) per day

☐ I drink at least **6-8** glasses of water per day

☐ I drink 2 or more sodas or energy drinks per day

☐ I misuse drugs, legal or illegal

☐ I have a wellness program at work

☐ I take other people's prescription medication

☐ I use sunscreen or protective clothing for planned time in the sun

23. Which of the following preventive procedures have you had in the past 12 months? (check ALL that apply)

☐ Mammogram (if woman)
☐ Pap smear (if woman)
☐ Prostate cancer screening (if man)
☐ Flu shot
☐ Colon/rectal exam
☐ Blood pressure check
☐ Blood sugar check
☐ Skin cancer screening
☐ None of above
☐ Vision screening
☐ Hearing screening
☐ Depression screening
☐ Cardiovascular screening
☐ Bone density test
☐ Dental cleaning/X-rays
☐ Physical exam
☐ Cholesterol screening

24. How important is exercise to you?

☐ Extremely important
☐ Very important
☐ Moderately important
☐ Slightly important
☐ Not at all important

25. In a typical week, how many days do you exercise?

☐ I don't regularly exercise
☐ Once a week
☐ 2 to 4 days a week
☐ 5 to 7 days a week

26. What do you most often do for exercise?

☐ Lift weights
☐ Walk
☐ Run
☐ Hike
☐ Swim
☐ Biking/Cycling
☐ Dance
☐ Aerobics
☐ Pilates
☐ Play a team sport
☐ Yoga
☐ Other (please specify) _____

27. Do you have a regular healthcare provider?

☐ Yes
☐ No

28. Do you currently have health insurance?

☐ Yes
☐ No (if "NO" skip to question 30.)
☐ Don't know

29. Who helps pay for your health insurance premium? (Proceed to question 31.)

☐ Employer
☐ Family Member's insurance
☐ Group other than employer
☐ Government (Medicare, Medicaid or ACA Exchange)
☐ I pay for 100% of my health insurance premium

☐ Other (please specify) _____

30. Why do you currently not have health insurance? (check ALL that apply)

☐ Insurance company refused for health reasons
☐ Employer does not pay for insurance
☐ Prefer not to participate in private insurance
☐ Dissatisfied with previous insurance plan or provider
☐ Do not know how to obtain health insurance
☐ prefer not to participate in government insurance
☐ Do not need insurance
☐ Do not believe in insurance
☐ Not eligible for employer paid insurance
☐ Lost or changed jobs
☐ Cannot afford insurance
☐ Other (please specify) _____

31. What is the biggest unmet need in Washington County?

_____

32. How has your health changed in the past 3 years?

☐ Much improved ☐ Better ☐ Same ☐ A bit worse ☐ Much worse

33. Studies show that sometimes childhood trauma affects adult health. In your childhood, were you exposed to any of the following? (Check all that apply)

☐ Physical Abuse
☐ Sexual Abuse
☐ Emotional Abuse
☐ Physical Neglect
☐ Emotional Neglect
☐ Mother treated violently
☐ Intimate partner violence
☐ Parental separation or divorce
☐ Incarcerated Household Member
☐ Substance misuse within the household
☐ Household mental illness
☐ Prefer not to say

What is your gender?

☐ Male
☐ Female

What is your age?

☐ Under 18
☐ 18-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60-69
☐ 70-79
☐ 80-89
☐ 90+

What is your highest level of education?

☐ K-8 grade
☐ Some high school
☐ High school graduate
☐ GED
☐ Technical school
☐ Some college
☐ College graduate
☐ Graduate school
☐ Post graduate

Including yourself, how many people live in your household?

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

How much total combined income did all members of your HOUSEHOLD earn last year?

☐ 0 t0 $9,999
☐ $10,000 to $24,999
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $124,999
☐ $125,000 to $149,999
☐ $150,000 to $174,999
☐ $175,000 to $199,999
☐ $200,000 and up
☐ Prefer not to answer

What is your race/ethnicity? (please select ALL that apply)

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian and other Pacific Islander
☐ White/Caucasian
☐ Prefer not to answer

☐ Other (please specify) _____

Condado Saludable de Washington
Evaluación de las necesidades de salud de la comunidad FY2019

Los líderes comunitarios de salud necesitan su ayuda para comprender mejor la salud de nuestra comunidad. Esta encuesta se usará para identificar las necesidades y hacer mejoras en los servicios de salud para las personas que viven en nuestra comunidad.

Respetamos su privacidad. Sus respuestas individuales no lo identificarán. Sus respuestas se combinarán de forma anónima con toda la información que se reciba.

Gracias por participar. Su opinión es muy importante.

Ingrese su código postal:

_____

1. En general, ¿cómo calificaría su salud integral?

☐ Excelente ☐ Muy buena ☐ Buena ☐ Favorable ☐ Deficiente

2. Por favor, seleccione todos los problemas de salud que enfrenta. (Marque TODOS los que apliquen)

☐ Alzheimer/Demencia
☐ Consumo excesivo de alcohol
☐ Asma
☐ Cáncer
☐ EPOC
☐ Odontológico
☐ Diabetes o prediabetes
☐ Consumo de drogas
☐ Enfermedad cardíaca
☐ Presión arterial alta
☐ Colesterol alto
☐ Dolor de espalda o articular
☐ Salud mental (TDAH, depresión, bipolar)
☐ Sobrepeso
☐ Problemas de sueño
☐ Tabaquismo
☐ Tabaco sin humo
☐ No tengo ningún problema de salud
☐ Otros (especifique)_____

3. En general, ¿cómo calificaría el estado de salud de la comunidad?

☐ Excelente ☐ Muy buena ☐ Buena ☐ Favorable ☐ Deficiente

4. ¿A dónde va por la atención médica de rutina?

☐ Consultorio médico
☐ Departamento de salud
☐ Sala de emergencias
☐ Community Free Clinic
☐ Atención de urgencias
☐ Tri-State Community Health Center
☐ Family HealthCare of Hagerstown
☐ V.A. Medical Center
☐ Otra clínica
☐ No recibo atención médica de rutina
☐ No buscaría atención médica
☐ Otros (especifique)_____

5. Si tiene una necesidad médica inmediata, ¿a dónde iría?

☐ Sala de emergencias
☐ Atención de urgencias
☐ Consultorio médico
☐ Departamento de salud
☐ Otra clínica
☐ No buscaría atención médica
☐ Otros (especifique)_____

6. ¿Hay algún factor que le impida recibir atención cuando la necesita? (marque TODOS los que apliquen)

☐ Costo
☐ Sin seguro
☐ No tengo un médico de familia
☐ No sé cómo encontrar un médico
☐ El médico que necesito no está viendo pacientes nuevos
☐ Barreras del idioma
☐ Creencias culturales/religiosas
☐ No puedo pagar el copago o el deducible
☐ No puedo conseguir una cita
☐ El consultorio médico no abre por la tarde o los fines de semana
☐ Transporte
☐ Miedo a los médicos
☐ Ninguna
☐ Otros (especifique)_____

7. En los últimos 12 meses, ¿se ha quedado sin medicamentos o no ha tomado los medicamentos recetados porque no puede pagarlos?

☐ Sí ☐ No ☐ No tomo medicamentos

8. ¿Qué es lo que MÁS se necesita para mejorar la salud de su familia? (marque máximo TRES)

☐ Oportunidades de trabajo	☐ Servicios de bienestar	☐ Vivienda asequible
☐ Educación	☐ Médicos especialistas	☐ Tratamiento de abuso de sustancias
☐ Ayuda para pagar los medicamentos	☐ Servicios odontológicos	☐ Dejar el consumo de tabaco
☐ Servicios de salud mental	☐ Transporte	☐ Asistencia financiera
☐ Exámenes gratuitos de salud	☐ Control de la natalidad	☐ No estoy seguro
☐ Lugares seguros para caminar/jugar	☐ Instalaciones recreativas	

☐ Otros (especifique)_____

9. ¿Qué tipos de exámenes de salud o servicios son necesarios para mantenerlo a usted y su familia saludables?
(marque máximo SEIS)

☐ Presión arterial	☐ Ayuda para perder peso	☐ Ejercicio/actividad física
☐ Glicemia	☐ Cuidado prenatal	☐ Salud mental/depresión
☐ Cáncer	☐ Planificación familiar	☐ Dejar de fumar
☐ Colesterol (grasas en sangre)	☐ Vacuna contra la gripe	☐ Enfermedades de transmisión sexual
☐ Odontológico	☐ Enfermedad cardíaca/Accidente cerebrovascular	☐ Prevención del suicidio
☐ Diabetes	☐ Audición	☐ Vacunación/Inmunizaciones
☐ Dieta/Nutrición	☐ VIH/SIDA	☐ Controles de bienestar de rutina
☐ Consumo de drogas y alcohol	☐ Visión	☐ Prevención de caídas para ancianos
☐ Desórdenes alimenticios	☐ Pérdida de memoria	

☐ Otros (especifique)_____

10. ¿Alguna vez le ha dicho un médico u otro profesional de la salud que tiene diabetes?

☐ Sí (Si la respuesta es "SÍ" pase a la pregunta 11)

☐ No (Si la respuesta es "NO" pase a la pregunta 12)

11. Si la respuesta es SÍ para diabetes, ¿cómo controla sus síntomas? (marque TODO lo que aplique)

☐ Medicamentos
☐ Dieta
☐ Ejercicios
☐ Médico de familia
☐ Endocrinólogo
☐ Programa educativo sobre la diabetes (pasado o presente)
☐ Grupo de apoyo
☐ Tuve diabetes gestacional durante el embarazo
☐ No estoy controlando mis síntomas
☐ Ninguna de las anteriores

☐ Otros (especifique)_____

12. ¿Está interesado en aprender cómo prevenir la diabetes?

☐ Sí
☐ No

13. ¿De cuáles problemas de salud necesita más información? (marque máximo SEIS)

☐ Consumo de alcohol
☐ Dieta/Nutrición
☐ Prevención de lesiones
☐ Alergias
☐ Cuidado prenatal
☐ Testamento en vida/Voluntades anticipadas
☐ Control de la natalidad
☐ Consumo de drogas
☐ Medicamentos
☐ Presión arterial
☐ Desórdenes alimenticios
☐ Salud mental/depresión
☐ Cáncer
☐ Dejar de fumar
☐ Donación de órganos
☐ Colesterol
☐ Prevención de caídas
☐ Ejercicio/Actividad física
☐ Demencia
☐ Enfermedad cardíaca
☐ Prevención del suicidio
☐ Salud dental
☐ VIH/SIDA y ETS
☐ Vacunación/Inmunizaciones
☐ Diabetes
☐ Hospicio o cuidados paliativos
☐ Prevención de brotes de enfermedades

☐ Otros (especifique)_____

14. ¿De dónde obtiene la MAYORÍA de su información sobre salud? (marque TODO lo que aplique)

☐ Doctor/Profesional de la salud	☐ Hospital	☐ Radio
☐ Facebook o Twitter	☐ Internet	☐ Grupo de la iglesia
☐ Otras redes sociales	☐ Biblioteca	☐ Escuela o universidad
☐ Familia o amigos	☐ Lugar de trabajo	☐ TV
☐ Departamento de salud	☐ Farmacia	☐ Periódico/Revista

☐ Otros (especifique)_____

15. En general, ¿cómo calificaría su salud mental o emocional integral?

☐ Excelente ☐ Muy buena ☐ Buena ☐ Favorable ☐ Deficiente

16. Durante el último mes, ¿cuántos días le ha molestado con frecuencia sentirse deprimido o desesperado?

☐ 0 - menos de 1 día ☐ 1-5 días ☐ 6-10 días ☐ más de 10 días

17. En el último mes, ¿a menudo le ha molestado el poco interés o placer por hacer las cosas?

☐ Sí

☐ No

18. ¿Alguna vez necesitó ayuda en salud mental y no pudo obtenerla?

☐ Sí

☐ No

☐ No he necesitado atención

☐ Prefiero no responder

19. ¿Alguna vez necesitó un tratamiento por consumo de sustancias y no pudo obtenerlo?

☐ Sí

☐ No

☐ No he necesitado atención

☐ Prefiero no responder

20. En los últimos 12 meses, ¿recibió atención odontológica?

☐ Sí (Si la respuesta es "SÍ" pase a la pregunta 22)

☐ No (Si la respuesta es "NO" pase a la pregunta 21)

21. Si la respuesta es NO, ¿por qué no recibió atención odontológica?

☐ Sin seguro

☐ Costo

☐ No sé cómo encontrar un odontólogo

☐ Miedo a los odontólogos

☐ Barreras del idioma

☐ No puedo pagar el copago o el deducible

☐ Transporte

☐ No necesité atención odontológica en los últimos 12 meses

☐ El odontólogo que necesito no está viendo pacientes nuevos

☐ Otros (especifique)_____

22. Por favor, marque TODOS los enunciados a continuación que apliquen para usted.

☐ Como al menos **5** porciones de frutas y vegetales cada día

☐ Consumo comida rápida más de una vez a la semana

☐ Fumo cigarrillos

☐ Consumo cigarrillos electrónicos

☐ Consumo tabaco sin humo

☐ Recibo una vacuna contra la gripe cada año

☐ Consumo marihuana medicinal

☐ Tomo más de **2** bebidas alcohólicas (si es mujer) o **3** (si es hombre) por día

☐ Tomo al menos **6-8** vasos de agua por día

☐ Tomo 2 o más gaseosas o bebidas energizantes por día

☐ Uso inadecuadamente las drogas, legales o ilegales

☐ Tengo un programa de bienestar en el trabajo

☐ Tomo medicamentos recetados a otras personas

☐ Uso protector solar o ropa protectora durante el tiempo de exposición al sol

☐ Ninguna de las anteriores aplica a mí

23. ¿Cuál de los siguientes procedimientos preventivos tuvo en los últimos 12 meses? (marque TODOS los que apliquen)

☐ Mamografía (si es mujer)
☐ Prueba de Papanicolaou (si es mujer)
☐ Examen de detección de cáncer de próstata (si es hombre)
☐ Vacuna contra la gripe
☐ Examen de colon/Recto
☐ Chequeo de presión arterial
☐ Chequeo de glicemia
☐ Examen de cáncer de piel
☐ Ninguna de las anteriores
☐ Examen de la vista
☐ Examen auditivo
☐ Chequeo para la detección de depresión
☐ Evaluación cardiovascular
☐ Prueba de densidad ósea
☐ Limpieza dental/Radiografías
☐ Examen físico
☐ Examen de colesterol

24. ¿Qué tan importante es el ejercicio para usted?

☐ Extremadamente importante
☐ Muy importante
☐ Moderadamente importante
☐ Ligeramente importante
☐ No tan importante

25. En una semana típica, ¿cuántos días hace ejercicio?

☐ No hago ejercicio con regularidad
☐ Una vez por semana
☐ 2 a 4 días a la semana
☐ 5 a 7 días a la semana

26. ¿Qué hace más a menudo para ejercitarse?

☐ Levantar pesas
☐ Caminar
☐ Correr
☐ Caminata
☐ Nadar
☐ Andar en bicicleta/Ciclismo
☐ Bailar
☐ Aeróbicos
☐ Pilates
☐ Practicar un deporte en equipo
☐ Yoga
☐ Otros (especifique)_____

27. ¿Tiene un proveedor de atención médica regular?

☐ Sí
☐ No

28. ¿Actualmente tiene seguro de salud?

☐ Sí
☐ No (Si la respuesta es "NO" pase a la pregunta 30)
☐ No sé

29. ¿Quién ayuda a pagar la prima de su seguro de salud? (Pase a la pregunta 31)

☐ Empleador
☐ Seguro de un miembro de la familia
☐ Grupo diferente al empleador
☐ Gobierno (Medicare, Medicaid o ACA Exchange)
☐ Pago el 100% de la prima de mi seguro de salud

☐ Otros (especifique)_____

30. ¿Por qué actualmente no tiene seguro de salud? (marque TODO lo que aplique)

☐ La compañía de seguros se negó por razones de salud
☐ El empleador no paga el seguro
☐ Prefiero no participar en seguros privados
☐ Insatisfecho con un plan o proveedor anterior de seguro
☐ No sé cómo obtener un seguro de salud
☐ Prefiero no participar en seguros del gobierno
☐ No necesito seguro
☐ No creo en el seguro
☐ No soy elegible para el seguro pagado por el empleador
☐ Pérdida o cambio de empleos
☐ No puedo pagar un seguro
☐ Otros (especifique)_____

31. ¿Cuál es la mayor necesidad no satisfecha en el condado de Washington?

_____

32. ¿Cómo ha cambiado su salud en los últimos 3 años?

☐ Mucho mejor ☐ Mejor ☐ Igual ☐ Un poco peor ☐ Mucho peor

33. Los estudios muestran que a veces los traumas infantiles afectan la salud de los adultos. En su infancia, ¿estuvo expuesto a alguno de los siguientes traumas? (marque TODOS los que apliquen)

☐ Abuso físico
☐ Abuso sexual
☐ Abuso emocional
☐ Negligencia física
☐ Negligencia emocional
☐ Madre tratada violentamente
☐ Violencia doméstica
☐ Separación de los padres o divorcio
☐ Miembro de la familia encarcelado
☐ Uso indebido de sustancias dentro del hogar
☐ Enfermedad mental en el hogar
☐ Prefiero no decirlo

¿Cuál es su sexo?

☐ Masculino
☐ Femenino

¿Cuál es su edad?

☐ Menor de 18 años
☐ 18-29 años
☐ 30-39 años
☐ 40-49 años
☐ 50-59 años
☐ 60-69 años
☐ 70-79 años
☐ 80-89 años
☐ Mayor de 90 años

¿Cuál es su nivel más alto de educación?

☐ Kínder - 8 grado
☐ Alguna educación superior
☐ Algunos estudios secundarios
☐ Graduado universitario
☐ Graduado de secundaria
☐ Estudios de posgrado
☐ GED
☐ Postgrado
☐ Escuela Técnica

Incluyéndose a sí mismo, ¿cuántas personas viven en su hogar?

☐ 1 ☐ 2 ☐ 3 ☐ 4 o más

¿Cuántos ingresos combinados totales ganaron todos los miembros de su hogar el año pasado?

☐ 0 a $9,999
☐ $10,000 a $24,999
☐ $25,000 a $49,999
☐ $50,000 a $74,999
☐ $75,000 a $99,999
☐ $100,000 a $124,999
☐ $125,000 a $149,999
☐ $150,000 a $174,999
☐ $175,000 a $199,999
☐ $200,000 y más
☐ Prefiero no responder

¿Cuál es su raza/etnia? (Por favor seleccione TODAS las que apliquen)

☐ Indio americano o nativo de Alaska
☐ Asiático
☐ Negro o afroamericano
☐ Hispano o Latino
☐ Nativo de Hawái u otras islas del Pacífico
☐ Blanco/Caucásico
☐ Prefiero no responder

☐ Otros (especifique)_____

Nursing Homes	Address
Coffman Nursing Home	1304 Pennsylvania Avenue, Hagerstown, MD 21742
Diakon Senior Living	19800 Tranquility Circle, Hagerstown, MD 21742
Western Maryland Hospital Center	1500 Pennsylvania Avenue, Hagerstown, MD 21742
Homewood at Williamsport	16505 Virginia Avenue, Williamsport, MD 21795
Twin Oaks-Williamsport Retirement Village	154 Artisan Street, Williamsport, MD 21795
Golden Living Center	750 Dual Highway, Hagerstown, MD 21740
Julia Manor Health Care Center	333 Mill Street, Hagerstown, MD 21740
Fahrney-Keedy	8507 Mapleville Road, Boonsboro, MD 21713
Reeders Memorial Home	141 South Main Street, Boonsboro, MD 21713
NMS Healthcare of Hagerstown	14014 Marsh Pike, Hagerstown, MD 21742

Home Health Care	Address
Meritus Home Health	1799 Howell Road, Hagerstown, MD 21740
Accessible Home Health Care of Frederick & Washington County	1185 Mt. Aetna Road, Suite 300, Hagerstown, MD 21740
Right at Home	223 North Prospect Street, Suite 203, Hagerstown, MD 21740
Stay Home Senior Services	1190 Mt. Aetna Road, Suite 101, Hagerstown, MD 21740

Adult Daycare	Address
Easterseals Adult Day Services	101 E. Baltimore Street, Hagerstown, MD 21740
Diakon Adult Day Services at Rvnwd	1109 Luther Drive, Hagerstown, MD 21740
Florida Avenue Medical Day Care (The A	838 Florida Avenue, Hagerstown, MD 21740

County Commission on Aging	Address

Washington County Commission on Aging	535 East Franklin Street, Hagerstown, MD 21740

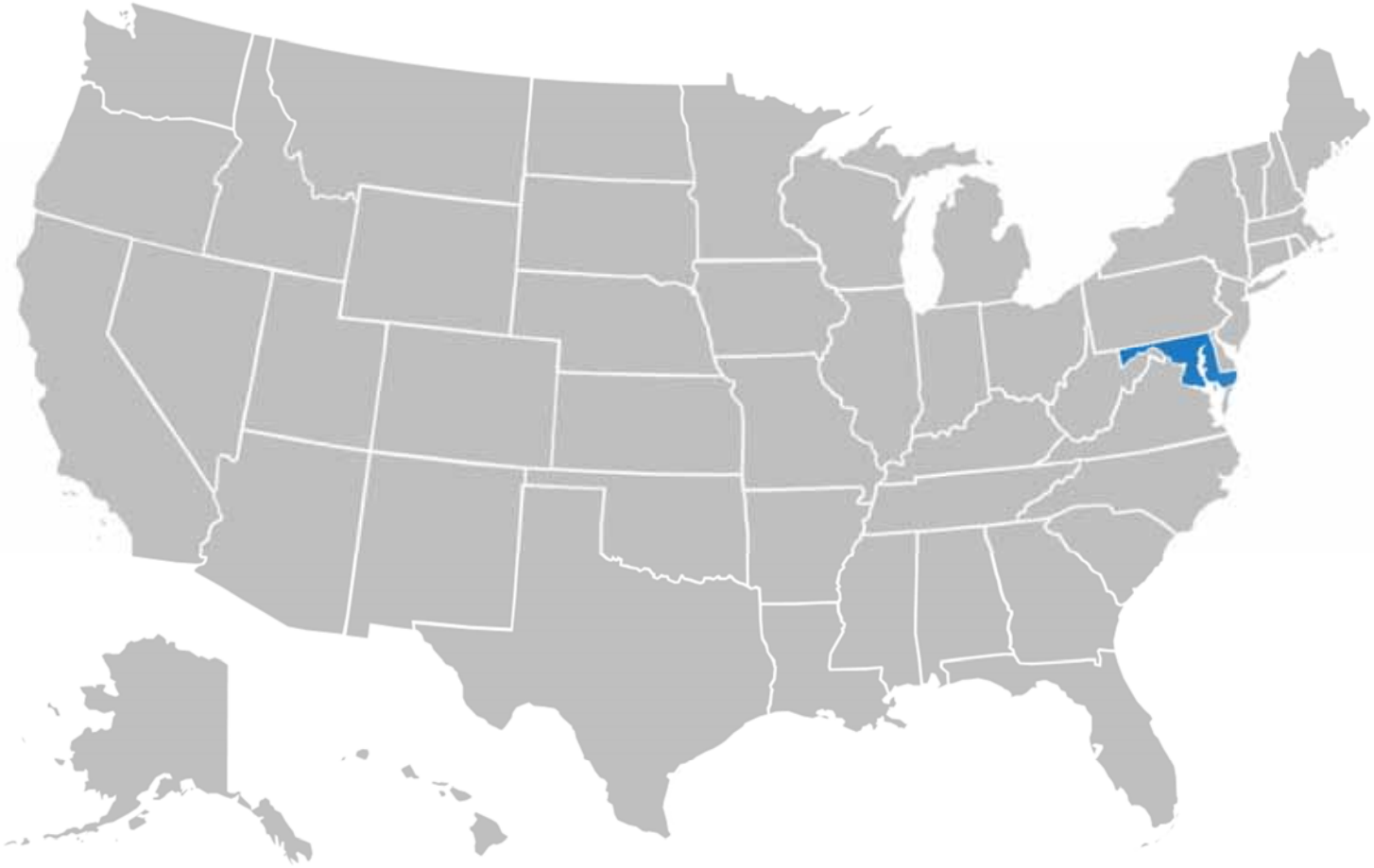
Senior Center	Address
Senior Center	535 Franklin Street, Hagerstown, MD 21740

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Maryland



2018 County Health Rankings Report

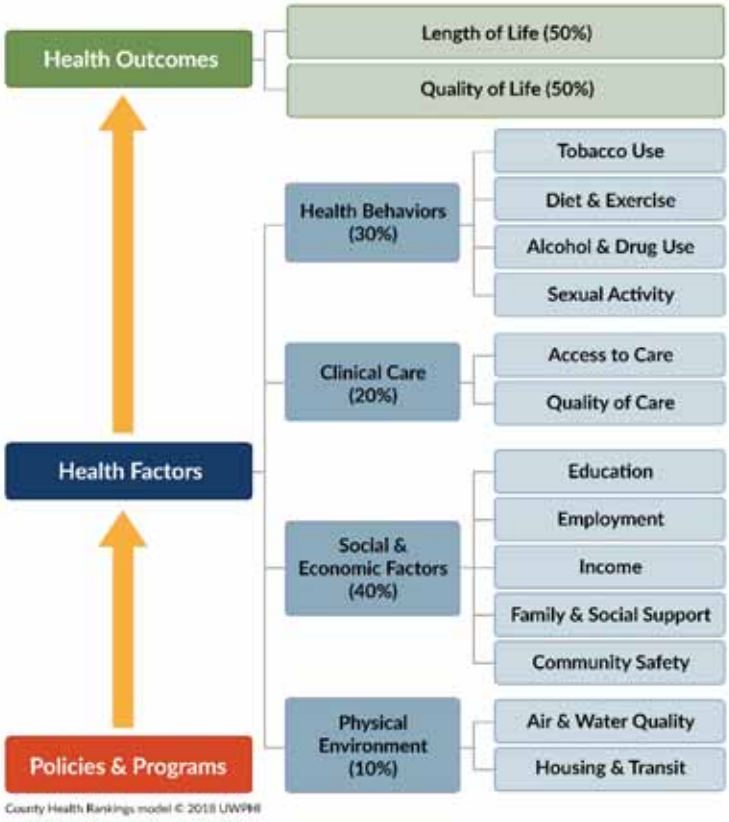
A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Support provided by
Robert Wood Johnson Foundation

Introduction

Ranking the health of nearly every county in the nation (based on the model to the right), County Health Rankings & Roadmaps (CHR&R) illustrates what we know when it comes to what is keeping people healthy or making them sick and shows what we can do to create healthier places to live, learn, work and play. CHR&R brings actionable data, evidence, guidance and stories to communities to make it easier for people to be healthy in their neighborhoods, schools and workplaces.



Our country has achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking and infectious diseases. But when you look closer, there are significant differences in health outcomes according to where we live, how much money we make or how we are treated. The data show that not everyone has benefited in the same way from these health improvements. There are fewer opportunities and resources for better health among groups that have been historically marginalized including people of color, people living in poverty, people with physical or mental disabilities, LGBTQ persons, and women.

This report explores the size and nature of health differences by place and race/ethnicity in Maryland and how state and community leaders can take action to create environments where all residents have the opportunity to live their healthiest lives. Specifically, this report will help illuminate:

1. What health equity is and why it matters
2. Differences in health outcomes within the state by place and racial/ethnic groups
3. Differences in health factors within the state by place and racial/ethnic groups
4. What communities can do to create opportunity and health for all

The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

What Is Health Equity?

We live in a nation that prides itself on being a land of opportunity - a place where everyone has a fair chance to lead the healthiest life possible regardless of where we live, how we are treated, or the circumstances we were born into; this is the prospect of health equity. However, this is not always our reality. More often the choices we make depend on the opportunities we have, such as a quality education, access to healthy foods and living in safe, affordable housing in crime-free neighborhoods. These opportunities are not the same for everyone.

Health disparities emerge when some groups of people have more access to opportunities and resources over their lifetime and across generations. For example, when children live in families with higher incomes, they typically experience stable housing in safer neighborhoods, have access to better-resourced and higher quality schools, and are better prepared for living wage jobs leading to upward economic mobility and good health. When children live in families with lower incomes and do not have access to these same opportunities, they face challenges to gaining a foothold on the ladder to economic security that helps them thrive.

Why Does It Matter?

Population projections indicate that our nation's youth are increasingly more racially and ethnically diverse. A healthy beginning is essential to a healthy future for our children and our nation.

Yet, child poverty rates remain high with nearly one in five living in poverty. And, in the majority of U.S. counties, rates for Black or Hispanic children are even higher than rates for White children.

Investing in the health and well-being of ALL young people now and in years to come is vital to our nation's future success and prosperity.

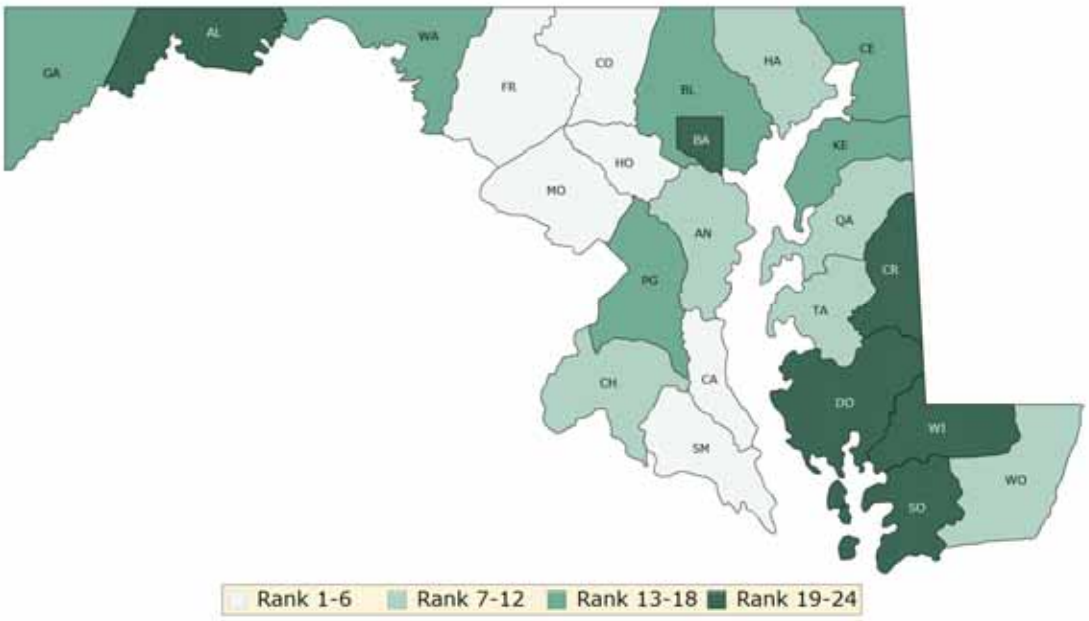
Differences in opportunity do not come about on their own or because of the actions of individuals alone. Often, they are the result of policies and practices at many levels that have created deep-rooted barriers to good health, such as unfair bank lending practices, school funding based on local property taxes, and policing and prison sentencing. The collective effect is that a fair and just opportunity to live a long and healthy life is not a reality for everyone. Now is the time to change how things are done.

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health and in the conditions and resources needed for optimal health by improving the health of marginalized groups, not by worsening the health of others. Our progress toward health equity will be measured by how health disparities change over time. This report provides data on differences in health and opportunities in Maryland that can help identify where action is needed to achieve greater equity and offers information on how to move from data to action.

Differences in Health Outcomes within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Outcomes?

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (% of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the % of low birth weight newborns. Detailed information on the underlying measures is available at **countyhealthrankings.org**



The green map above shows the distribution of Maryland's **health outcomes**, based on an equal weighting of length and quality of life. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 12 at the end of this report.

How Do Health Outcomes Vary by Race/Ethnicity?

Length and quality of life vary not only based on where we live, but also by our racial/ethnic background. In Maryland there are differences by race/ethnicity in length and quality of life that are masked when we only look at differences by place. The table below presents the five underlying measures that make up the Health Outcomes Rank. Explore the table to see how health differs between the healthiest and the least healthy counties in Maryland, and among racial/ethnic groups.

Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in Maryland

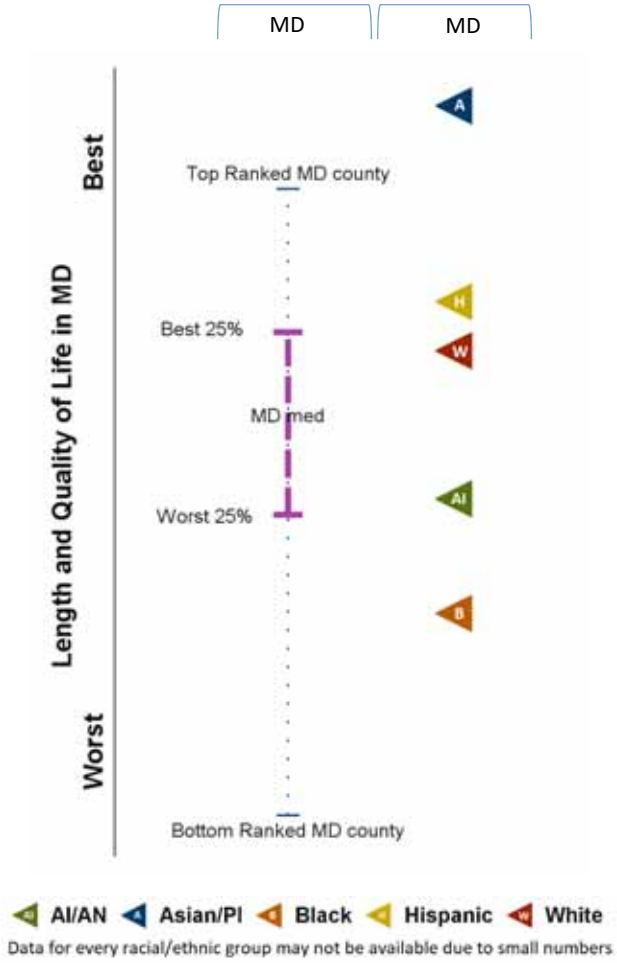
	Healthiest MD County	Least Healthy MD County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	3,700	12,500	3,900	2,800	9,200	3,400	6,400
Poor or Fair Health (%)	10%	19%	25%	9%	15%	24%	12%
Poor Physical Health Days (avg)	2.4	3.7	5.5	1.6	3.0	3.6	3.1
Poor Mental Health Days (avg)	2.8	4.1	5.2	2.0	3.3	3.4	3.8
Low Birthweight (%)	7%	12%	9%	8%	12%	7%	7%

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

N/A = Not available. Data for all racial/ethnic groups may not be available due to small numbers

Health Outcomes in Maryland

Differences by: **Place** **Race/Ethnicity**



AI/AN -American Indian/Alaskan Native/Native American
Asian/PI - Asian/Pacific Islander

The graphic to the left compares measures of length and quality of life by place (Health Outcomes ranks) and by race/ethnicity. To learn more about this composite measure, see the technical notes on page 13.

In Maryland, **measures of length and quality of life** indicate:

- American Indians/Alaskan Natives are most similar in health to those living in the middle 50% of counties.
- Asians/Pacific Islanders are healthier than those living in the top ranked county.
- Blacks are most similar in health to those living in the least healthy quartile of counties.
- Hispanics are most similar in health to those living in the healthiest quartile of counties.
- Whites are most similar in health to those living in the middle 50% of counties.

(Quartiles refer to the map on page 4.)

Across the US, values for measures of length and quality of life for Native American, Black and Hispanic residents are regularly worse than for Whites and Asians. For example, even in the healthiest counties in the US, Black and American Indian premature death rates are about 1.5 times higher than White rates. Not only are these differences unjust and avoidable, they will also negatively impact our changing nation's future prosperity.

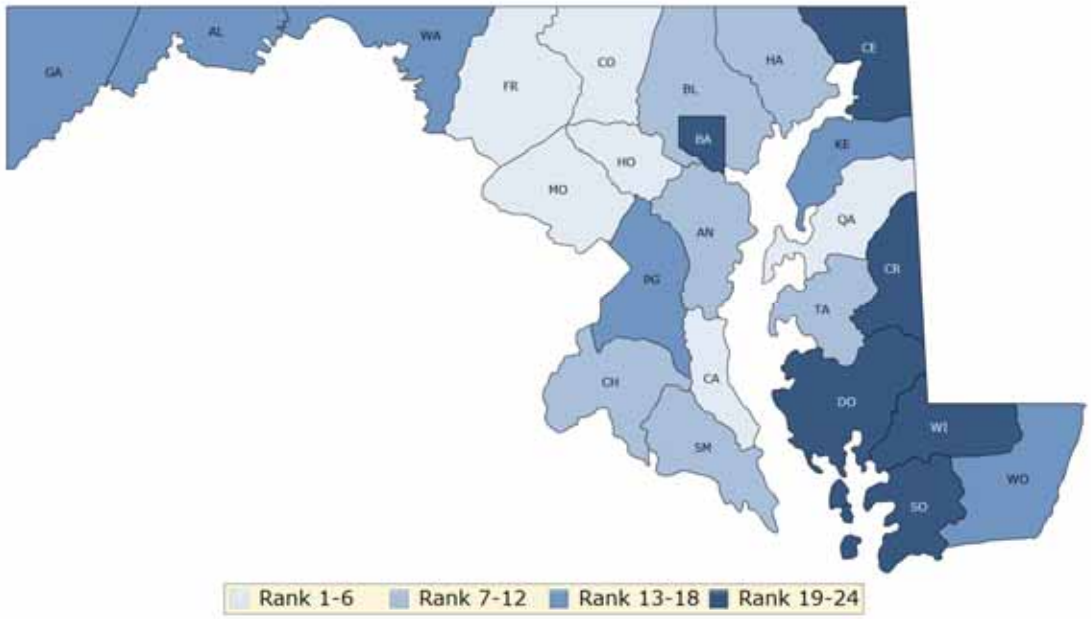
Changing the Course in Kansas City

A decade ago, public health officials identified an 8-year gap in life expectancy between the city's White and Black populations. Segregation and discrimination over the past century fueled this disparity, but community residents and city leaders joined forces to tackle tough conversations on race, stem the violence, increase educational opportunities, improve access to care and ensure economic justice. Today the disparity in life expectancy has been reduced to 6.9 years. Learn more at rwjf.org/prize.

Differences in Health Factors within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Factors?

Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family & social support, community safety), and the physical environment (air & water quality, housing & transit).



The blue map above shows the distribution of Maryland's **health factors** based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Detailed information on the underlying measures is available at **countyhealthrankings.org.** The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 12.

What are the Factors That Drive Health and Health Equity?

Health is influenced by a range of factors. However, social and economic factors, like connected and supportive communities, good schools, stable jobs, and safe neighborhoods, are foundational to achieving long and healthy lives. These social and economic factors also influence other important drivers of health and health equity. Social and economic factors impact our ability to make healthy choices, afford medical care or housing, and even manage stress leading to serious health problems. The choices we make are based on the choices we have.

Across the nation, there are meaningful differences in social and economic factors among counties and among racial/ethnic groups. Even within counties, policies and practices marginalize many racial and ethnic groups, keeping them from resources and supports necessary to thrive. Limited access to opportunities is what creates disparities in health, impacting how well and how long we live.

How Do Social and Economic Opportunities for Health Vary in Maryland?

Social and economic factors vary depending on where we live and by our racial/ethnic background. The following four data graphics illustrate differences among counties and by racial/ethnic groups in social and economic opportunities for health in Maryland. These graphics show that it is important to explore differences by place and race/ethnicity in order to tell a more holistic story about the health of your community.

This report explores state-wide data. To dive deeper into your county data, visit Use the Data at www.countyhealthrankings.org

Consider these questions as you look at the data graphics throughout this report:

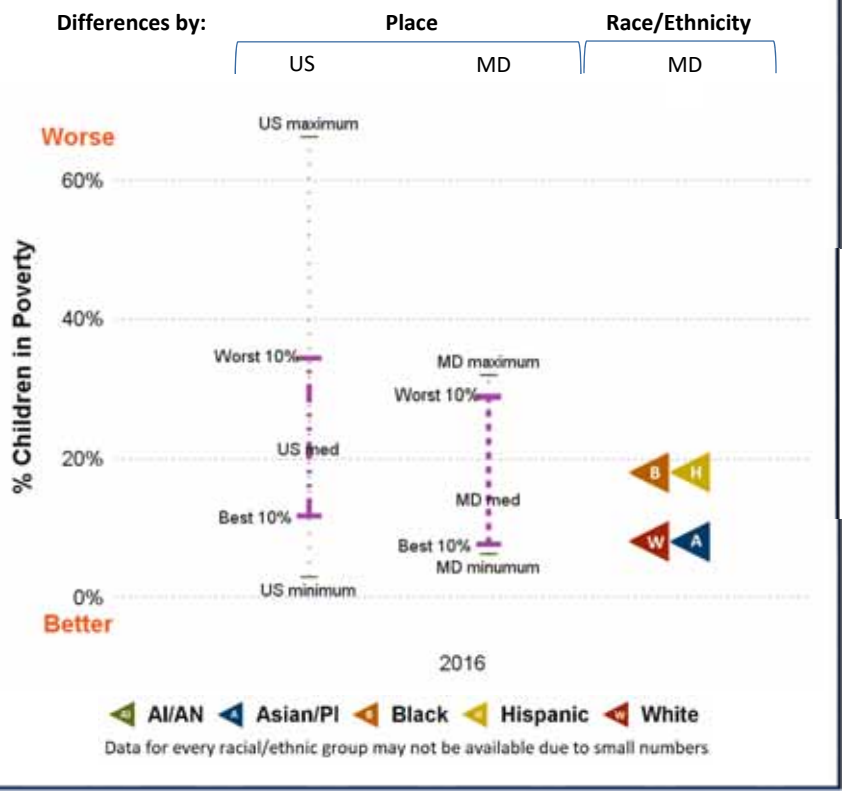
- What differences do you see among counties in your state?
- What differences do you see by racial/ethnic groups in your state?
- How do counties in your state compare to all U.S. counties?
- What patterns do you see? For example, do some racial/ethnic groups fare better or worse across measures?

Children in Poverty

Poverty limits opportunities for quality housing, safe neighborhoods, healthy food, living wage jobs, and quality education. As poverty and related stress increase, health worsens.

The graphic to the right shows:

- In Maryland, 13% of children are living in poverty compared to the U.S. rate of 20%.
- Children in poverty rates among Maryland counties range from 6% to 32%.
- Children in poverty rates among racial/ethnic groups in Maryland range from 8% to 18%.



US and state values and the state minimum and maximum can be found in the table on page 14

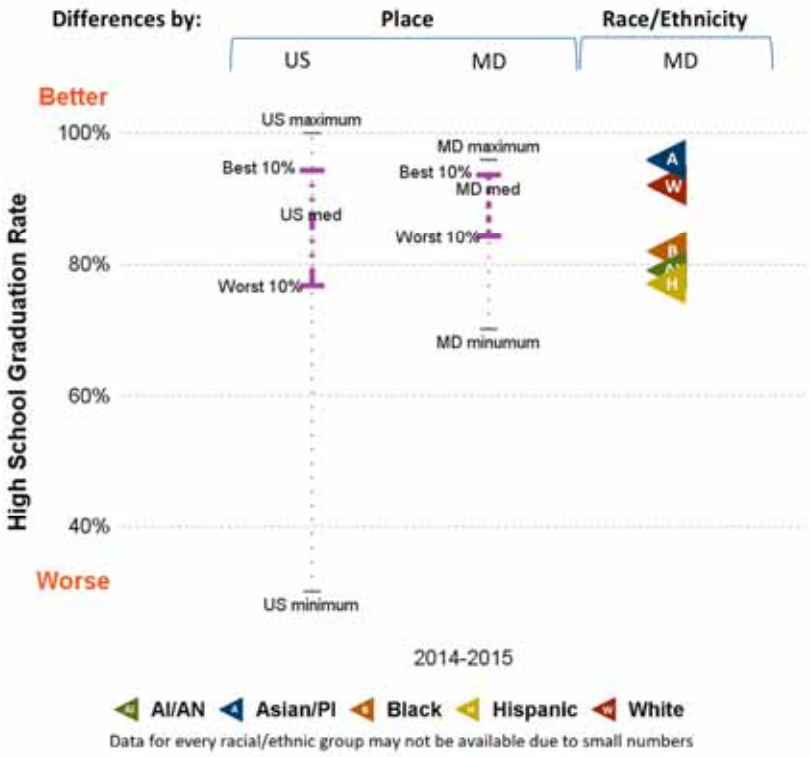
American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

High School Graduation

Higher rates of educational achievement are linked to better jobs and higher incomes resulting in better health. Education is also connected to lifespan: on average, college graduates live nine years longer than those who didn't complete high school.

The graphic to the right shows:

- Maryland's high school graduation rate is 87% compared to the U.S. rate of 83%.
- High school graduation rates among Maryland counties range from 70% to 96%.
- High school graduation rates among racial/ethnic groups in Maryland range from 77% to 96%.



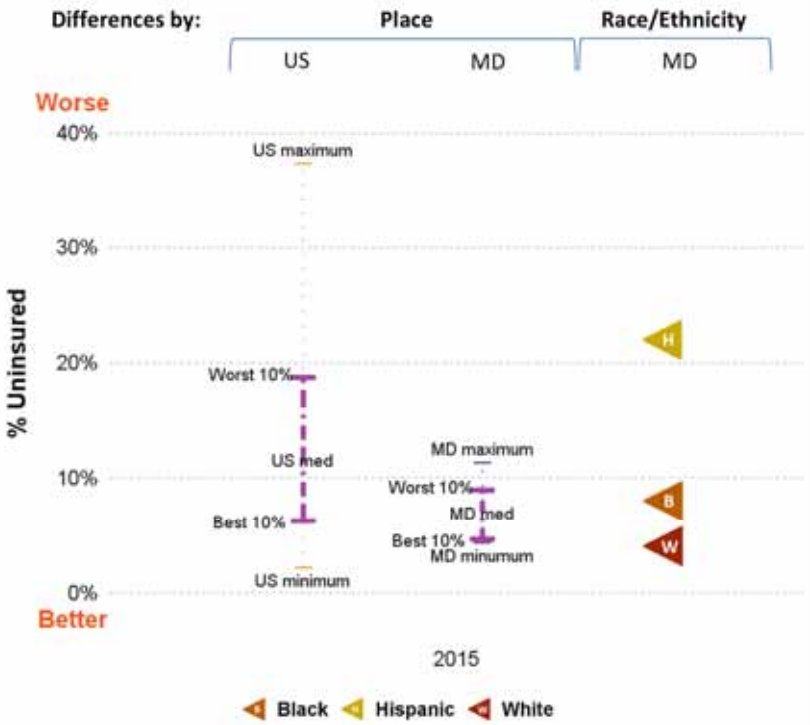
Data for every racial/ethnic group may not be available due to small numbers

Health Insurance

Health insurance helps individuals and families access needed primary care, specialists, and emergency care. Those without insurance are often diagnosed at later, less treatable disease stages and at higher costs than those with insurance.

The graphic to the right shows:

- The uninsured rate in Maryland is 7% compared to the U.S. rate of 11%.
- Uninsured rates among Maryland counties range from 4% to 11%.
- Uninsured rates among racial/ethnic groups in Maryland range from 4% to 22%.



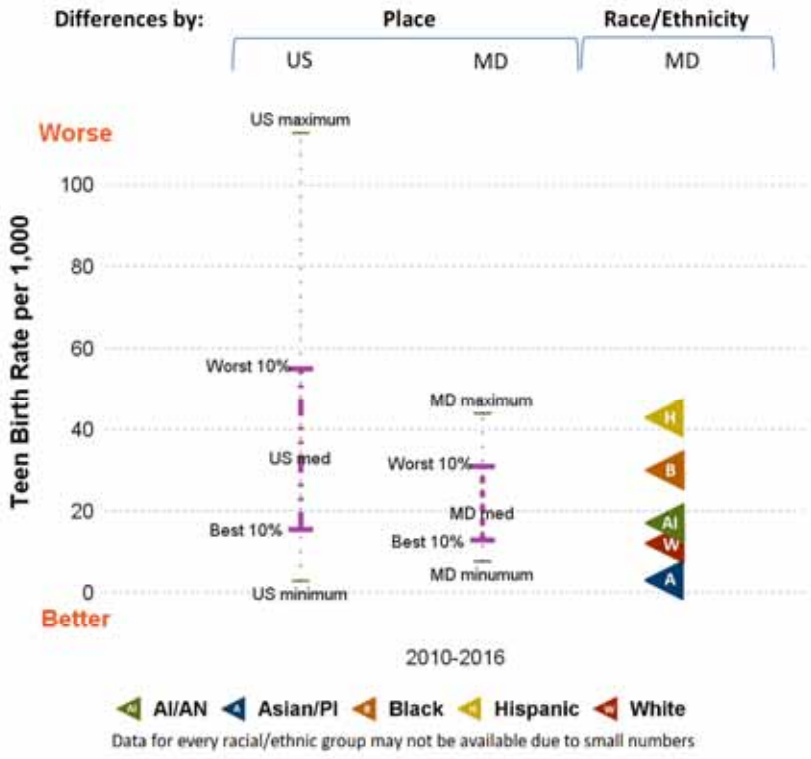
Data for Asians and Native Americans are not available for this measure

Teen Births

Teenage motherhood is more likely to occur in communities with fewer opportunities for education or jobs. Teen mothers are less likely to complete high school and face challenges to upward economic mobility. In turn, their children often have fewer social and economic supports and worse health outcomes.

The graphic to the right shows:

- The teen birth rate in Maryland is 21 births per 1,000 female population, ages 15-19, compared to the U.S. rate of 27 per 1,000.
- Teen birth rates among Maryland counties range from 8 to 44 per 1,000.
- Teen births for racial/ethnic groups in Maryland range from 3 to 43 per 1,000.



US and state values and the state minimum and maximum can be found in the table on page 14

American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

Spartanburg County Closing the Gap

Community leaders in Spartanburg County, SC took a good hard look at their data in 2008 and discovered they had the worst teen birth rate in the whole state. Deciding to face this issue head on, they brought together teens, providers, parents, and partners to create solutions - a warm welcoming teen center, accessible and respectful reproductive health care, and open discussions about sexuality. Recent data show improvements - rates have receded by 50% from 2010 to 2016 for all 15-19 year olds. And while disparities in teen births among racial/ethnic groups in SC continue, the gap has closed for teen births among Black and White females in Spartanburg County (in 2016, 23.3 per 1,000 and 23.9 per 1,000, respectively). Learn more at rwjf.org/prize.

What Communities Can Do to Create Opportunity and Health for All

This report shows some of the differences in opportunity for people in Maryland based on where they live and their race or ethnicity. But how can you turn this information into action? Below are some evidence-informed approaches to consider as your community moves forward:

Invest in education from early childhood through adulthood to boost employment and career prospects

- Strengthen parents' skills, including ways to foster children's learning and development in home and community settings
- Undertake policy initiatives to improve pre-K-12 education in the classroom, school, district or state level, focusing on raising school attendance and high school graduation rates
- Implement community and school-based supports that will improve access to and quality of early childhood care and education, beginning in infancy
- Offer alternative learning models and technology to help students develop social and work-ready skills
- Support higher education opportunity for all through college application assistance and financial aid

Increase or supplement income and support asset development in low income households

- Increase public and private sector wages and offer benefits for low-income earners through living wages and paid leave
- Expand elibigility for earned-income tax credits and increase credit amount
- Assist parents by expanding refundable child care tax credits and increasing child care subsidies

Ensure that everyone has adequate, affordable health care coverage and receives culturally competent services and care

- Make health care services accessible and available in community, school, and clinical settings, including medical, dental, vision, mental health care, and long-term care
- Increase access to sex education and contraceptives in school, clinic, and community settings
- Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase literacy
- Provide culturally-sensitive care coordination and system navigation, including language interpretation and care tailored to patients' norms, beliefs, and values

Foster social connections within communities and cultivate empowered and civically engaged youth

- Establish positive relationships among youth and adult mentors and provide youth with leadership opportunities in schools, community groups, and local governments
- Create safe places to convene, such as community centers, with activities, programs, and supportive technologies for all ages and abilities
- Support information sharing, collaboration and networking to inform decision-making using social media and in-person approaches

To learn more about specific strategies that can support your work, visit **What Works for Health,** a living resource of evidence-informed policies and programs to make a difference locally. You can search for policies and programs that have been tested or implemented in communities like yours, or adapt strategies that have been tested elsewhere but seem like a good 'fit'. You can also learn about each strategy's likely impact on disparities.
Visit countyhealthrankings.org/whatworks

Communities Driving Local Change

We can work together to reshape the policies, programs, and practices that have marginalized some and, without action, will perpetuate health disparities. We can create environments where people are treated fairly, where everyone has a voice in decisions that affect them, and where all have a chance to succeed.

The 35 RWJF Culture of Health Prize winners are prime examples of making this a reality. For examples of how several communities, such as the below are cultivating a shared belief in good health for all, visit www.rwjf.org/prize.

- Columbia Gorge Region, OR/WA
- Richmond, VA
- Chelsea, MA
- Santa Monica, CA

Moving With Data to Action

County Health Rankings & Roadmaps offers a range of community supports including data, evidence, guidance and stories to support communities moving from awareness to action. Visit our website to learn more – **countyhealthrankings.org.**

- CHR&R provides a snapshot of a community's health and a starting point to explore ways to improve health and increase health equity. Use the Data will help you learn more about the data and find other sources as you begin to assess your needs and resources and focus on what's important.

- Our Partner Center helps changemakers in all sectors make connections and leverage collective power to put ideas into action.

- Our Action Center provides step-by-step guidance to help communities assess their needs, drive local policy and systems changes, and evaluate the impacts of their health improvement efforts. Our team of community coaches are available to communities across the nation to guide local collaborations and individuals to accelerate learning and action.

Guidance in the Action Center focuses on areas like:

- Working together is at the heart of making meaningful change. When people share a vision and commitment to improve health, it can yield better results than working alone. CHR&R's Work Together guide can help you build and sustain partnerships that reflect the diversity of your community. Together you can identify the challenges and solutions that can make a difference.

- Taking time to choose policies and programs that have been shown to work and that are a good fit for your community will maximize your chances of success. CHR&R's Choose Effective Policies & Programs guide can help you explore and select strategies to address priority issues.

- Once you have decided what you want to do, the next step is to make it happen. CHR&R's guide to Act on What's Important can help your community build on strengths, leverage available resources, and respond to unique needs.

- What you say and how you say it can motivate people to take the right action at the right time. CHR&R's Communicate guide can help you to develop strategic messages and deliver those messages effectively.

2018 County Health Rankings for the 24 Ranked Counties in Maryland

County	Health Outcomes	Health Factors
Allegany	20	18
Anne Arundel	7	9
Baltimore	13	11
Baltimore City	24	24
Calvert	4	5
Caroline	22	21
Carroll	3	3
Cecil	17	20

County	Health Outcomes	Health Factors
Charles	11	12
Dorchester	21	22
Frederick	5	4
Garrett	15	14
Harford	8	8
Howard	2	1
Kent	16	13
Montgomery	1	2

County	Health Outcomes	Health Factors
Prince George's	14	16
Queen Anne's	9	6
Somerset	23	23
St. Mary's	6	10
Talbot	10	7
Washington	18	17
Wicomico	19	19
Worcester	12	15

Stay Up-To-Date with County Health Rankings & Roadmaps

For the latest updates on our Rankings, community support, RWJF Culture of Health Prize communities, and more visit countyhealthrankings.org/news. You can see what we're featuring on our webinar series, what communities are doing to improve health, and how you can get involved!

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that “race” is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 15. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under Rankings Methods.

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit What Works for Health.

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that “darker is bad”.
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

2018 County Health Rankings for Maryland: Measures and National/State Results

Measure	Description	US	MD	MD Minimum	MD Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	6,700	6,500	3,700	12,500
Poor or fair health	% of adults reporting fair or poor health	16%	14%	9%	22%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	3.1	2.4	4.5
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.5	2.8	4.6
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	9%	6%	12%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	14%	7%	21%
Adult obesity	% of adults that report a BMI ≥ 30	28%	29%	21%	45%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.7	9.1	6.1	9.5
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	23%	22%	16%	33%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	83%	93%	39%	100%
Excessive drinking	% of adults reporting binge or heavy drinking	18%	17%	14%	20%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	29%	30%	20%	60%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	478.8	459.3	141.5	1,080.3
Teen births	# of births per 1,000 female population ages 15-19	27	21	8	44
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	11%	7%	4%	11%
Primary care physicians	Ratio of population to primary care physicians	1,320:1	1,140:1	3,220:1	510:1
Dentists	Ratio of population to dentists	1,480:1	1,320:1	2,720:1	680:1
Mental health providers	Ratio of population to mental health providers	470:1	460:1	2,530:1	240:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	49	47	29	81
Diabetes monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	85%	85%	81%	90%
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	63%	64%	59%	75%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	83%	87%	70%	96%
Some college	% of adults ages 25-44 with some post-secondary education	65%	69%	37%	85%
Unemployment	% of population aged 16 and older unemployed but seeking work	4.9%	4.3%	3.2%	9.0%
Children in poverty	% of children under age 18 in poverty	20%	13%	6%	32%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	5	4.6	3.5	6.3
Children in single-parent households	% of children that live in a household headed by a single parent	34%	34%	21%	64%
Social associations	# of membership associations per 10,000 population	9.3	8.9	5.9	18.2
Violent crime	# of reported violent crime offenses per 100,000 population	380	465	130	1,389
Injury deaths	# of deaths due to injury per 100,000 population	65	64	33	126
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	8.7	9.5	8.3	11.1
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	NA	NA	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	19%	17%	12%	24%
Driving alone to work	% of workforce that drives alone to work	76%	74%	60%	85%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	35%	49%	19%	64%

2018 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2014-2016
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2016
	Poor physical health days	Behavioral Risk Factor Surveillance System	2016
	Poor mental health days	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	National Center for Health Statistics – Natality files	2010-2016
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2016
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2014
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2015
	Physical inactivity	CDC Diabetes Interactive Atlas	2014
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & U.S. Census Files	2010 & 2016
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2016
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2012-2016
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2015
	Teen births	National Center for Health Statistics – Natality files	2010-2016
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2015
	Primary care physicians	Area Health Resource File/American Medical Association	2015
	Dentists	Area Health Resource File/National Provider Identification file	2016
	Mental health providers	CMS, National Provider Identification file	2017
Quality of Care	Preventable hospital stays	Dartmouth Atlas of Health Care	2015
	Diabetes monitoring	Dartmouth Atlas of Health Care	2014
	Mammography screening	Dartmouth Atlas of Health Care	2014
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	EDFacts	2014-2015
	Some college	American Community Survey	2012-2016
Employment	Unemployment	Bureau of Labor Statistics	2016
Income	Children in poverty	Small Area Income and Poverty Estimates	2016
	Income inequality	American Community Survey	2012-2016
Family and Social Support	Children in single-parent households	American Community Survey	2012-2016
	Social associations	County Business Patterns	2015
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2012-2014
	Injury deaths	CDC WONDER mortality data	2012-2016
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution – particulate matter*	Environmental Public Health Tracking Network	2012
	Drinking water violations	Safe Drinking Water Information System	2016
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2010-2014
	Driving alone to work	American Community Survey	2012-2016
	Long commute – driving alone	American Community Survey	2012-2016

*Not available for AK and HI.

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CHNA FY2019 Talking Points

What is the purpose of this survey? The survey provides an opportunity for the citizens of Washington County to give input about what the true health needs are facing people who live here.

How will the information be used? Health providers and non-profit service organizations will use the information to better fill in the gaps and meet health needs that have been identified. In a time of limited resources we want to make the best decisions possible in providing services that will most effectively help the people who live here.

Is my information confidential? A person who answers the survey cannot be identified. There is no way to know if someone participated or not. Like-answers to questions will be grouped together and all results will be made public.

Why are you asking about income and race? We ask for socio-economic information to ensure that we have a broad representation of our community. These answers are optional and are not required.

Who is Healthy Washington County? Healthy Washington County is made of diverse community organizations who have a desire to help people living in Washington County be as healthy as possible. Some current members include the Washington County Public School System, Meritus Health the Herald Mail and the Washington County Health Department.

How will I learn what the results were? A summary and recommendations will be made public, anticipated in early January 2019. Meritus Medical Center plans to make the results publically available from 2019 – 2028.

What organizations are involved?

Brook Lane Health Services

Community Free Clinic

Community Foundation of Washington County

Comstock Center/ Johns Hopkins University

Hagerstown – Washington County Chamber of Commerce

HEAL of Washington County

Meritus Healthcare Foundation

Meritus Medical Center

Tri-State Community Health Center

Tri-State Health Partners

United Way

Walnut Street Community Health Center/ Family Healthcare of Hagerstown

Washington County Health Department

Washington County Mental Health Authority

Washington County Public Schools

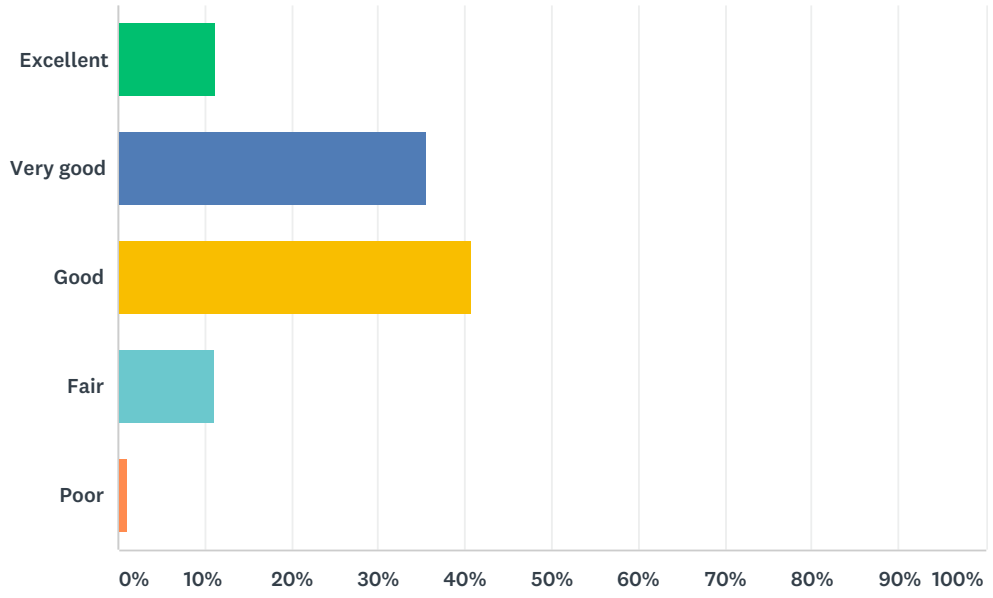
Who has contributed any direct financial resources to this process? To date, Meritus Health and Brook Lane Health Services.

Q1 Please enter your zip code:

Answered: 1,514 Skipped: 0

Q2 In general, how would you rate your overall health?

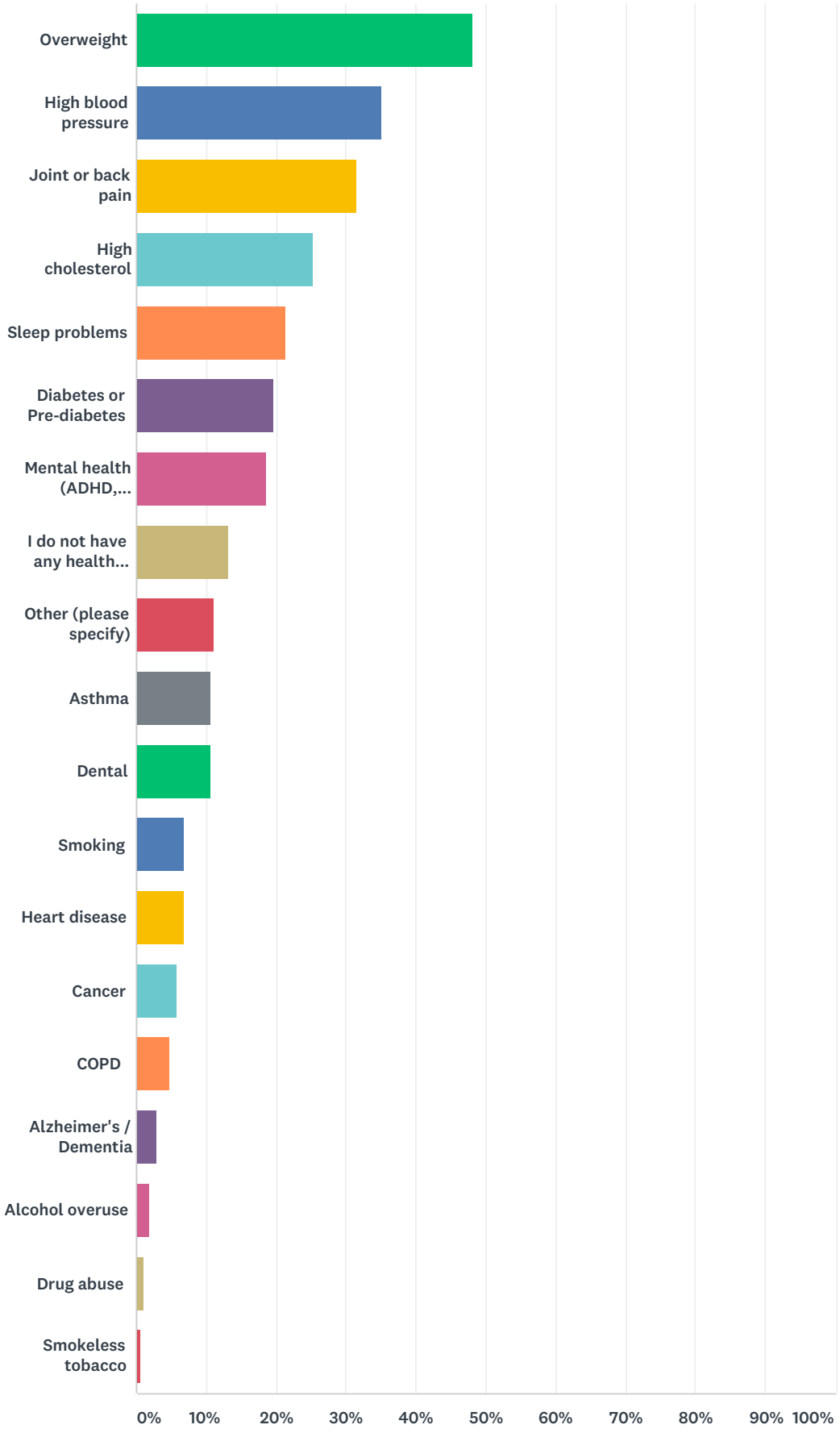
Answered: 1,401 Skipped: 113



ANSWER CHOICES	RESPONSES	
Excellent	11.35%	159
Very good	35.62%	499
Good	40.90%	573
Fair	11.06%	155
Poor	1.07%	15
TOTAL		1,401

Q3 Please select all health concerns that you face (Choose ALL that apply).

Answered: 1,423 Skipped: 91

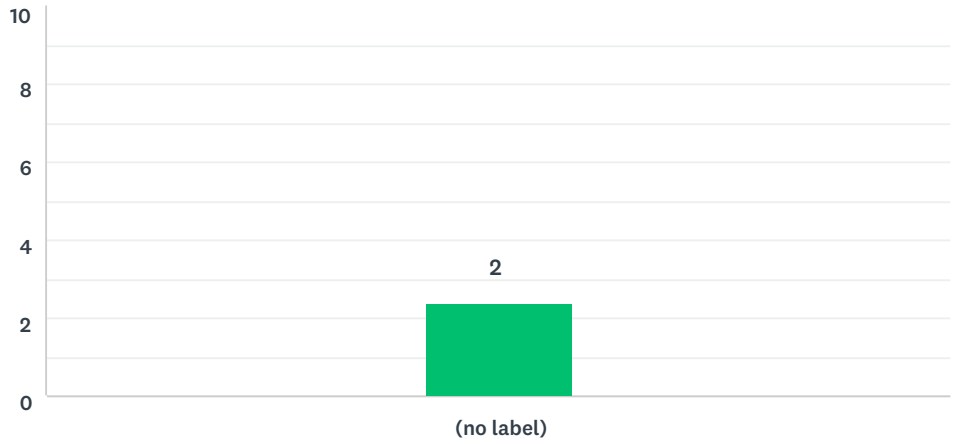


ANSWER CHOICES	RESPONSES

Overweight	48.21%	686
High blood pressure	35.14%	500
Joint or back pain	31.62%	450
High cholesterol	25.37%	361
Sleep problems	21.43%	305
Diabetes or Pre-diabetes	19.68%	280
Mental health (ADHD, Depression, Bi-polar)	18.62%	265
I do not have any health challenges	13.21%	188
Other (please specify)	11.17%	159
Asthma	10.75%	153
Dental	10.75%	153
Smoking	6.89%	98
Heart disease	6.82%	97
Cancer	5.76%	82
COPD	4.71%	67
Alzheimer's / Dementia	2.88%	41
Alcohol overuse	1.83%	26
Drug abuse	0.98%	14
Smokeless tobacco	0.56%	8
Total Respondents: 1,423		

Q4 Overall, how would you rate the health status of the community?

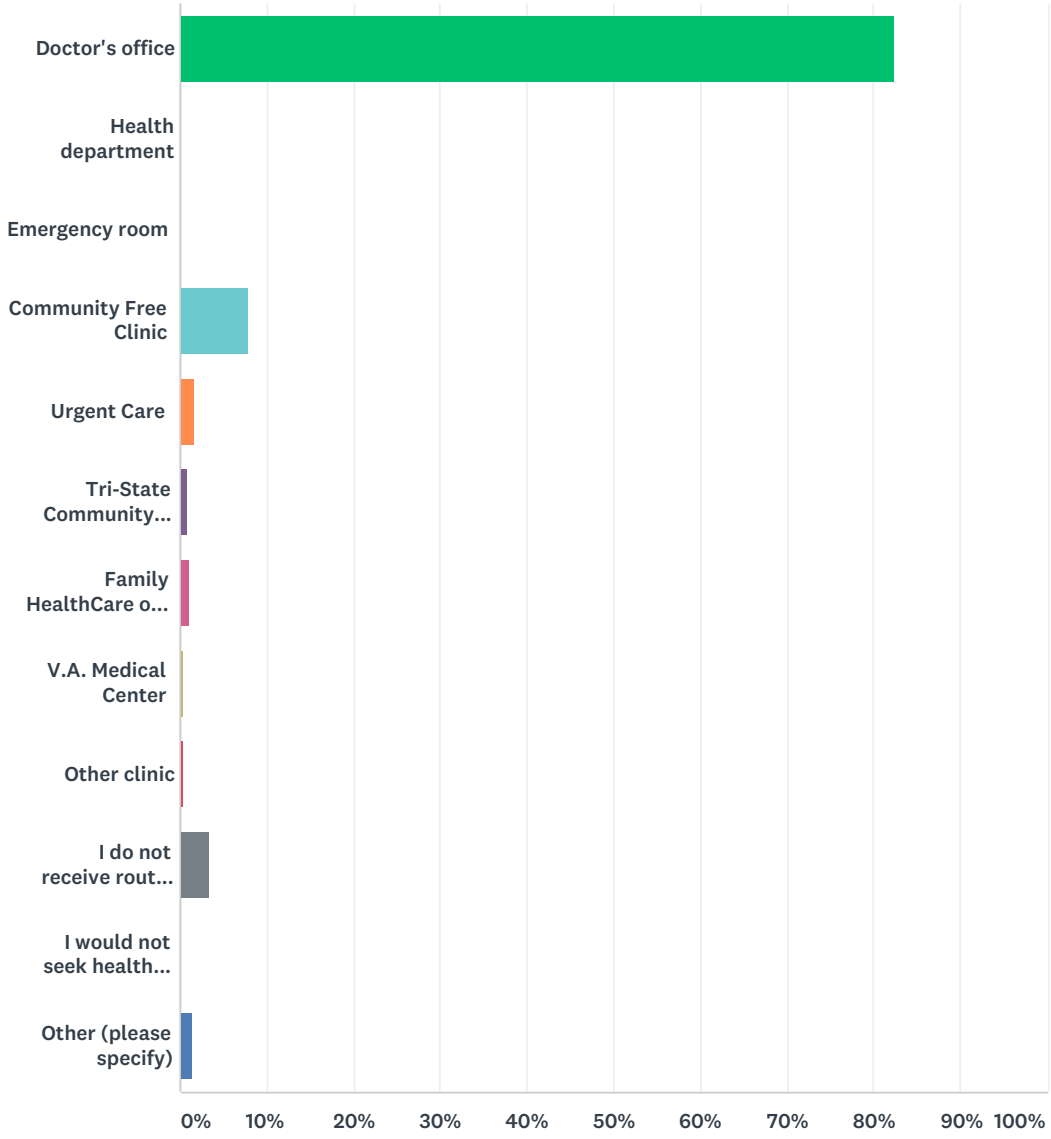
Answered: 1,413 Skipped: 101



	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	1.42% 20	5.59% 79	33.33% 471	45.58% 644	14.08% 199	1,413	2.35

Q5 Where do you go for routine health care?

Answered: 1,409 Skipped: 105

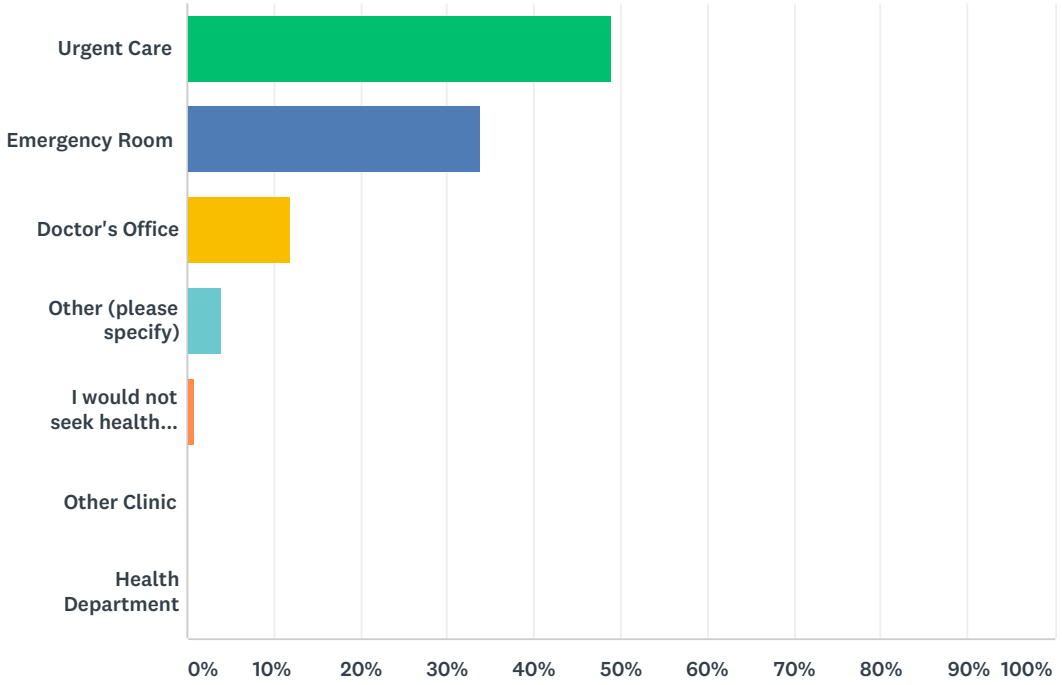


ANSWER CHOICES	RESPONSES	
Doctor's office	82.33%	1,160
Health department	0.00%	0
Emergency room	0.14%	2
Community Free Clinic	7.95%	112
Urgent Care	1.77%	25
Tri-State Community Health Center	0.92%	13
Family HealthCare of Hagerstown	1.14%	16
V.A. Medical Center	0.43%	6

Other clinic	0.43%	6
I do not receive routine health care	3.26%	46
I would not seek health care	0.21%	3
Other (please specify)	1.42%	20
TOTAL		1,409

Q6 If you experienced an immediate medical need, where would you go?

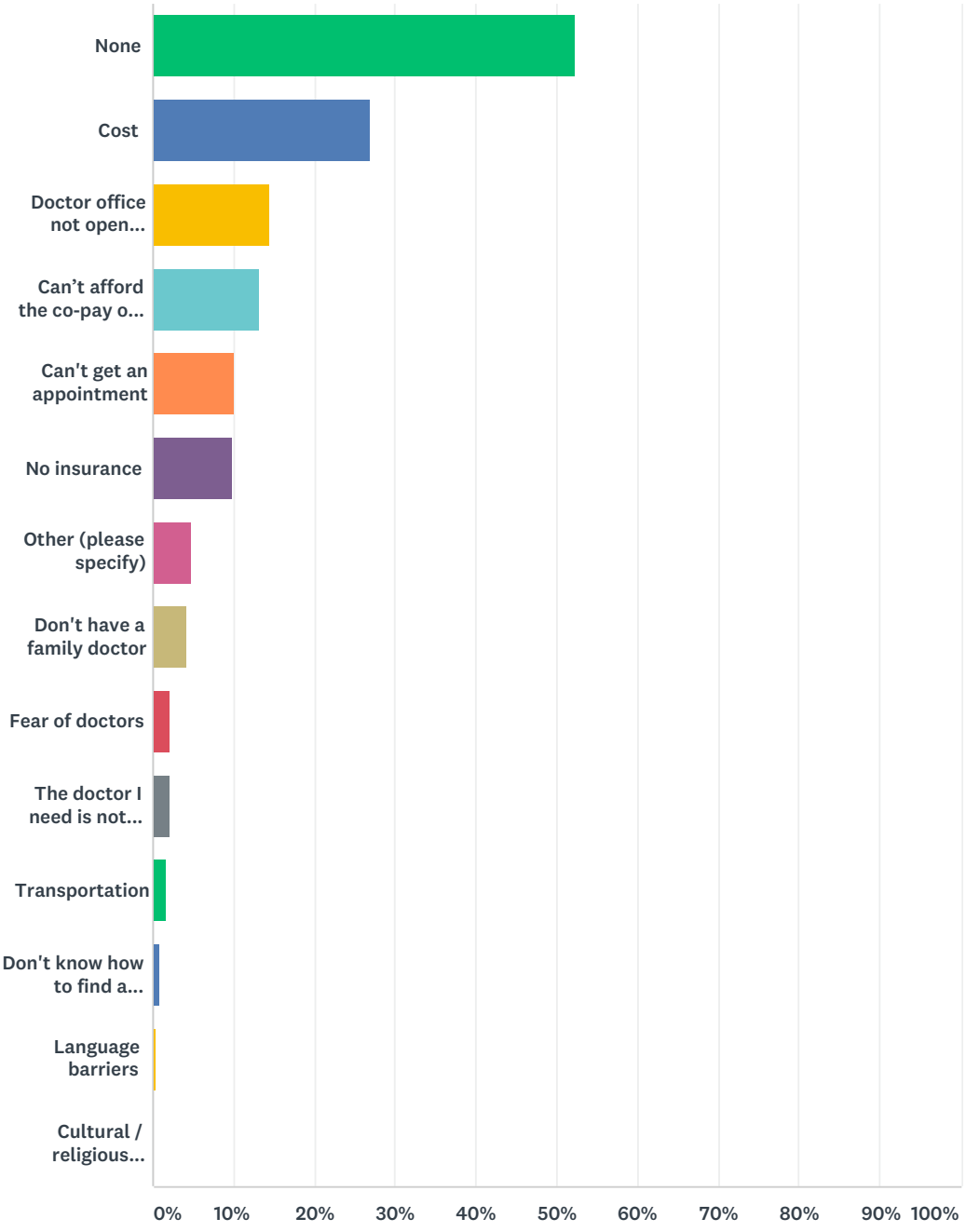
Answered: 1,409 Skipped: 105



ANSWER CHOICES	RESPONSES	
Urgent Care	48.97%	690
Emergency Room	33.92%	478
Doctor's Office	11.92%	168
Other (please specify)	4.05%	57
I would not seek health care	0.92%	13
Other Clinic	0.21%	3
Health Department	0.00%	0
TOTAL		1,409

Q7 Are there any issues that stop you from getting care when you need it? (Check ALL that apply)

Answered: 1,366 Skipped: 148

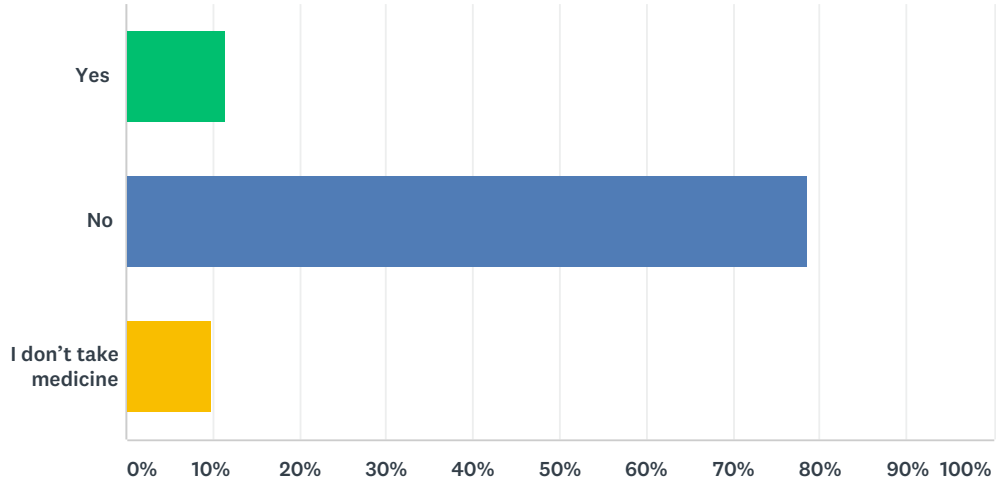


ANSWER CHOICES	RESPONSES	
None	52.27%	714
Cost	27.09%	370
Doctor office not open evenings or weekends	14.49%	198
Can't afford the co-pay or deductible	13.25%	181

Can't get an appointment	9.96%	136
No insurance	9.81%	134
Other (please specify)	4.83%	66
Don't have a family doctor	4.25%	58
Fear of doctors	2.20%	30
The doctor I need is not taking new patients	2.05%	28
Transportation	1.61%	22
Don't know how to find a doctor	0.81%	11
Language barriers	0.44%	6
Cultural / religious beliefs	0.15%	2
Total Respondents: 1,366		

Q8 In the past 12 months, have you gone without medicine, or not taken medicine as prescribed because you could not afford it?

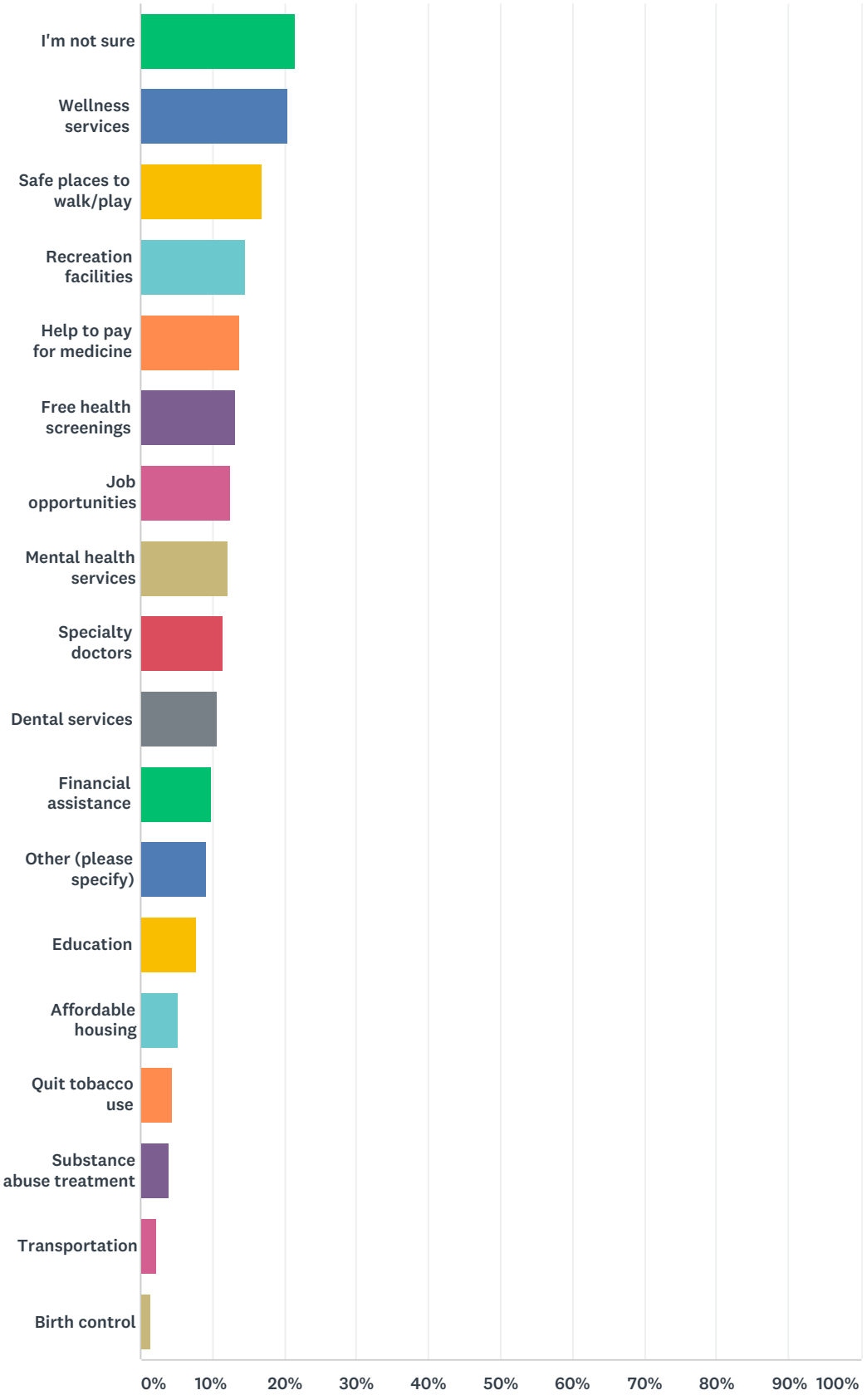
Answered: 1,397 Skipped: 117



ANSWER CHOICES	RESPONSES	
Yes	11.52%	161
No	78.74%	1,100
I don't take medicine	9.74%	136
TOTAL		1,397

Q9 What is MOST needed to improve the health of your family? (Check up to THREE)

Answered: 1,313 Skipped: 201

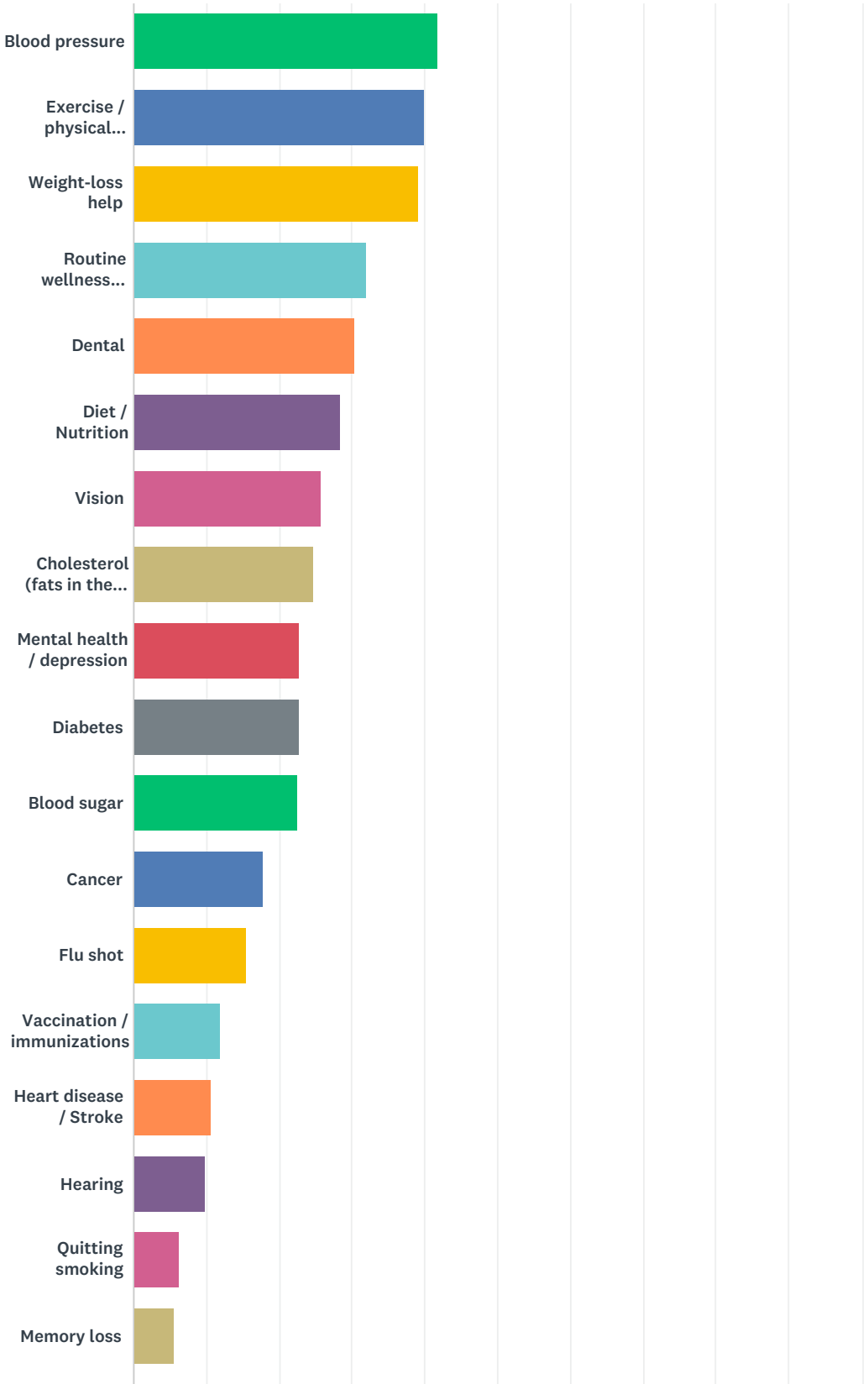


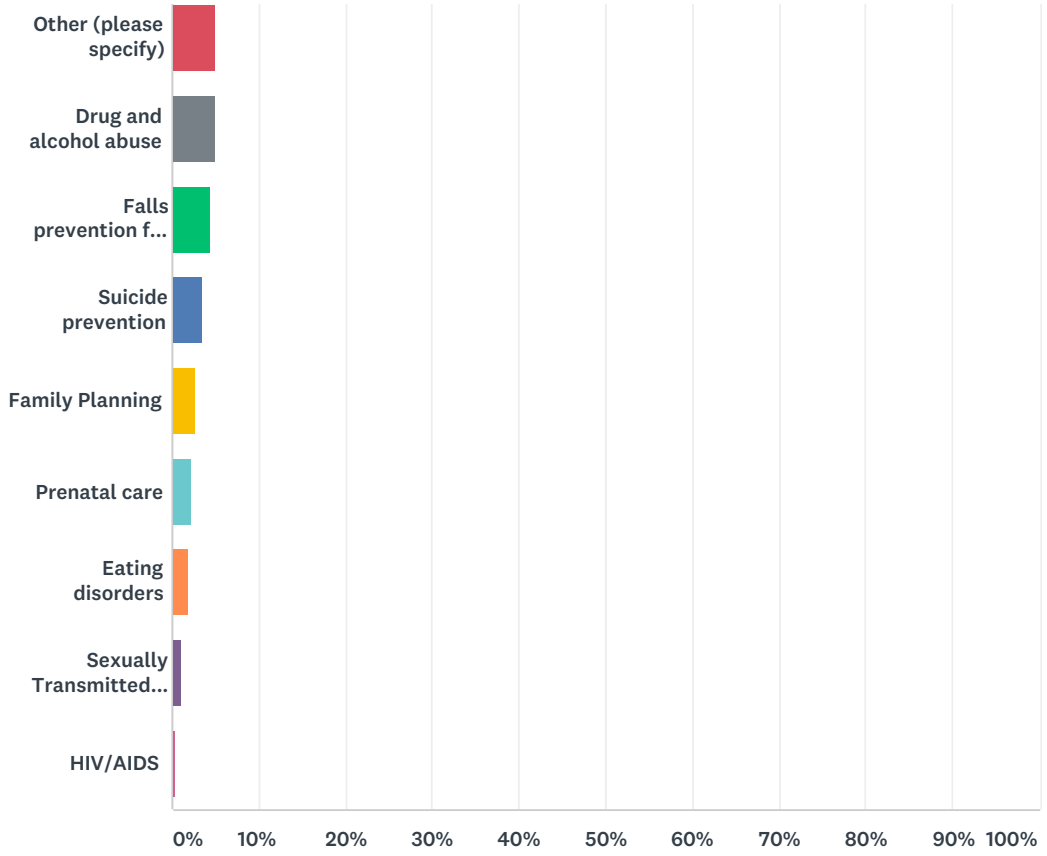
ANSWER CHOICES	RESPONSES	
I'm not sure	21.48%	282

Wellness services	20.56%	270
Safe places to walk/play	16.91%	222
Recreation facilities	14.70%	193
Help to pay for medicine	13.79%	181
Free health screenings	13.10%	172
Job opportunities	12.49%	164
Mental health services	12.19%	160
Specialty doctors	11.42%	150
Dental services	10.59%	139
Financial assistance	9.75%	128
Other (please specify)	9.14%	120
Education	7.84%	103
Affordable housing	5.33%	70
Quit tobacco use	4.49%	59
Substance abuse treatment	3.96%	52
Transportation	2.36%	31
Birth control	1.37%	18
Total Respondents: 1,313		

Q10 What types of health screenings and/or services are needed to keep you and your family healthy? (Check up to SIX)

Answered: 1,313 Skipped: 201



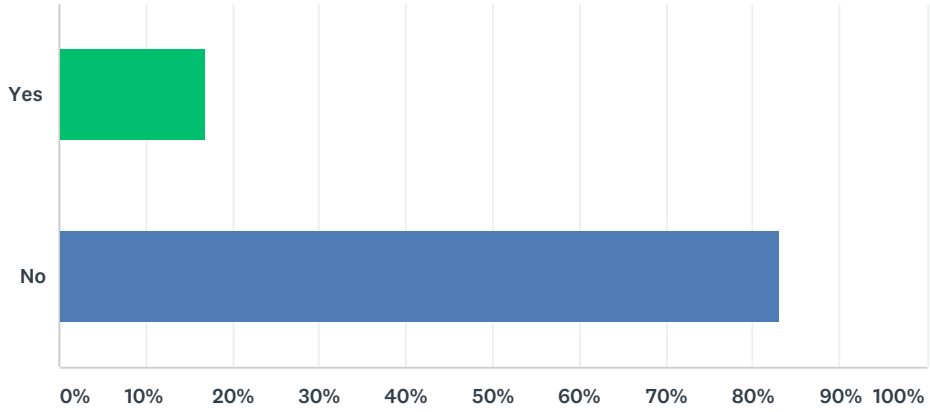


ANSWER CHOICES	RESPONSES	
Blood pressure	41.89%	550
Exercise / physical activity	39.98%	525
Weight-loss help	39.22%	515
Routine wellness checkups	32.06%	421
Dental	30.31%	398
Diet / Nutrition	28.48%	374
Vision	25.82%	339
Cholesterol (fats in the blood)	24.75%	325
Mental health / depression	22.85%	300
Diabetes	22.77%	299
Blood sugar	22.70%	298
Cancer	17.82%	234
Flu shot	15.54%	204
Vaccination / immunizations	11.96%	157
Heart disease / Stroke	10.74%	141
Hearing	9.82%	129
Quitting smoking	6.25%	82

Memory loss	5.64%	74
Other (please specify)	5.10%	67
Drug and alcohol abuse	5.03%	66
Falls prevention for the elderly	4.49%	59
Suicide prevention	3.50%	46
Family Planning	2.74%	36
Prenatal care	2.36%	31
Eating disorders	1.83%	24
Sexually Transmitted Diseases	1.07%	14
HIV/AIDS	0.38%	5
Total Respondents: 1,313		

Q11 Have you ever been told by a doctor or other health professional that you have diabetes?

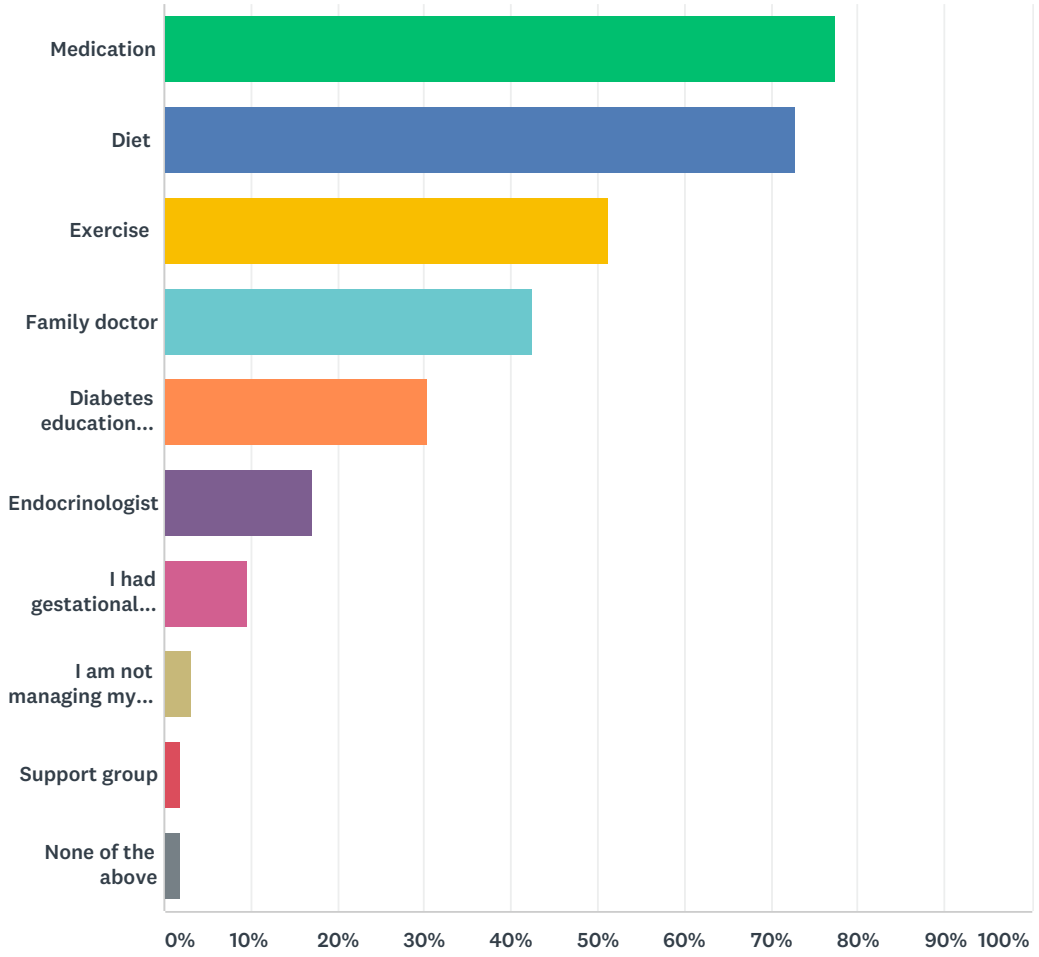
Answered: 1,309 Skipped: 205



ANSWER CHOICES	RESPONSES	
Yes	16.88%	221
No	83.12%	1,088
TOTAL		1,309

Q12 If YES for diabetes, how are you managing your symptoms? (Check ALL that apply)

Answered: 217 Skipped: 1,297

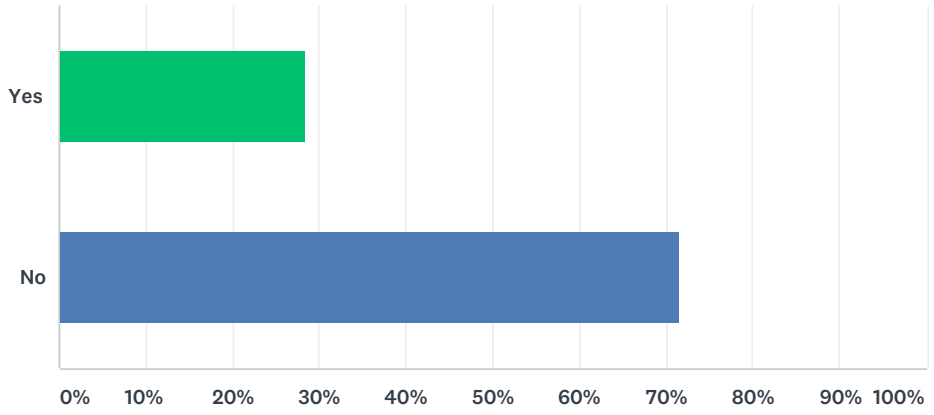


ANSWER CHOICES	RESPONSES	
Medication	77.42%	168
Diet	72.81%	158
Exercise	51.15%	111
Family doctor	42.40%	92
Diabetes education program (past or present)	30.41%	66
Endocrinologist	17.05%	37
I had gestational diabetes during pregnancy	9.68%	21
I am not managing my symptoms	3.23%	7
Support group	1.84%	4
None of the above	1.84%	4

Total Respondents: 217	

Q13 Are you interested in learning how to prevent diabetes?

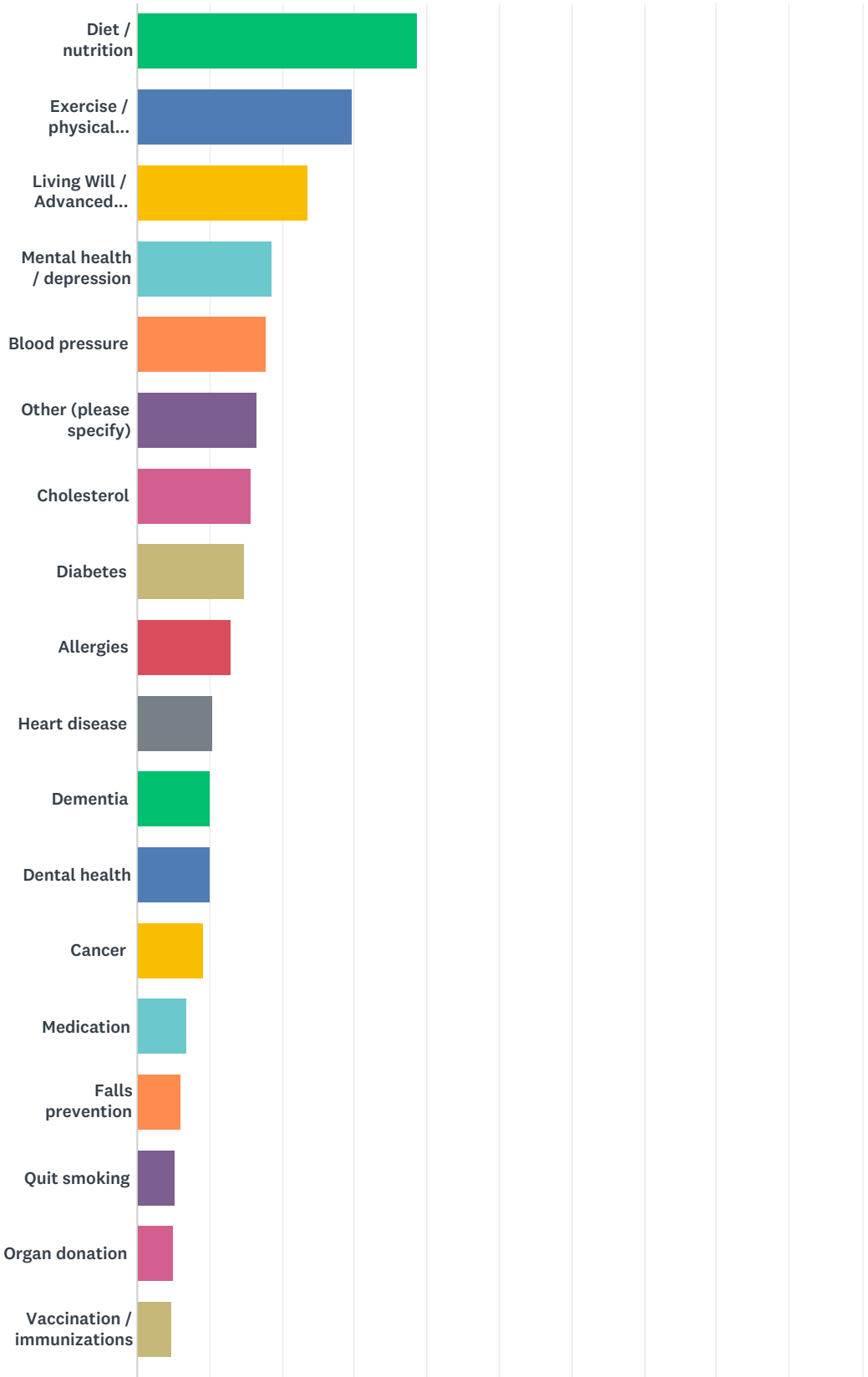
Answered: 1,093 Skipped: 421

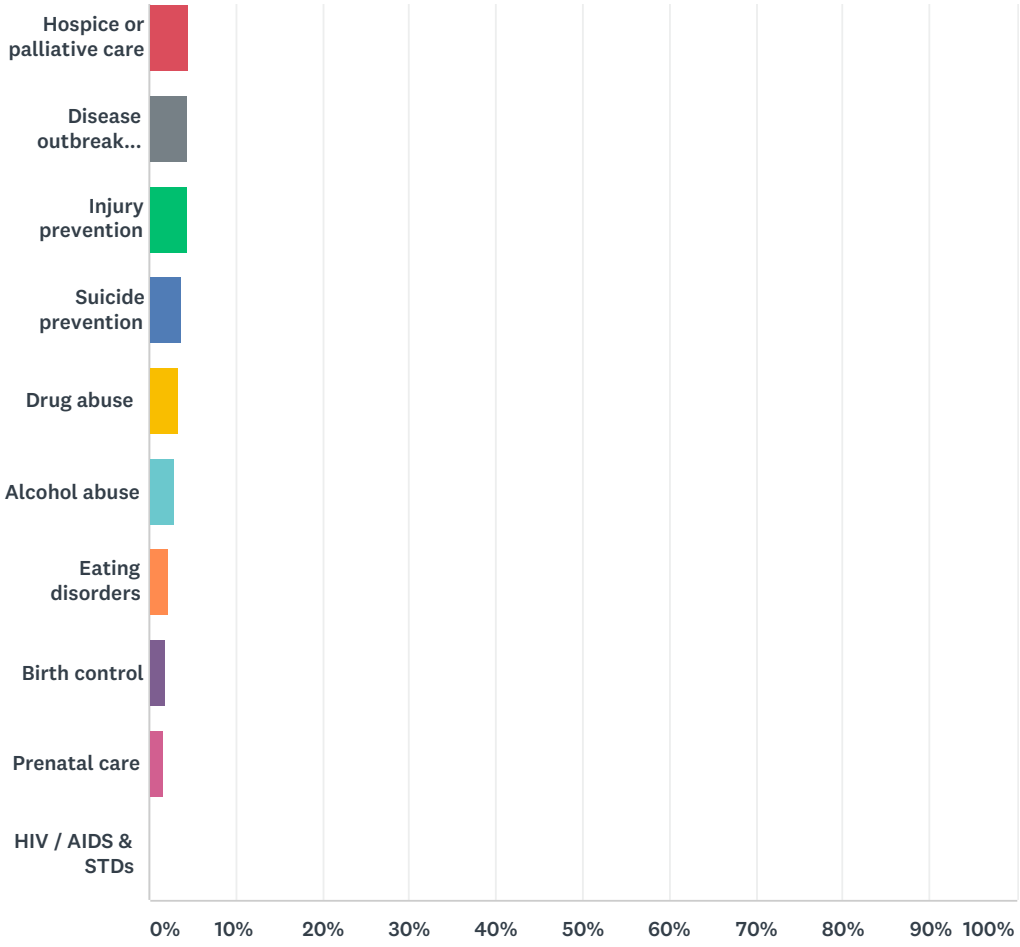


ANSWER CHOICES	RESPONSES	
Yes	28.55%	312
No	71.45%	781
TOTAL		1,093

Q14 What health issues do you need more information about? (Please check up to SIX)

Answered: 1,263 Skipped: 251



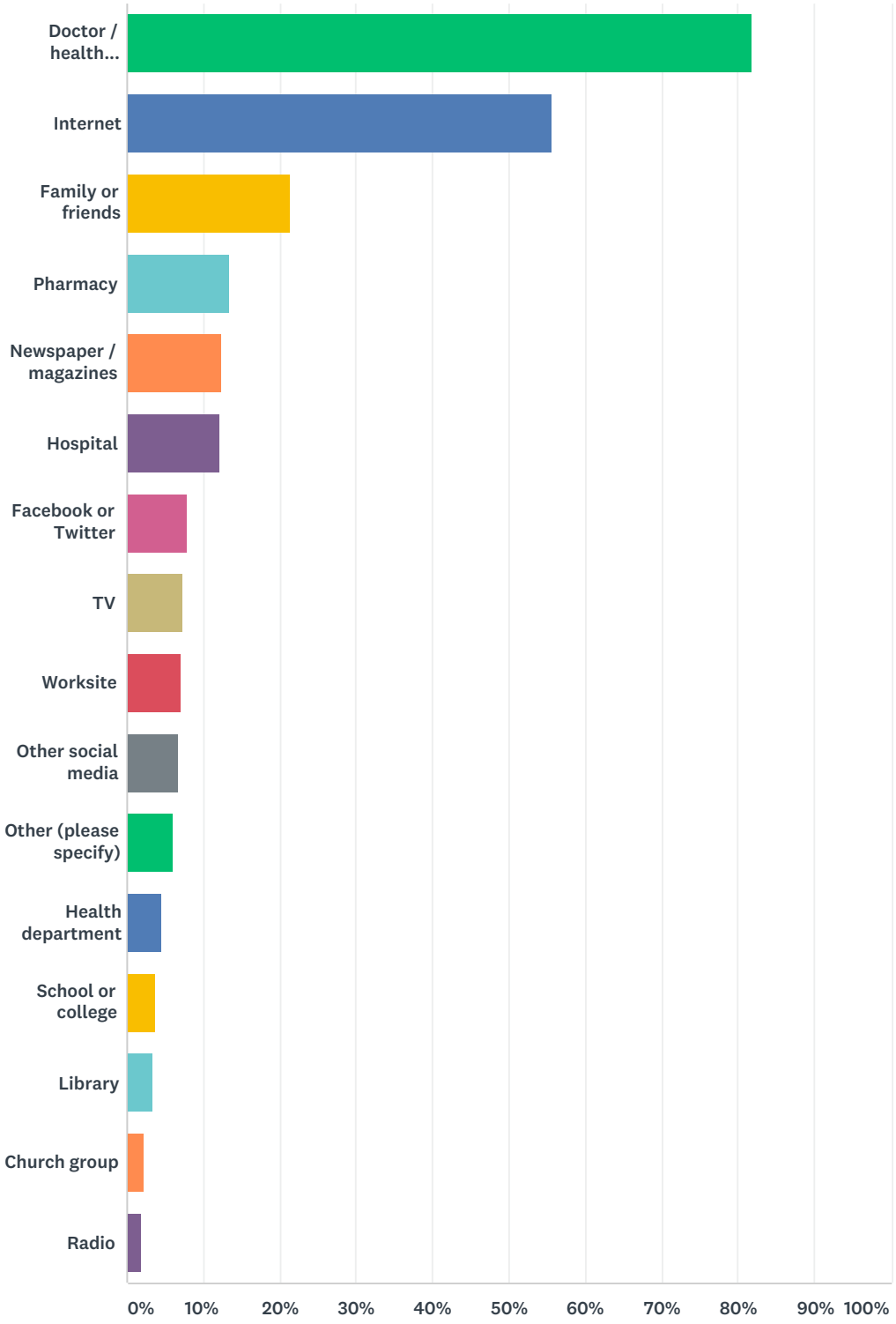


ANSWER CHOICES	RESPONSES	
Diet / nutrition	38.64%	488
Exercise / physical activity	29.77%	376
Living Will / Advanced Directives	23.67%	299
Mental health / depression	18.69%	236
Blood pressure	17.74%	224
Other (please specify)	16.47%	208
Cholesterol	15.60%	197
Diabetes	14.89%	188
Allergies	13.06%	165
Heart disease	10.37%	131
Dementia	10.06%	127
Dental health	9.98%	126
Cancer	9.11%	115
Medication	6.97%	88
Falls prevention	6.02%	76

Quit smoking	5.23%	66
Organ donation	4.99%	63
Vaccination / immunizations	4.91%	62
Hospice or palliative care	4.67%	59
Disease outbreak prevention	4.43%	56
Injury prevention	4.35%	55
Suicide prevention	3.72%	47
Drug abuse	3.25%	41
Alcohol abuse	2.93%	37
Eating disorders	2.38%	30
Birth control	1.98%	25
Prenatal care	1.66%	21
HIV / AIDS & STDs	0.24%	3
Total Respondents: 1,263		

Q15 Where do you get MOST of your health information? (Check ALL that apply)

Answered: 1,263 Skipped: 251

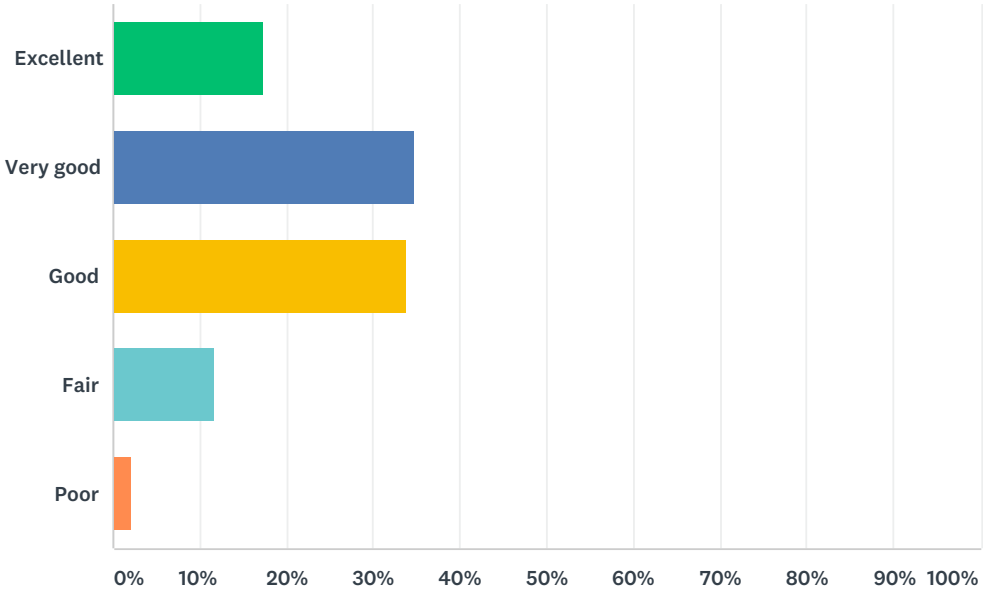


ANSWER CHOICES	RESPONSES

Doctor / health professional	81.79%	1,033
Internet	55.66%	703
Family or friends	21.38%	270
Pharmacy	13.38%	169
Newspaper / magazines	12.35%	156
Hospital	12.11%	153
Facebook or Twitter	8.00%	101
TV	7.28%	92
Worksite	7.05%	89
Other social media	6.65%	84
Other (please specify)	6.10%	77
Health department	4.59%	58
School or college	3.72%	47
Library	3.25%	41
Church group	2.30%	29
Radio	1.90%	24
Total Respondents: 1,263		

Q16 In general, how would you rate your overall mental or emotional health?

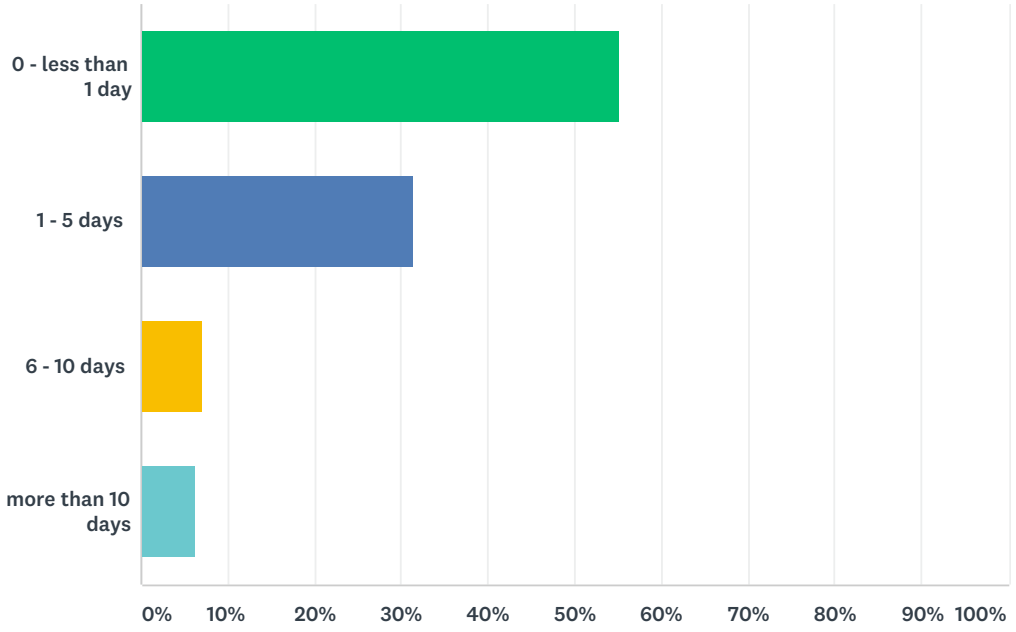
Answered: 1,249 Skipped: 265



ANSWER CHOICES	RESPONSES	
Excellent	17.45%	218
Very good	34.83%	435
Good	33.95%	424
Fair	11.77%	147
Poor	2.00%	25
TOTAL		1,249

Q17 During the past month have you often been bothered by feeling down, depressed or hopeless?

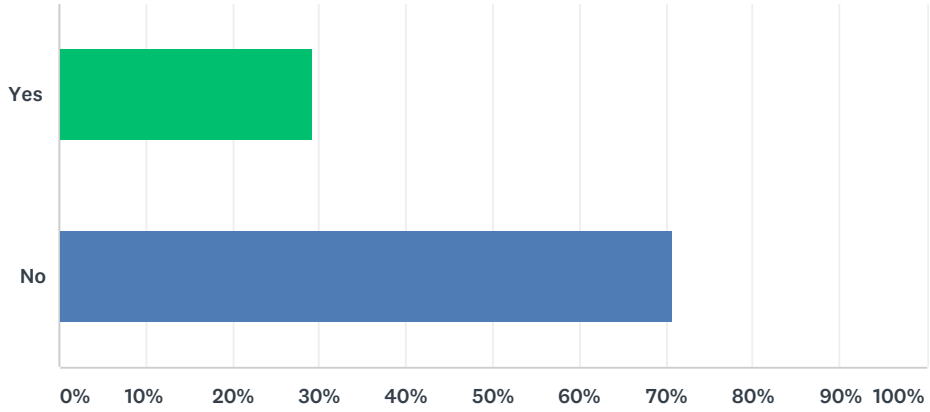
Answered: 1,249 Skipped: 265



ANSWER CHOICES	RESPONSES	
0 - less than 1 day	55.32%	691
1 - 5 days	31.31%	391
6 - 10 days	7.13%	89
more than 10 days	6.24%	78
TOTAL		1,249

Q18 In the past month have you often been bothered by little interest or pleasure in doing things?

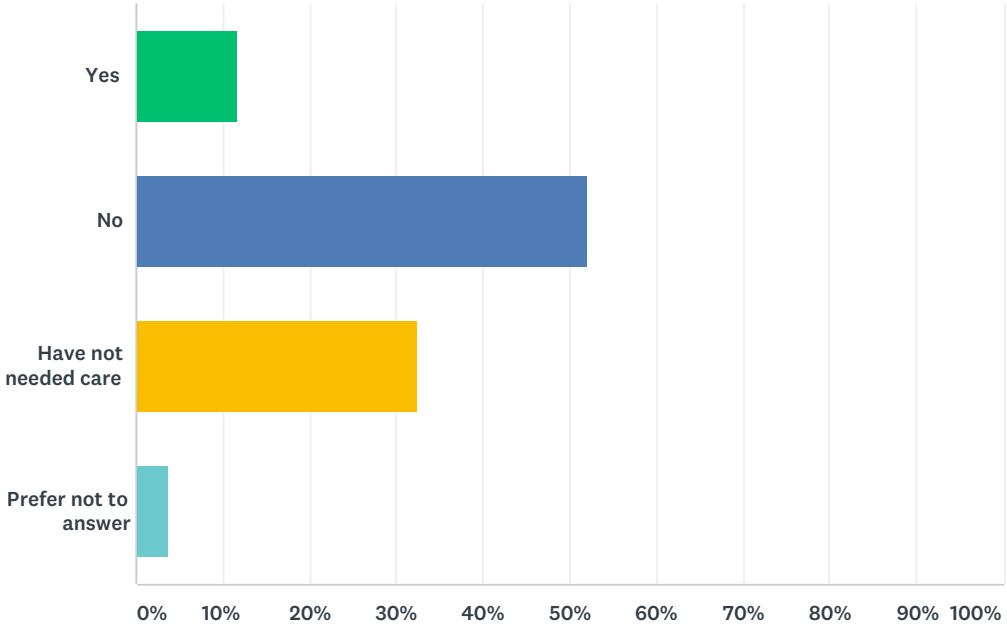
Answered: 1,249 Skipped: 265



ANSWER CHOICES	RESPONSES	
Yes	29.30%	366
No	70.70%	883
TOTAL		1,249

Q19 Have you ever needed mental health treatment and couldn't get it?

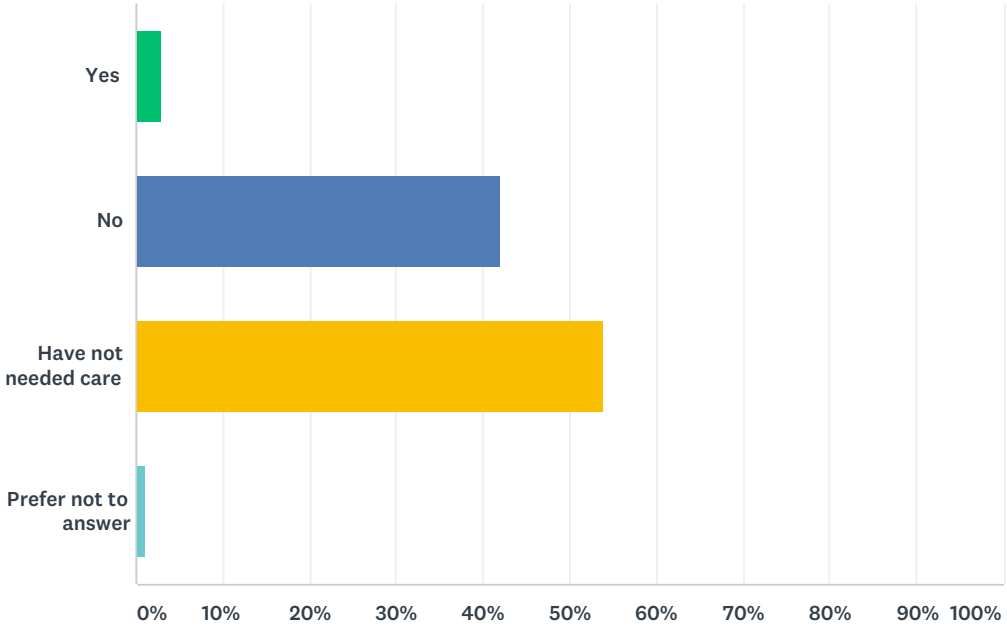
Answered: 1,249 Skipped: 265



ANSWER CHOICES	RESPONSES	
Yes	11.69%	146
No	52.04%	650
Have not needed care	32.51%	406
Prefer not to answer	3.76%	47
TOTAL		1,249

Q20 Have you ever needed substance use treatment and couldn't get it?

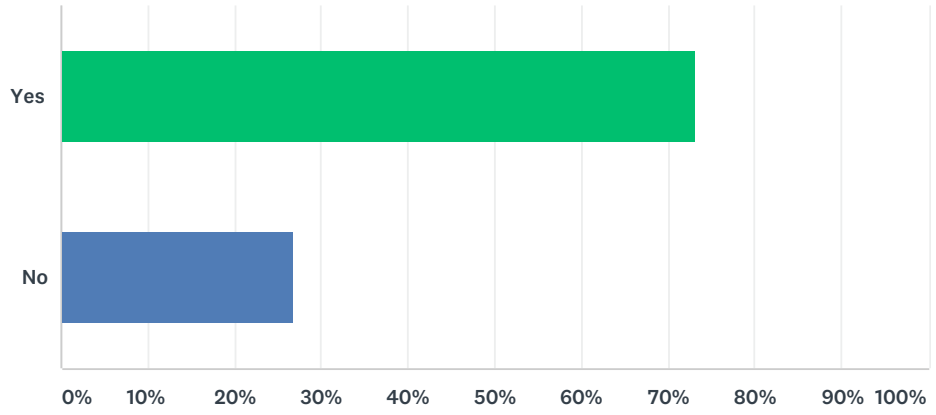
Answered: 1,239 Skipped: 275



ANSWER CHOICES	RESPONSES	
Yes	2.99%	37
No	41.97%	520
Have not needed care	53.91%	668
Prefer not to answer	1.13%	14
TOTAL		1,239

Q21 In the last 12 months did you receive dental care?

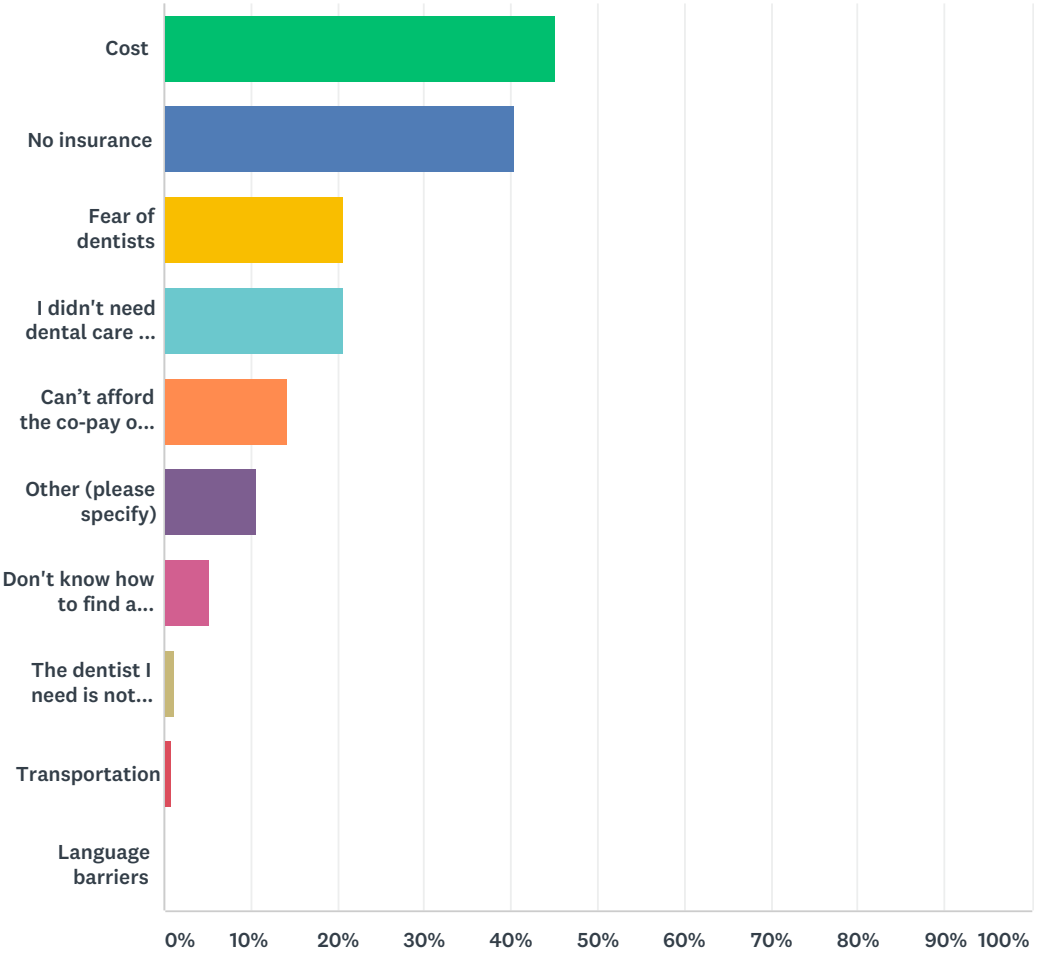
Answered: 1,247 Skipped: 267



ANSWER CHOICES	RESPONSES	
Yes	73.22%	913
No	26.78%	334
TOTAL		1,247

Q22 If NO, why have you not received dental care?

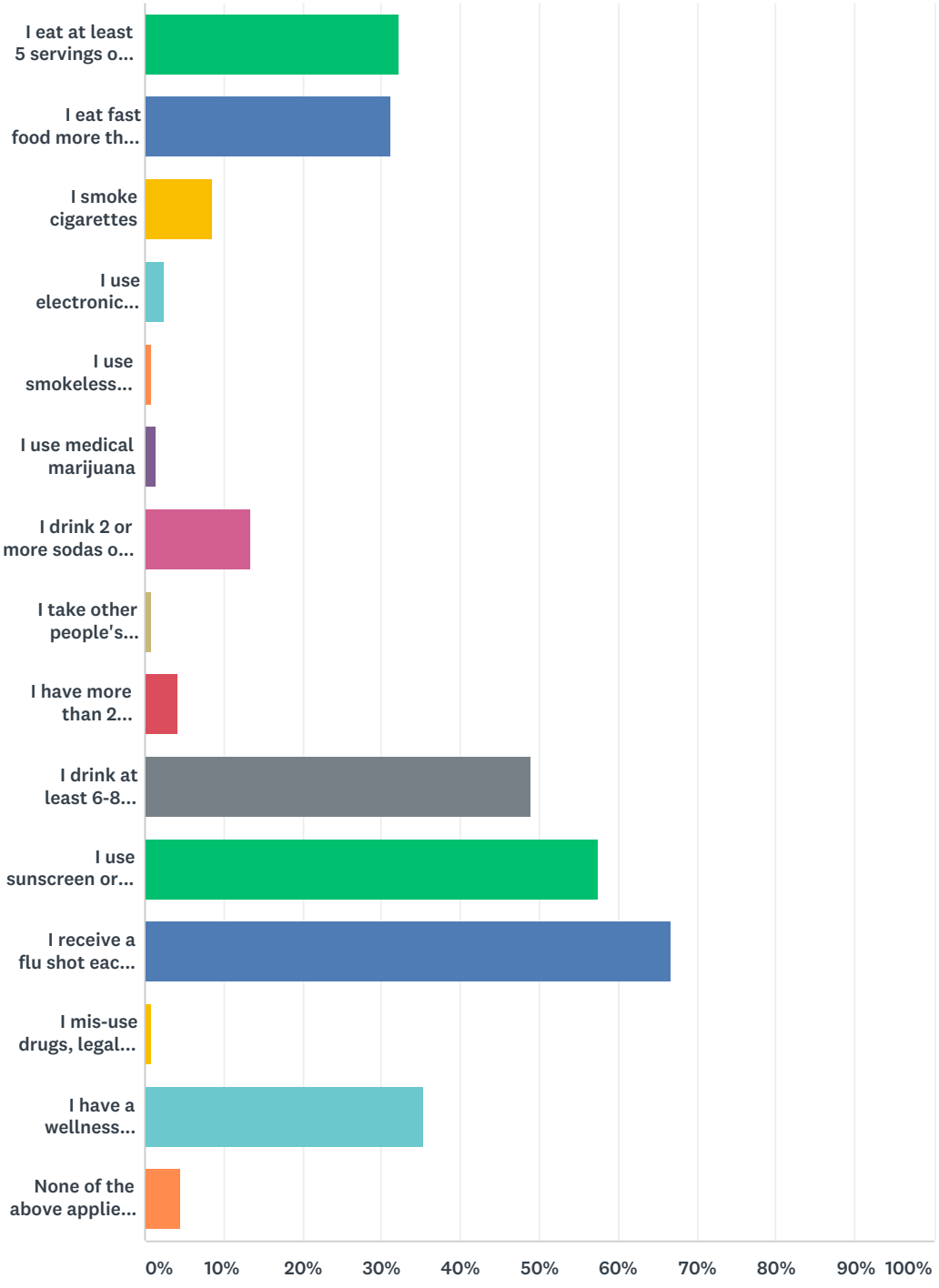
Answered: 325 Skipped: 1,189



ANSWER CHOICES	RESPONSES	
Cost	45.23%	147
No insurance	40.31%	131
Fear of dentists	20.62%	67
I didn't need dental care in the past 12 months	20.62%	67
Can't afford the co-pay or deductible	14.15%	46
Other (please specify)	10.77%	35
Don't know how to find a dentist	5.23%	17
The dentist I need is not taking new patients	1.23%	4
Transportation	0.92%	3
Language barriers	0.31%	1
Total Respondents: 325		

Q23 Please choose ALL statements below that apply to you.

Answered: 1,213 Skipped: 301

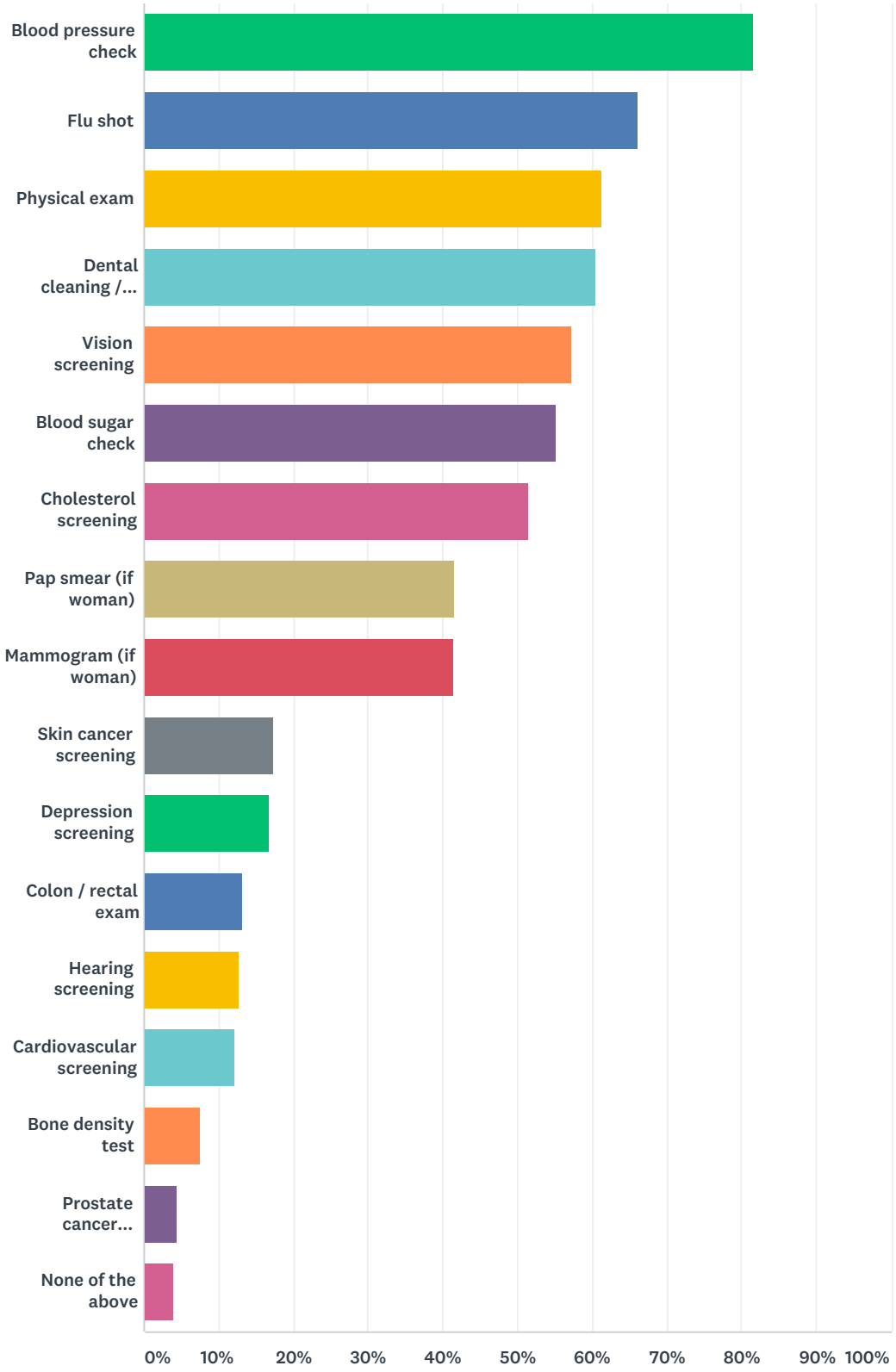


ANSWER CHOICES	RESPONSES	
I eat at least 5 servings of fruits and vegetables each day	32.32%	392
I eat fast food more than once per week	31.08%	377
I smoke cigarettes	8.66%	105

I use electronic cigarettes	2.56%	31
I use smokeless tobacco	0.91%	11
I use medical marijuana	1.40%	17
I drink 2 or more sodas or energy drinks per day	13.36%	162
I take other people's prescription medication	0.91%	11
I have more than 2 alcoholic drinks (if female) or 3 (if male) per day	4.20%	51
I drink at least 6-8 glasses of water per day	48.97%	594
I use sunscreen or protective clothing for planned time in the sun	57.63%	699
I receive a flu shot each year	66.69%	809
I mis-use drugs, legal or illegal	0.91%	11
I have a wellness program at work	35.37%	429
None of the above applies to me	4.53%	55
Total Respondents: 1,213		

Q24 Which of the following preventive procedures have you had in the past 12 months? (Check ALL that apply).

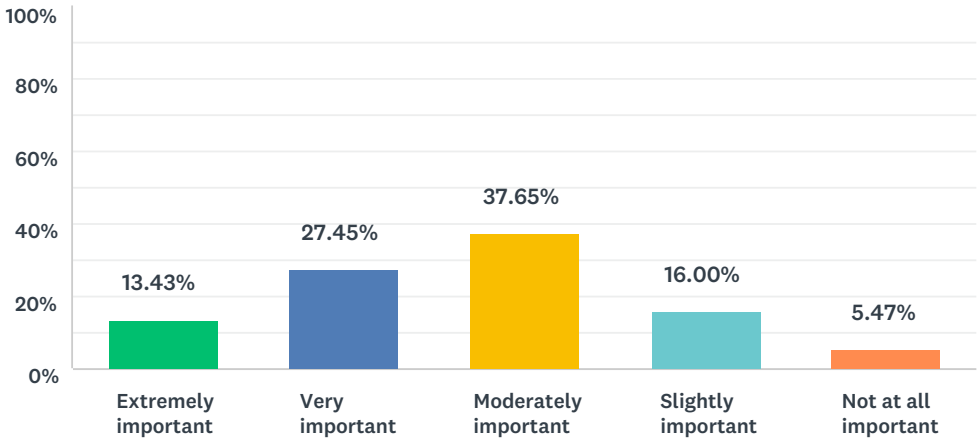
Answered: 1,213 Skipped: 301



ANSWER CHOICES	RESPONSES	
Blood pressure check	81.62%	990
Flu shot	66.12%	802
Physical exam	61.34%	744
Dental cleaning / X-rays	60.51%	734
Vision screening	57.38%	696
Blood sugar check	55.23%	670
Cholesterol screening	51.36%	623
Pap smear (if woman)	41.71%	506
Mammogram (if woman)	41.47%	503
Skin cancer screening	17.39%	211
Depression screening	16.65%	202
Colon / rectal exam	13.19%	160
Hearing screening	12.78%	155
Cardiovascular screening	12.04%	146
Bone density test	7.58%	92
Prostate cancer screening (if man)	4.45%	54
None of the above	4.04%	49
Total Respondents: 1,213		

Q25 How important is exercise to you?

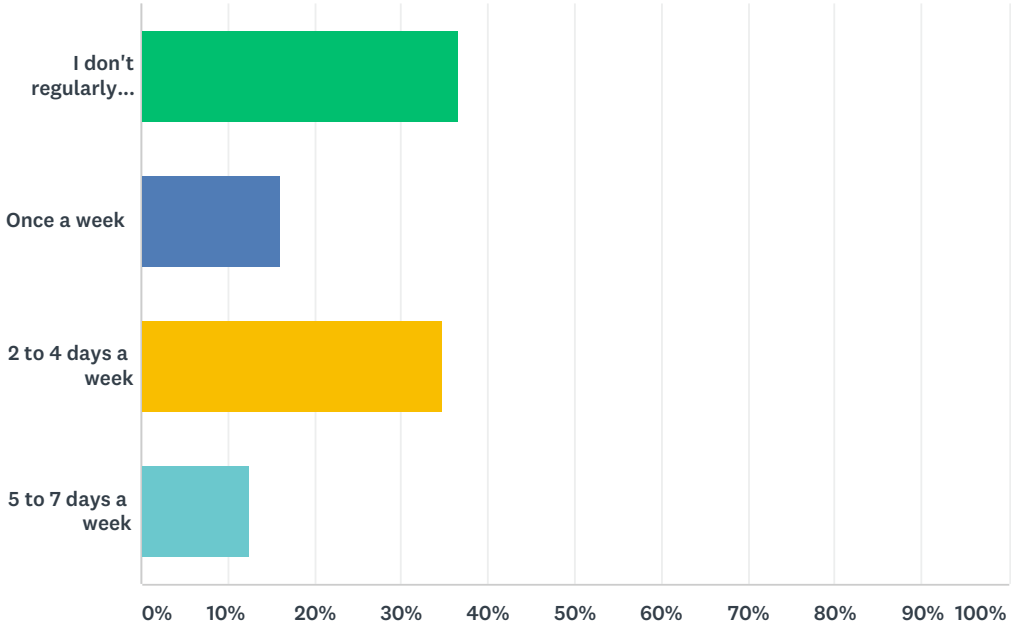
Answered: 1,206 Skipped: 308



ANSWER CHOICES	RESPONSES	
Extremely important	13.43%	162
Very important	27.45%	331
Moderately important	37.65%	454
Slightly important	16.00%	193
Not at all important	5.47%	66
TOTAL		1,206

Q26 In a typical week, how many days do you exercise?

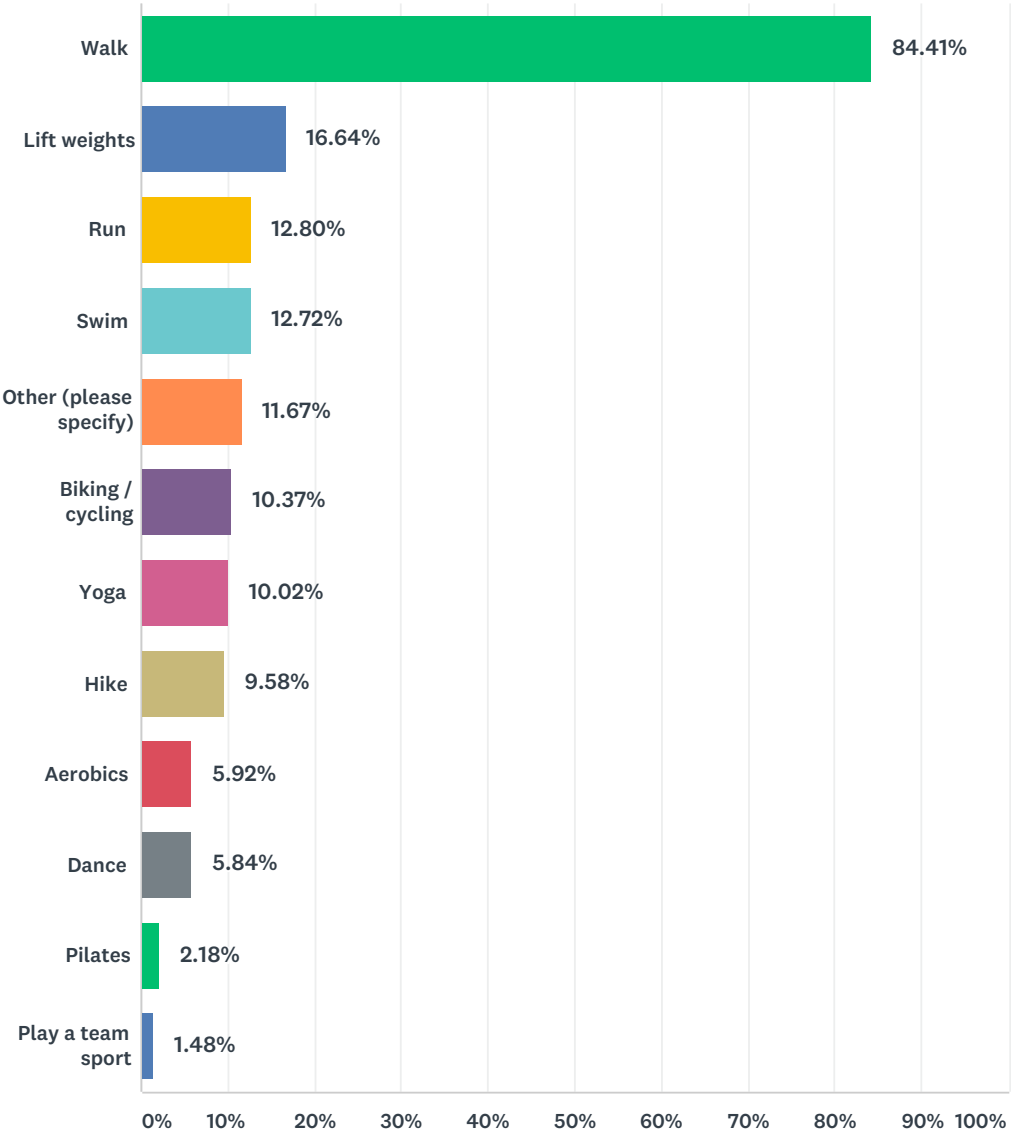
Answered: 1,198 Skipped: 316



ANSWER CHOICES	RESPONSES	
I don't regularly exercise	36.56%	438
Once a week	16.11%	193
2 to 4 days a week	34.72%	416
5 to 7 days a week	12.60%	151
TOTAL		1,198

Q27 What do you most often do for exercise?

Answered: 1,148 Skipped: 366

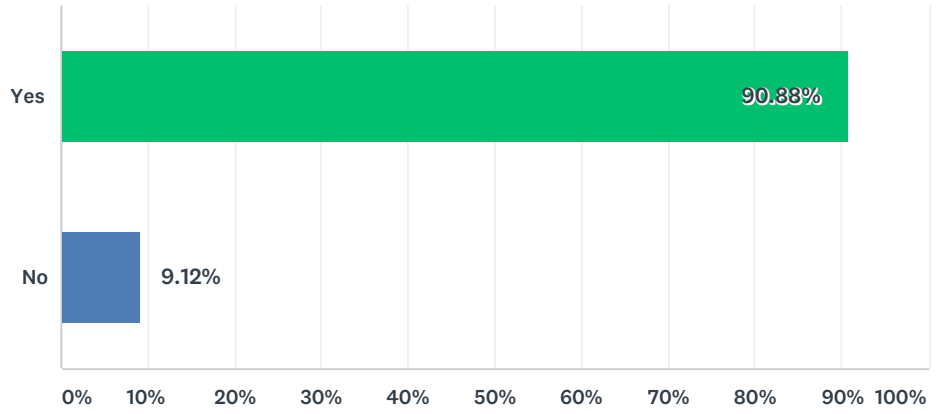


ANSWER CHOICES	RESPONSES	
Walk	84.41%	969
Lift weights	16.64%	191
Run	12.80%	147
Swim	12.72%	146
Other (please specify)	11.67%	134
Biking / cycling	10.37%	119
Yoga	10.02%	115
Hike	9.58%	110

Aerobics	5.92%	68
Dance	5.84%	67
Pilates	2.18%	25
Play a team sport	1.48%	17
Total Respondents: 1,148		

Q28 Do you have a regular healthcare provider?

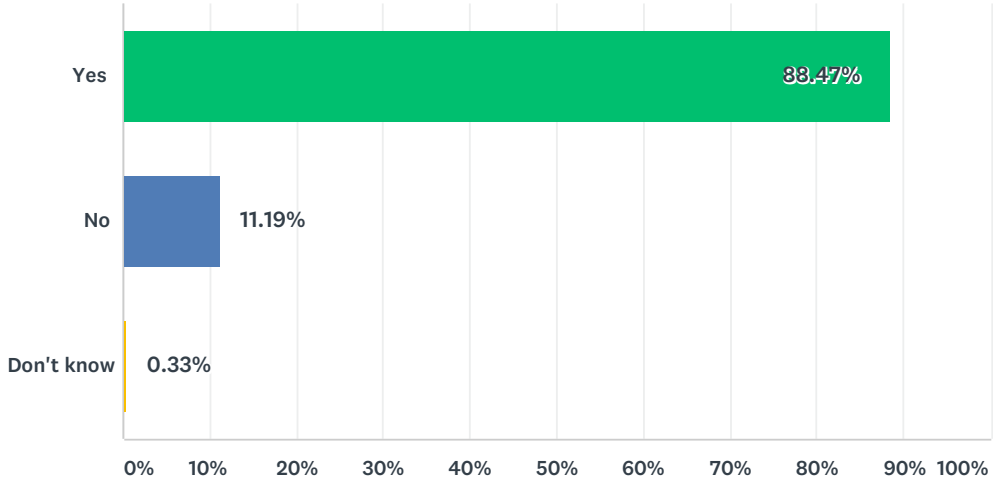
Answered: 1,206 Skipped: 308



ANSWER CHOICES	RESPONSES	
Yes	90.88%	1,096
No	9.12%	110
TOTAL		1,206

Q29 Do you currently have health insurance?

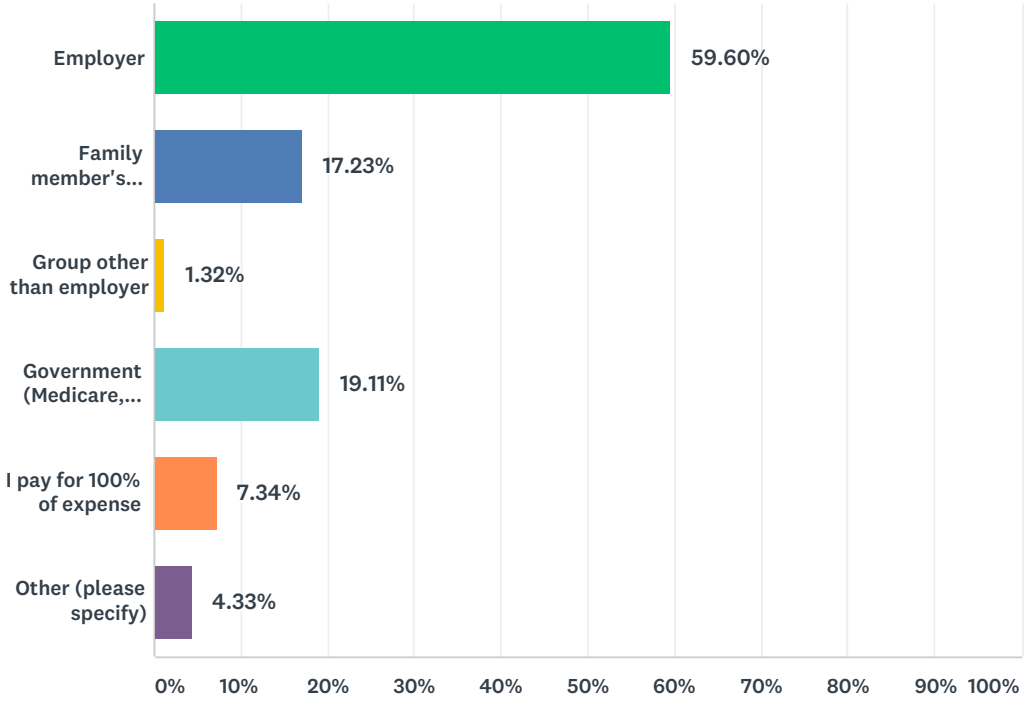
Answered: 1,206 Skipped: 308



ANSWER CHOICES	RESPONSES	
Yes	88.47%	1,067
No	11.19%	135
Don't know	0.33%	4
TOTAL		1,206

Q30 Who helps pay for your health insurance premium?

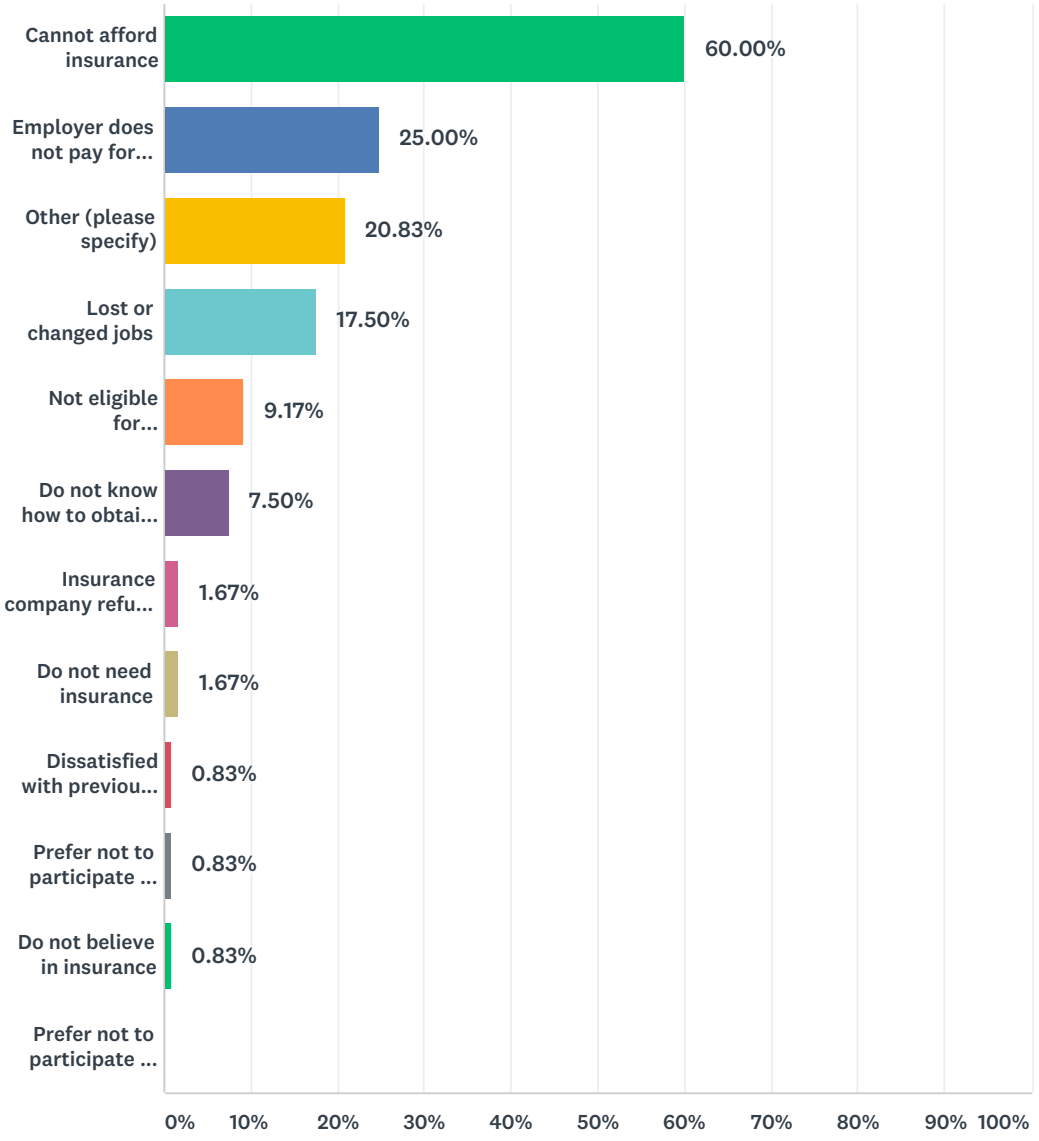
Answered: 1,062 Skipped: 452



ANSWER CHOICES	RESPONSES	
Employer	59.60%	633
Family member's insurance	17.23%	183
Group other than employer	1.32%	14
Government (Medicare, Medicaid or ACA Exchange)	19.11%	203
I pay for 100% of expense	7.34%	78
Other (please specify)	4.33%	46
Total Respondents: 1,062		

Q31 Why do you currently not have health insurance? (Check all that apply)

Answered: 120 Skipped: 1,394



ANSWER CHOICES	RESPONSES	
Cannot afford insurance	60.00%	72
Employer does not pay for insurance	25.00%	30
Other (please specify)	20.83%	25
Lost or changed jobs	17.50%	21
Not eligible for employer-paid insurance	9.17%	11
Do not know how to obtain health insurance	7.50%	9
Insurance company refused coverage for health reasons	1.67%	2

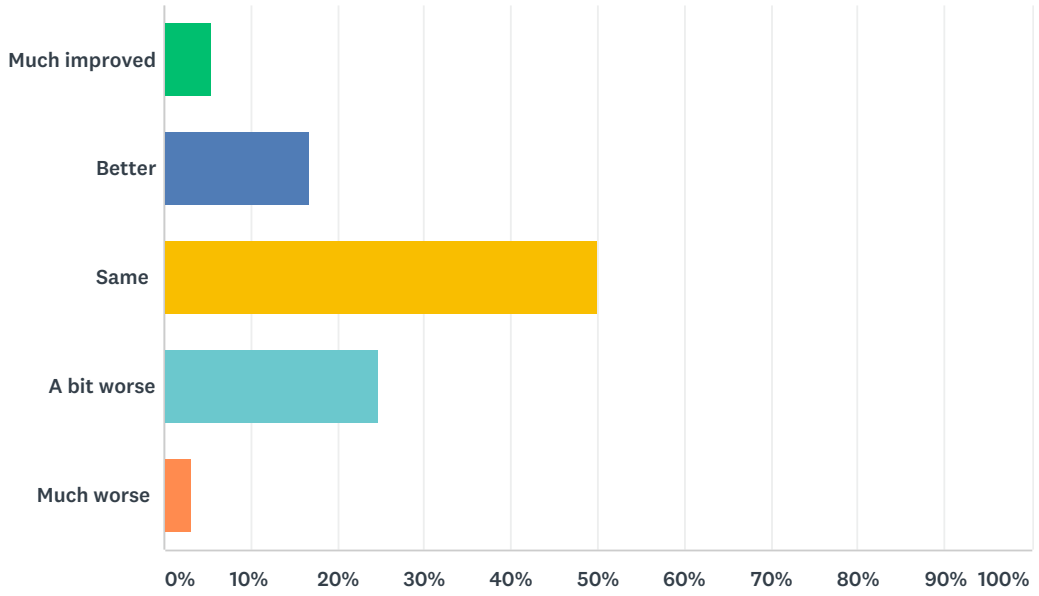
Do not need insurance	1.67%	2
Dissatisfied with previous insurance plan or provider	0.83%	1
Prefer not to participate in government insurance	0.83%	1
Do not believe in insurance	0.83%	1
Prefer not to participate in private insurance	0.00%	0
Total Respondents: 120		

Q32 What is the biggest unmet health need in Washington County?

Answered: 829 Skipped: 685

Q33 How has your health changed in the past 3 years?

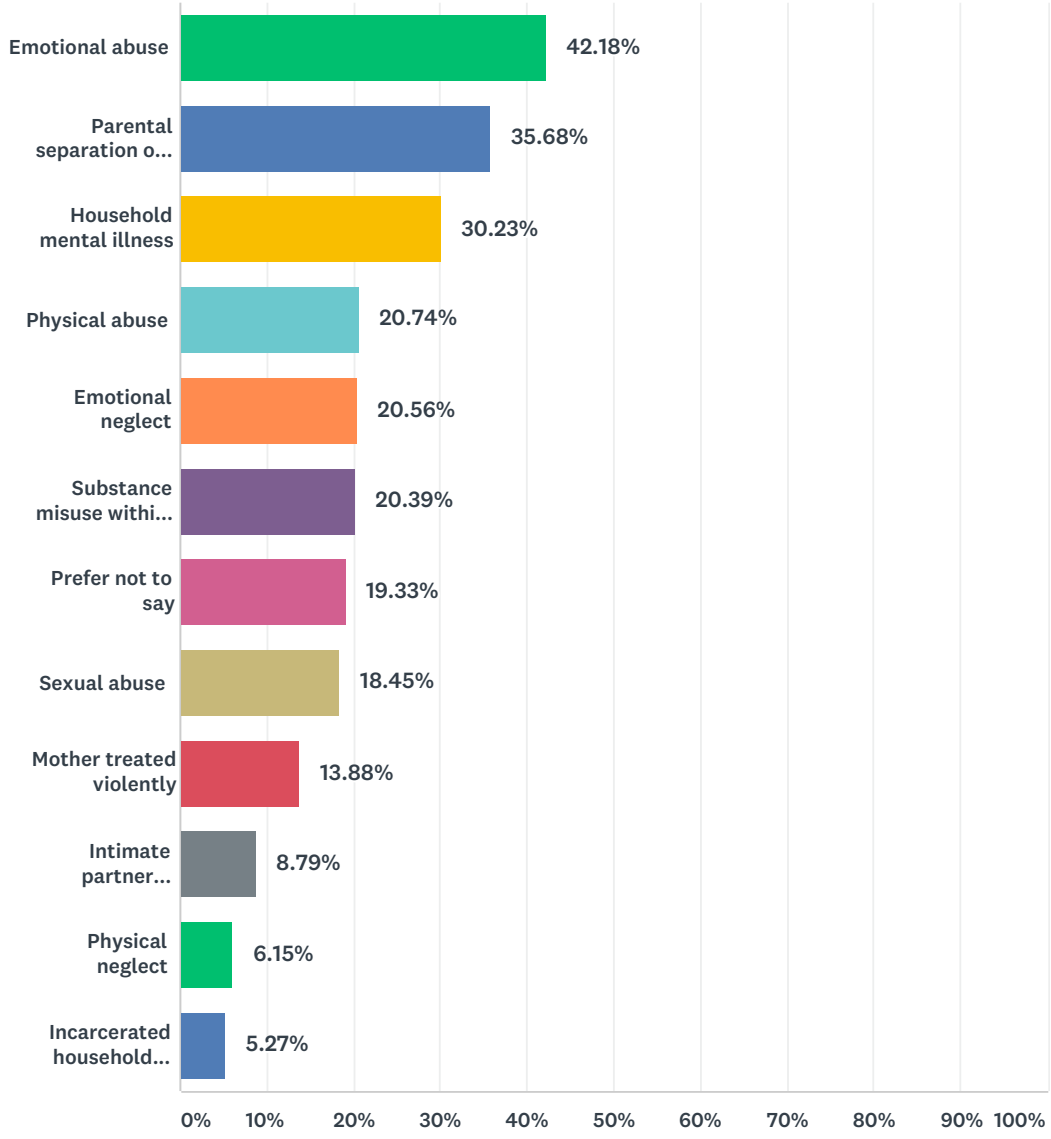
Answered: 1,168 Skipped: 346



ANSWER CHOICES	RESPONSES	
Much improved	5.48%	64
Better	16.78%	196
Same	50.00%	584
A bit worse	24.66%	288
Much worse	3.08%	36
TOTAL		1,168

Q34 Studies show that sometimes childhood trauma affects adult health. In your childhood, were you exposed to any of the following? (Check all that apply)

Answered: 569 Skipped: 945

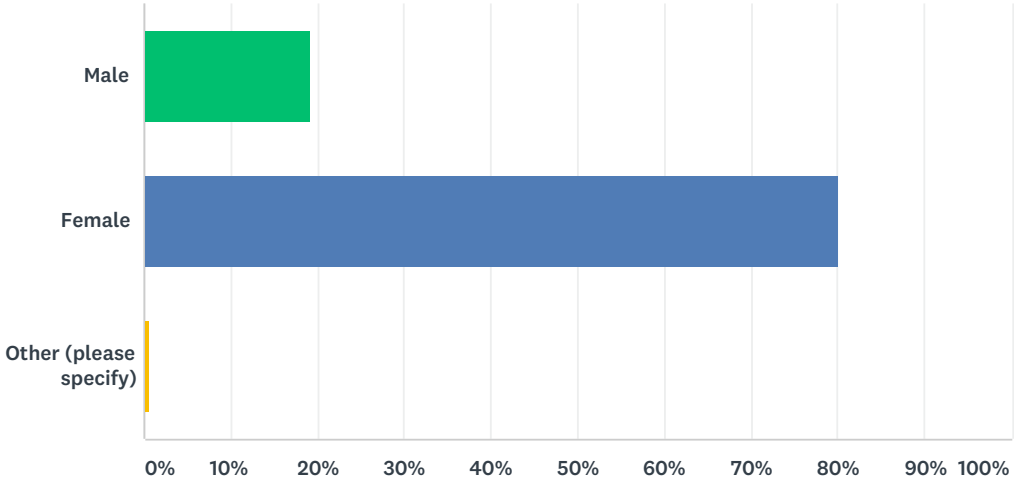


ANSWER CHOICES	RESPONSES	
Emotional abuse	42.18%	240
Parental separation or divorce	35.68%	203
Household mental illness	30.23%	172
Physical abuse	20.74%	118
Emotional neglect	20.56%	117
Substance misuse within the household	20.39%	116

Prefer not to say	19.33%	110
Sexual abuse	18.45%	105
Mother treated violently	13.88%	79
Intimate partner violence	8.79%	50
Physical neglect	6.15%	35
Incarcerated household member	5.27%	30
Total Respondents: 569		

Q35 What is your gender?

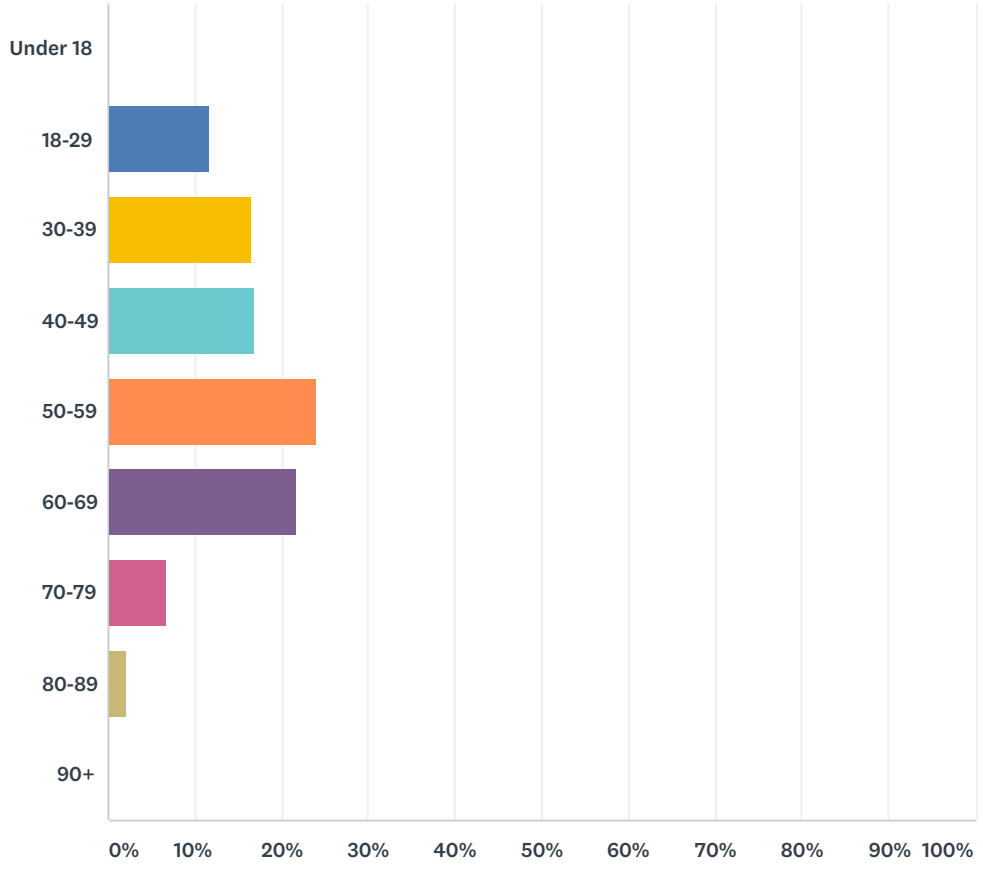
Answered: 1,179 Skipped: 335



ANSWER CHOICES	RESPONSES	
Male	19.34%	228
Female	80.07%	944
Other (please specify)	0.59%	7
TOTAL		1,179

Q36 What is your age?

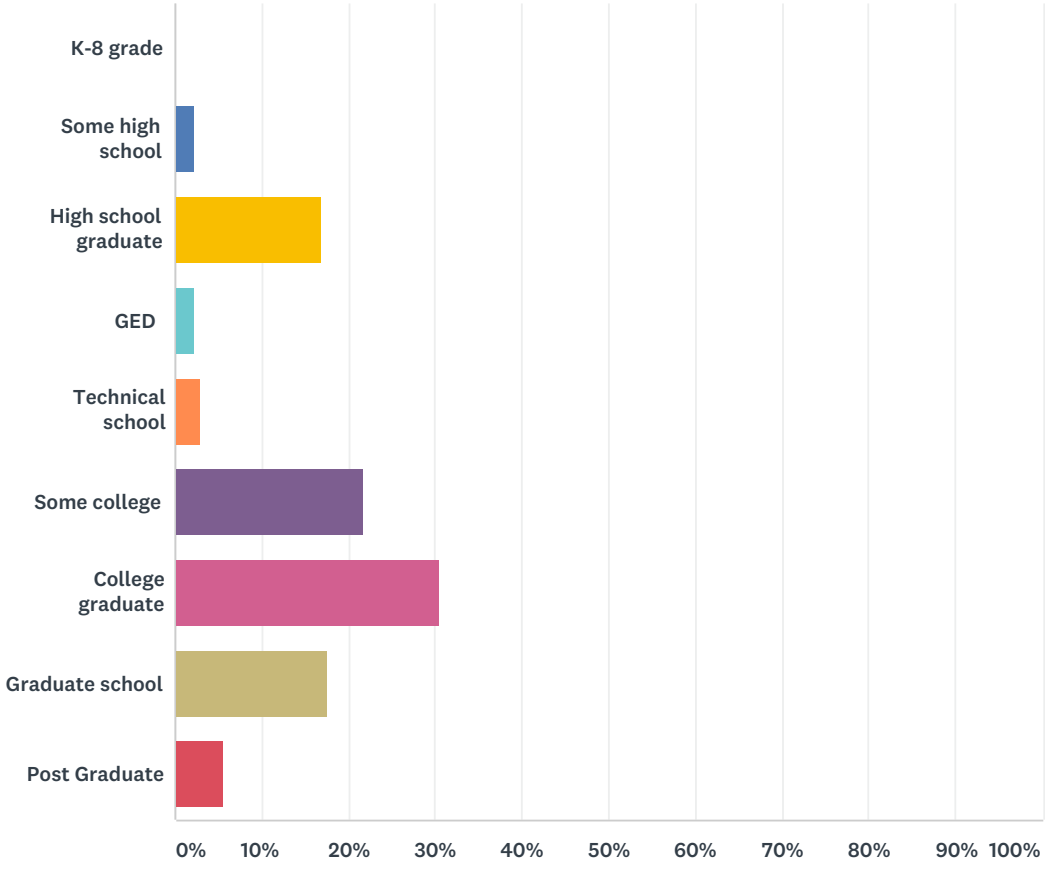
Answered: 1,179 Skipped: 335



ANSWER CHOICES	RESPONSES	
Under 18	0.25%	3
18-29	11.62%	137
30-39	16.45%	194
40-49	16.88%	199
50-59	24.09%	284
60-69	21.71%	256
70-79	6.79%	80
80-89	2.04%	24
90+	0.17%	2
TOTAL		1,179

Q37 What is your highest level of education?

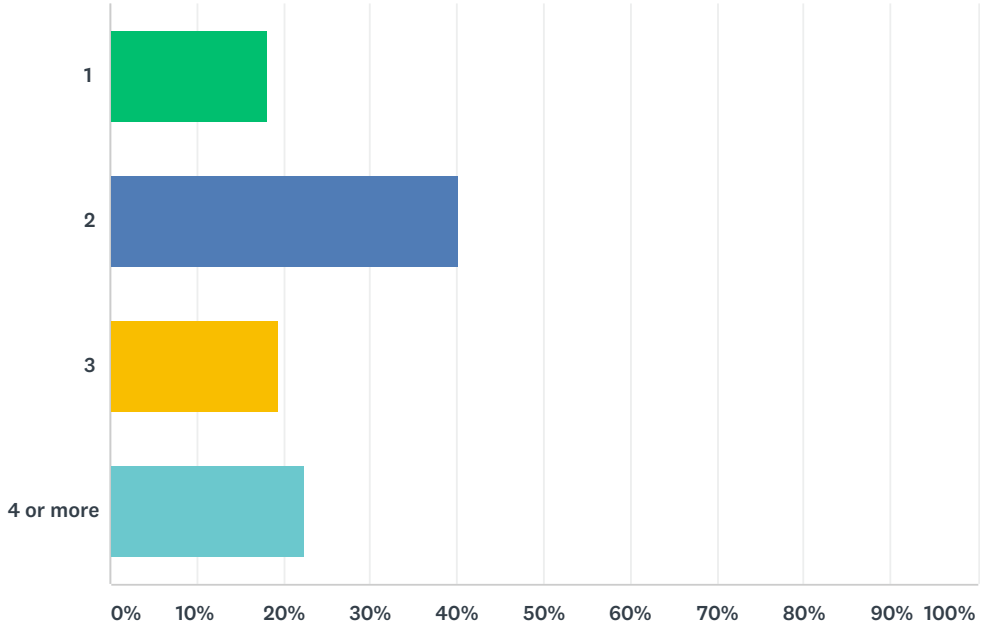
Answered: 1,174 Skipped: 340



ANSWER CHOICES	RESPONSES	
K-8 grade	0.17%	2
Some high school	2.30%	27
High school graduate	16.87%	198
GED	2.21%	26
Technical school	2.90%	34
Some college	21.81%	256
College graduate	30.49%	358
Graduate school	17.63%	207
Post Graduate	5.62%	66
TOTAL		1,174

Q38 Including yourself, how many people live in your household?

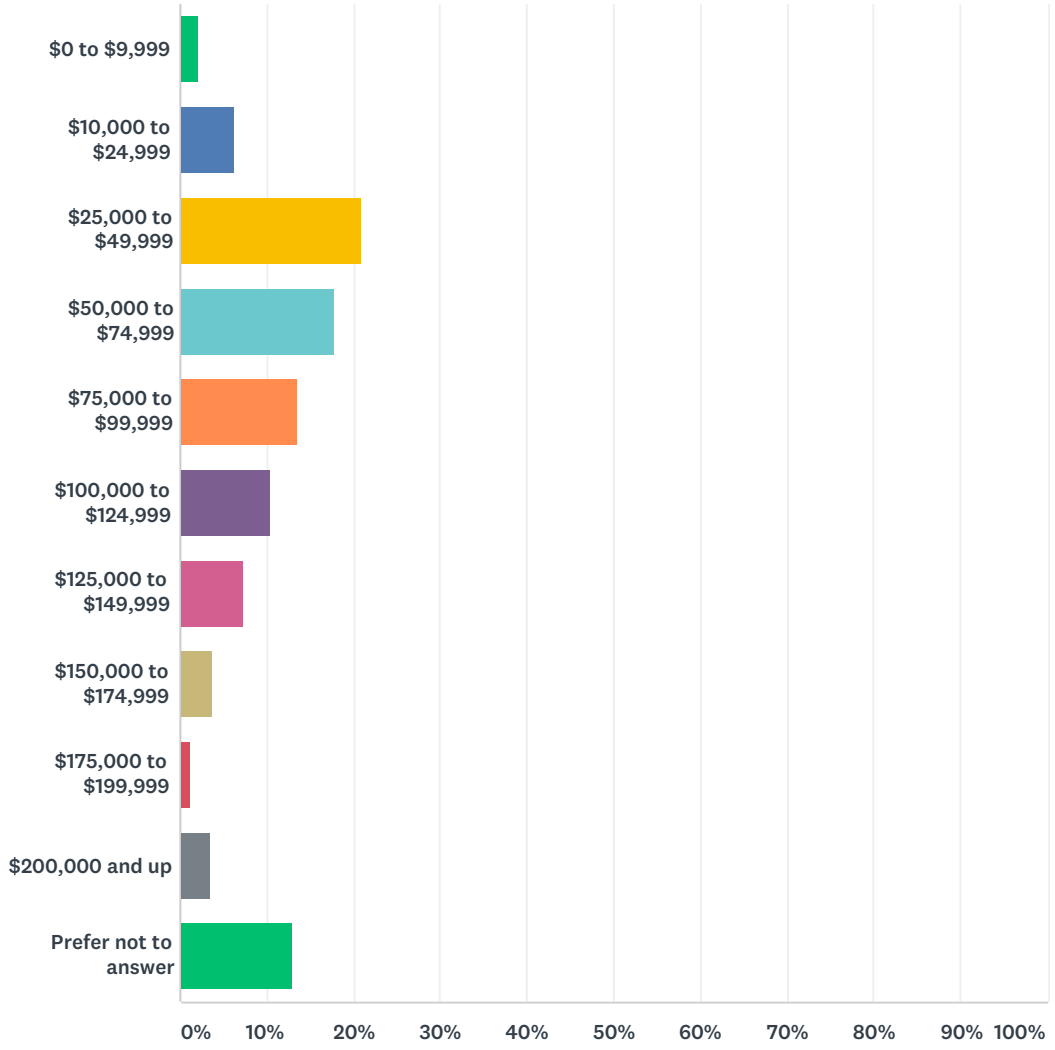
Answered: 1,165 Skipped: 349



ANSWER CHOICES	RESPONSES	
1	18.11%	211
2	40.17%	468
3	19.40%	226
4 or more	22.32%	260
TOTAL		1,165

Q39 How much total combined money did all members of your HOUSEHOLD earn last year?

Answered: 1,155 Skipped: 359

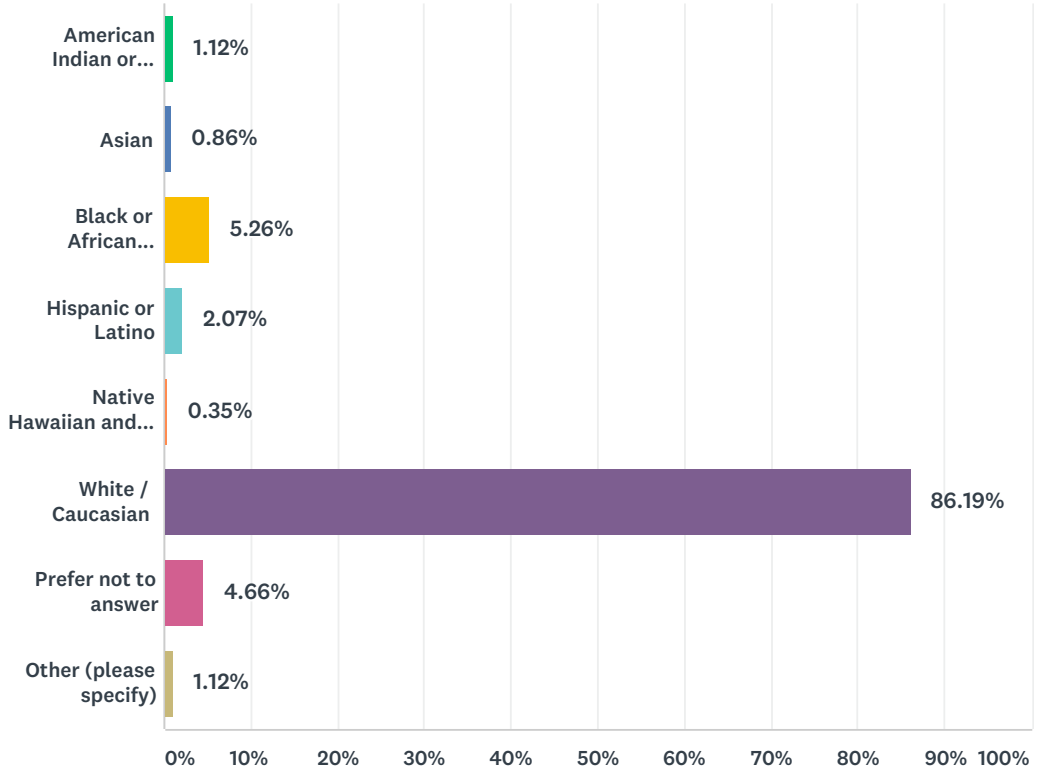


ANSWER CHOICES	RESPONSES	
$0 to $9,999	1.99%	23
$10,000 to $24,999	6.23%	72
$25,000 to $49,999	20.95%	242
$50,000 to $74,999	17.75%	205
$75,000 to $99,999	13.68%	158
$100,000 to $124,999	10.39%	120
$125,000 to $149,999	7.36%	85
$150,000 to $174,999	3.72%	43
$175,000 to $199,999	1.30%	15

$200,000 and up	3.64%	42
Prefer not to answer	12.99%	150
TOTAL		1,155

Q40 What is your race / ethnicity? (Please select all that apply.)

Answered: 1,159 Skipped: 355



ANSWER CHOICES	RESPONSES	
American Indian or Alaskan Native	1.12%	13
Asian	0.86%	10
Black or African American	5.26%	61
Hispanic or Latino	2.07%	24
Native Hawaiian and other Pacific Islander	0.35%	4
White / Caucasian	86.19%	999
Prefer not to answer	4.66%	54
Other (please specify)	1.12%	13
Total Respondents: 1,159		

maryland health connection℠

DATA REPORT

DECEMBER 31, 2018

SUMMARY DASHBOARD

QHPs are measured since Nov. 1 when enrollment began for 2019. Medicaid enrollments, which continue year-round, are as of report cover date.

SYSTEM DASHBOARD

Applications
47,367
associated to users

Completed
23,992

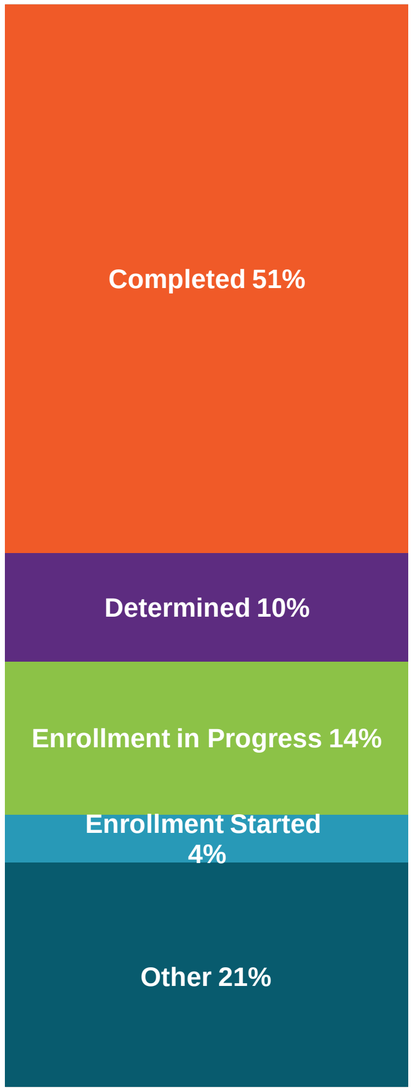
Determined
4,765

Enrollment in Progress
6,673

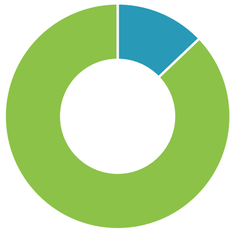
Enrollment Started
2,112

Other
9,825

Other includes: blank status, inactive, cancelled, denied, in process, partially enrolled and submitted.

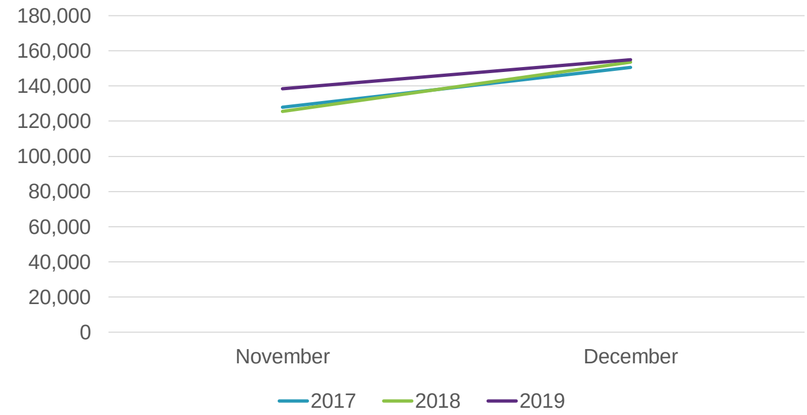


Qualified Health Plans (QHP) vs. Medicaid Enrollment



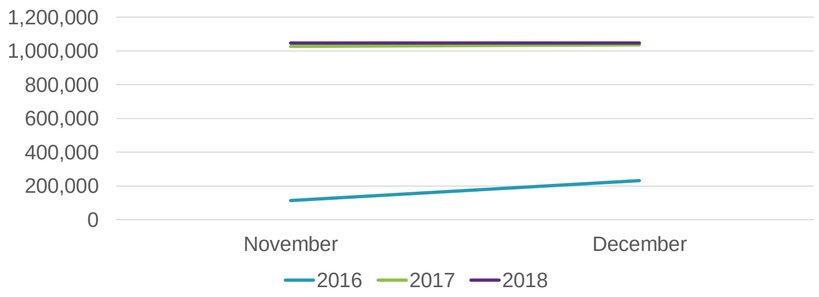
Enrolled in QHP

154,946



Enrolled in Medicaid

1,046,579



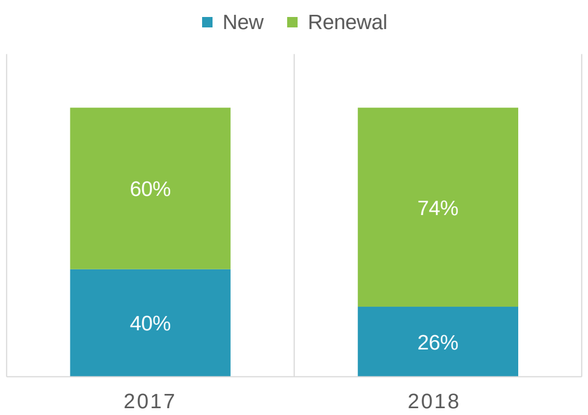
MAGI Medicaid enrollments (based Modified Adjusted Growth Income), covered in chart above, go through Maryland Health Connection. Non-MAGI Medicaid, about 300,000 enrollments with other eligibility criteria, go through the Maryland Department of Health (MDH).

QUALIFIED HEALTH PLANS DASHBOARD

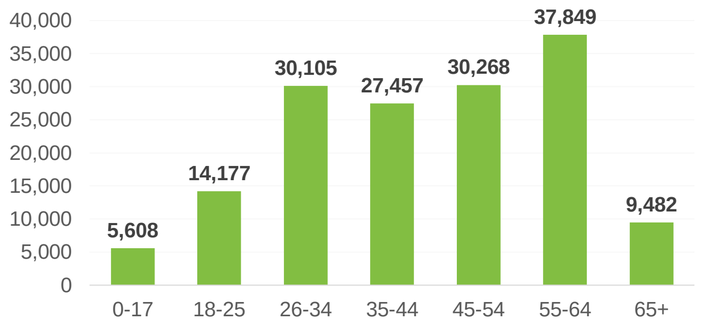
Period is from start of open enrollment Nov. 1 to the end date on report cover.

Total QHP Enrollees

154,946

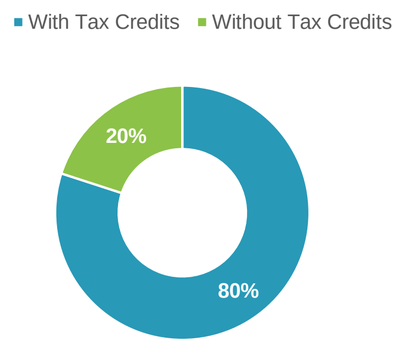


QHP Consumers by Age Group

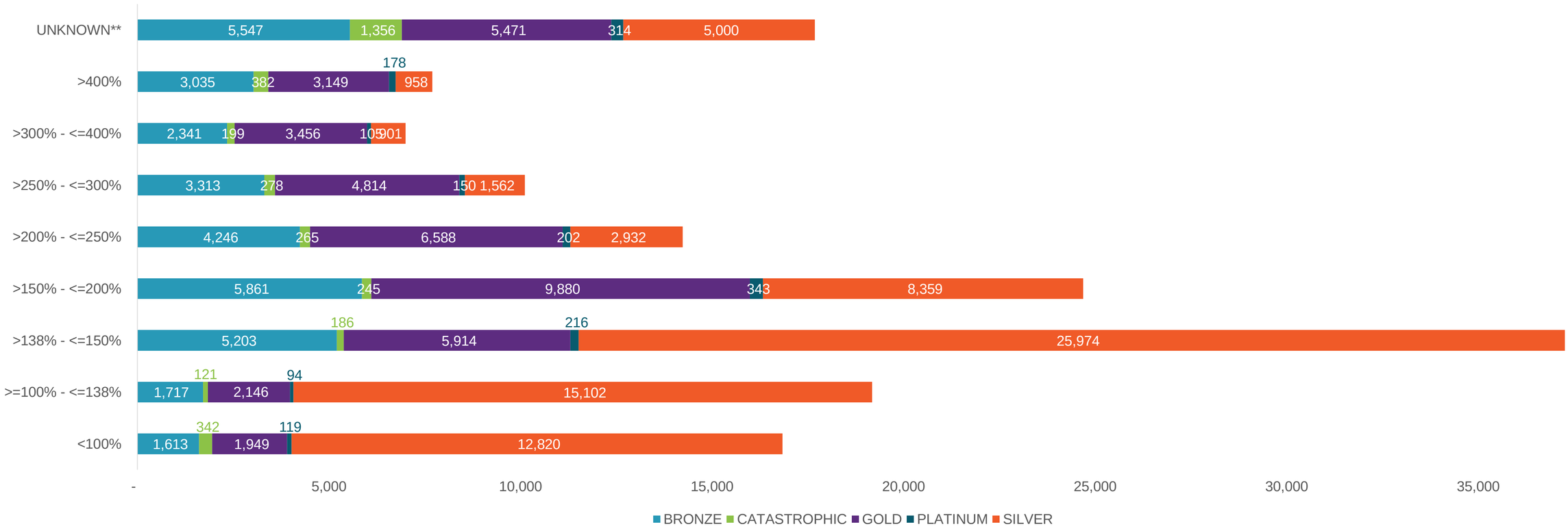


Target Enrollment for 18-34-year-olds:
30%
Current Enrollment for 18-34-year-olds:
29%

Financial Help



QHP Enrollment by Household Income and Metal Level

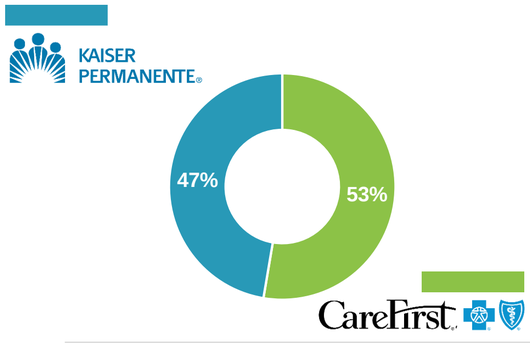


**Enrollees who did not submit household income information and thus were not eligible for financial help.
Household income eligibility based on percentages above the Federal Poverty Level, defined as $12,140 for an individual and $25,100 for a family of four.

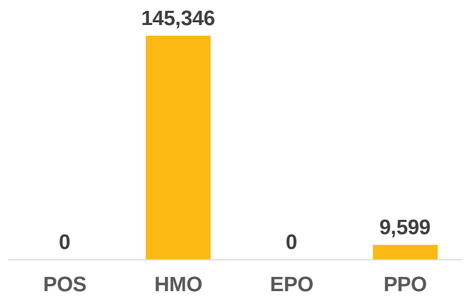
QUALIFIED HEALTH PLANS SELECTIONS

Period is from start of open enrollment Nov. 1 to the end date on report cover.

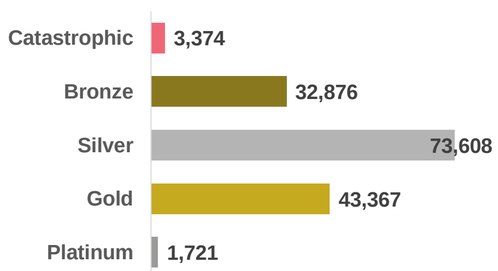
QHP Consumers by Carrier



Enrollment by Plan Type



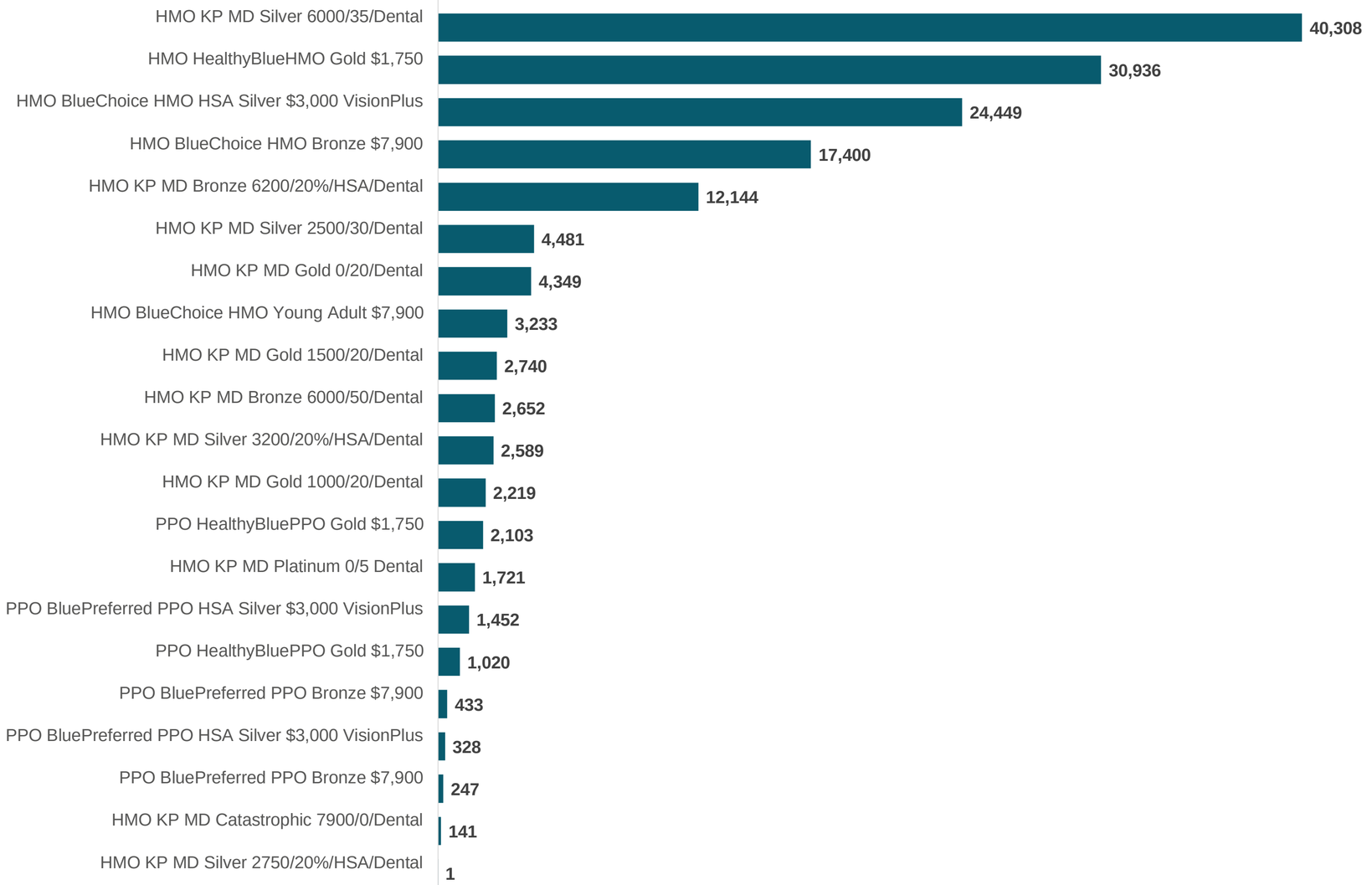
Enrollment by Metal Level



Metal levels (platinum, gold, silver, bronze) differ based on how you and the insurance company share the cost of your care. For example, insurance companies cover 90 cents on the dollar for platinum plans and 60 cents on the dollar for bronze plans. Financial help is only available through silver plans.

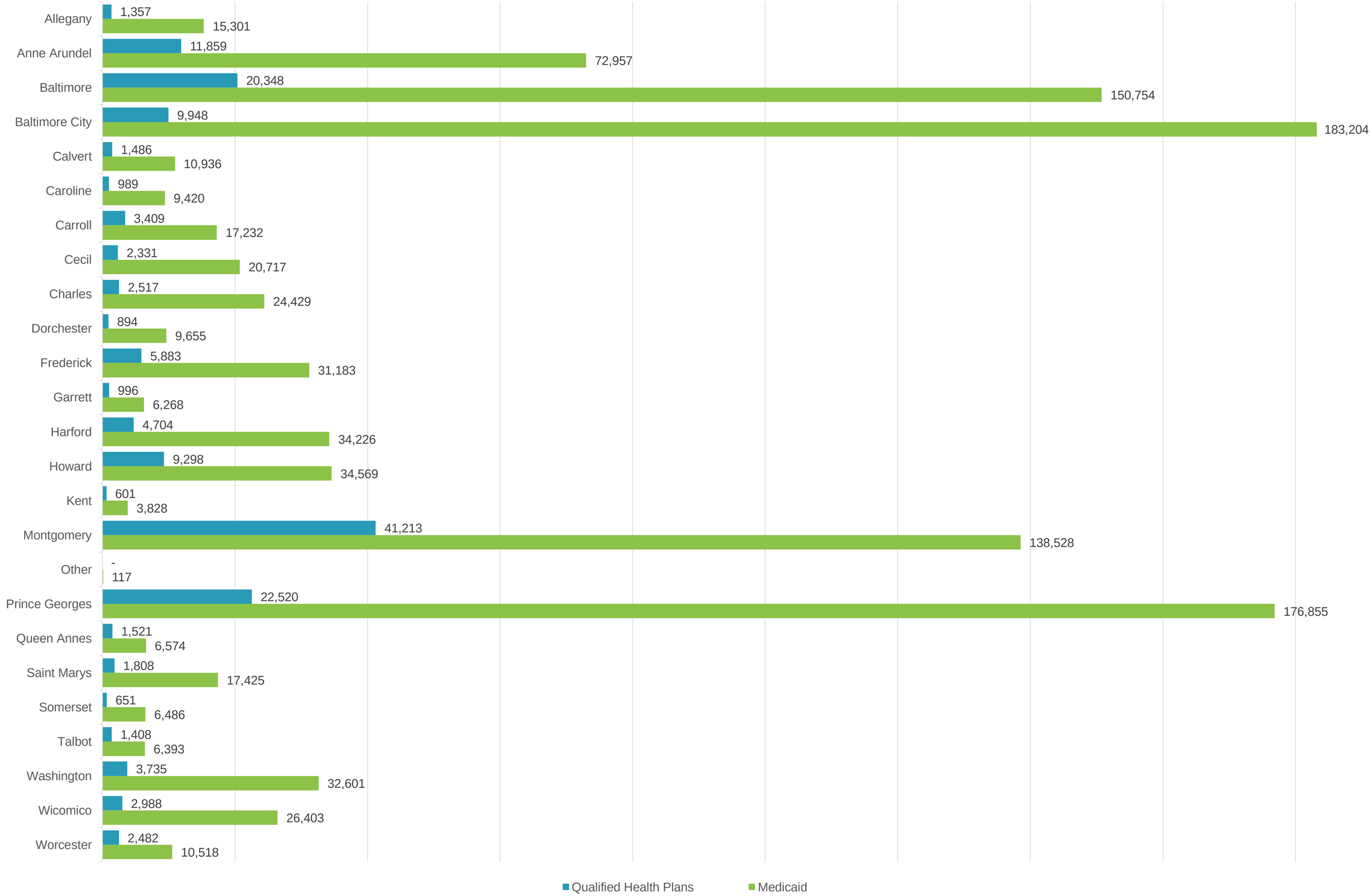
There are also different play types. Some allow you to see almost any doctor or healthcare facility; others limit your choices to a network of doctors and facilities or require you to pay more if you use providers outside the network.

Enrollment by Plan Choice



ENROLLMENT DISTRIBUTION BY COUNTY

Period is from start of open enrollment Nov. 1 to the end date on report cover.



“Other” enrollees may include dependents living out of state and residents of border counties whose mailing addresses may be in the ZIP code of a neighboring state.

QUALIFIED HEALTH PLANS BY COUNTY

Change compares period beginning with start of open enrollment Nov. 1 and ending on end date on the report cover with comparable time frame a year earlier (closest date available +/- 3 days).

Largest Growth by Month

Wicomico

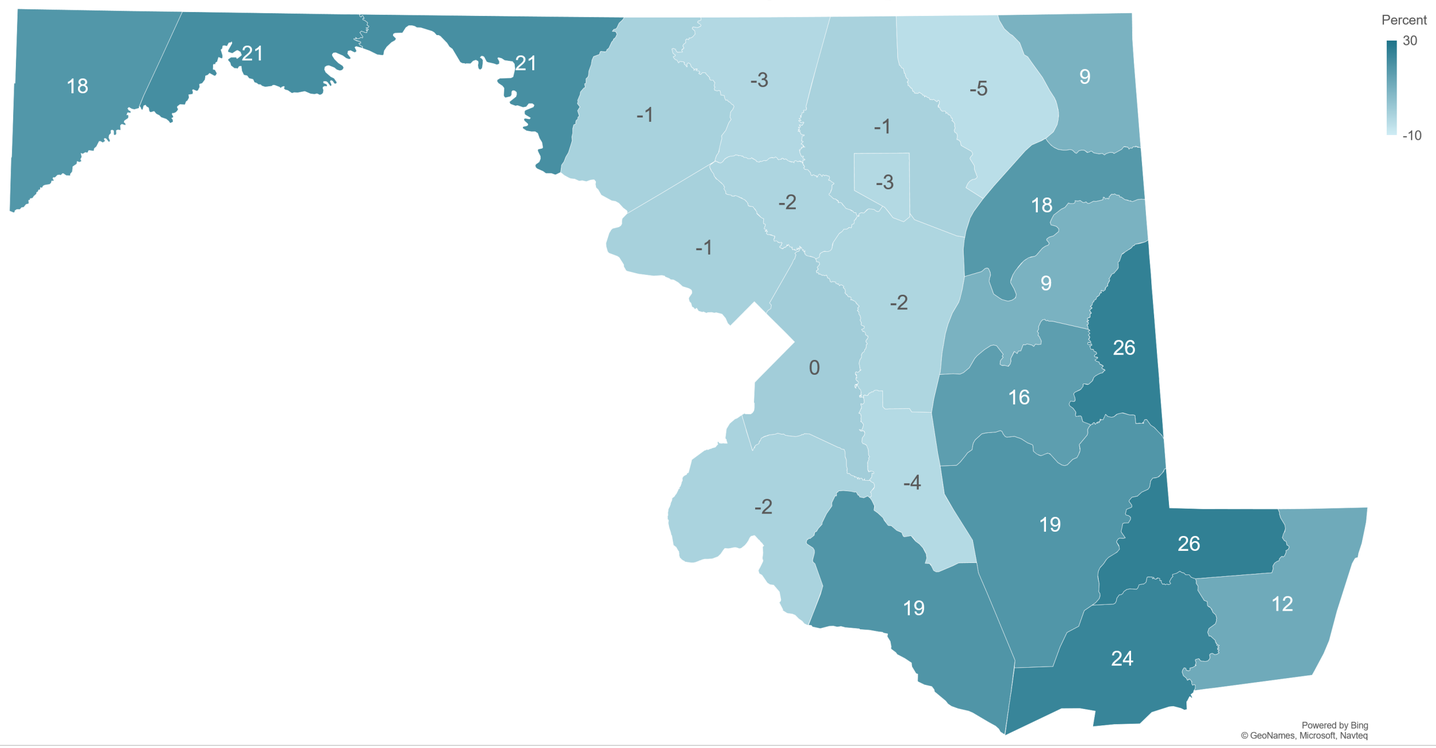
26% change

Smallest Growth by Month

Harford

-5% change

Percent Enrollment Comparison by Month



Largest Growth by Year

Wicomico

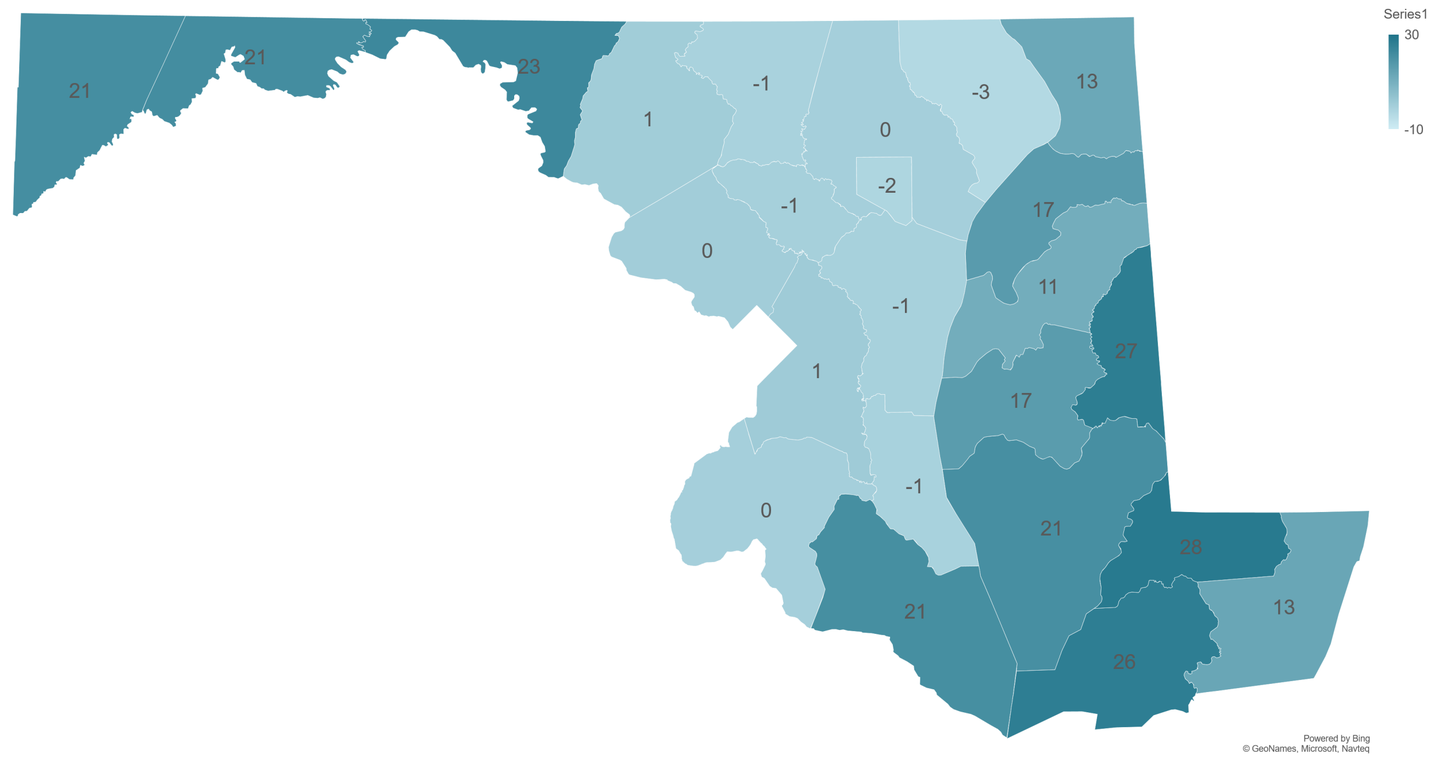
28% change

Smallest Growth by Year

Harford

-3% change

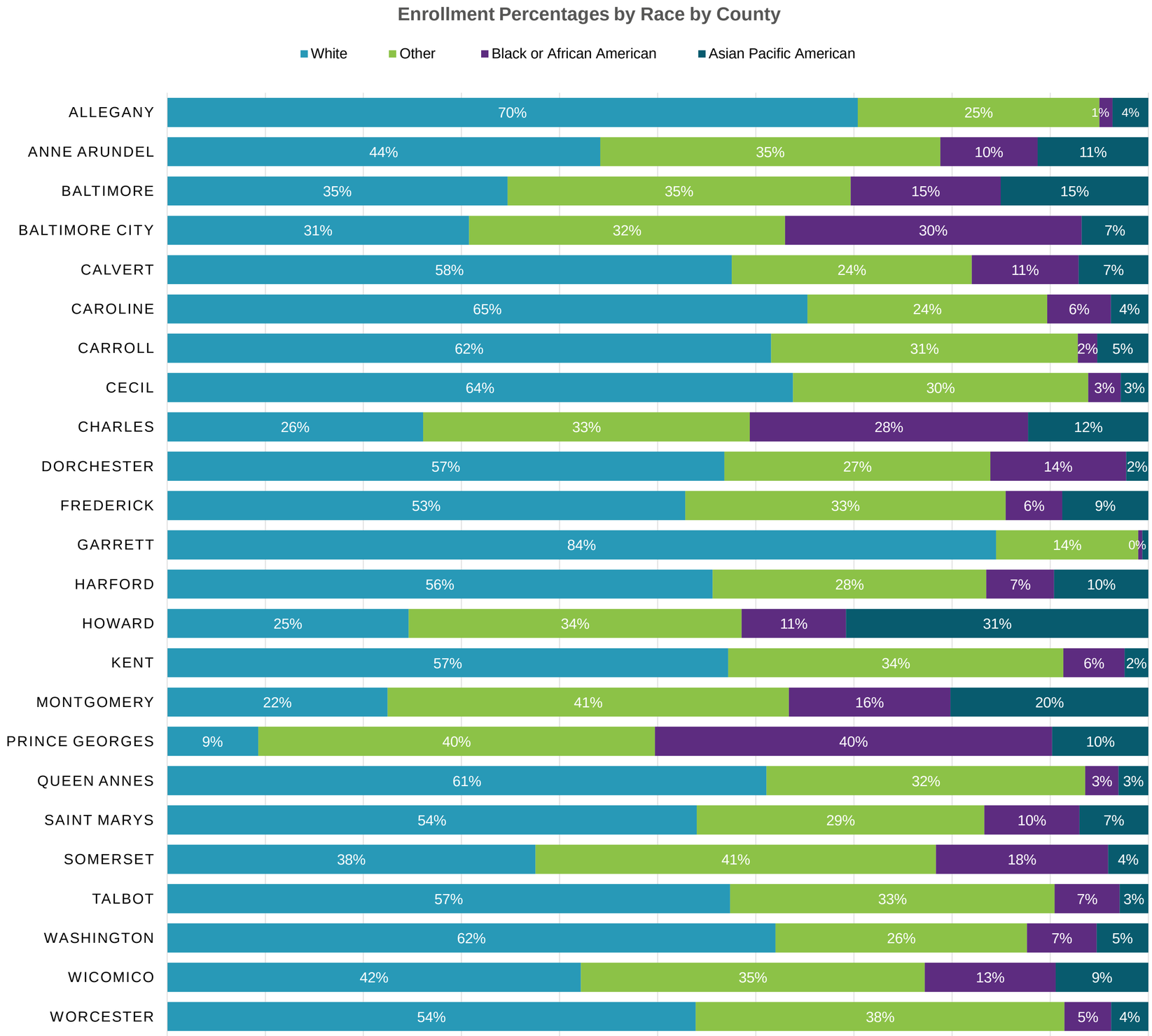
Percent Enrollment Comparison by Year

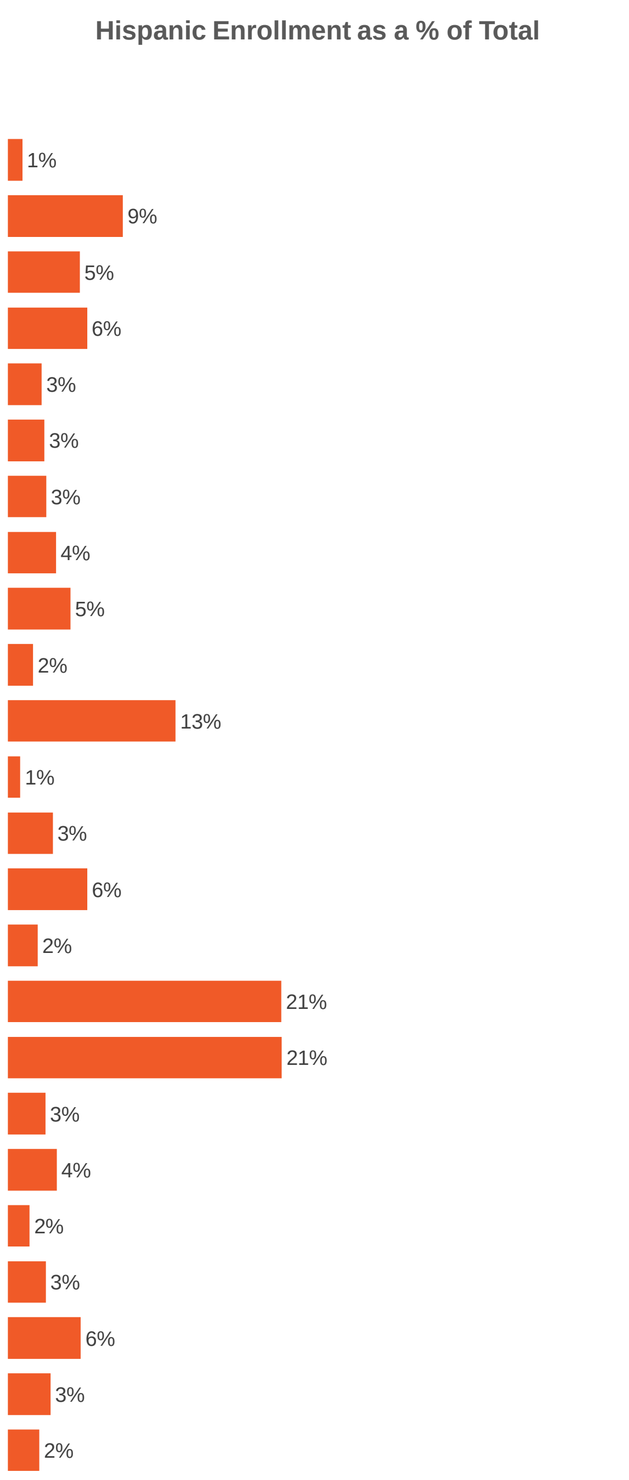


County lines include bodies of water.

QUALIFIED HEALTH PLANS RACE AND ETHNICITY

Period is from start of open enrollment Nov. 1 to the end date on report cover.





Race/ethnicity is reported voluntarily.

Individuals reporting voluntarily as Hispanic by ethnicity are also counted under race as they reported it.

MEDICAID BY COUNTY

Change compares enrollment on DATE OF report cover with one year earlier.

Largest Growth by Month

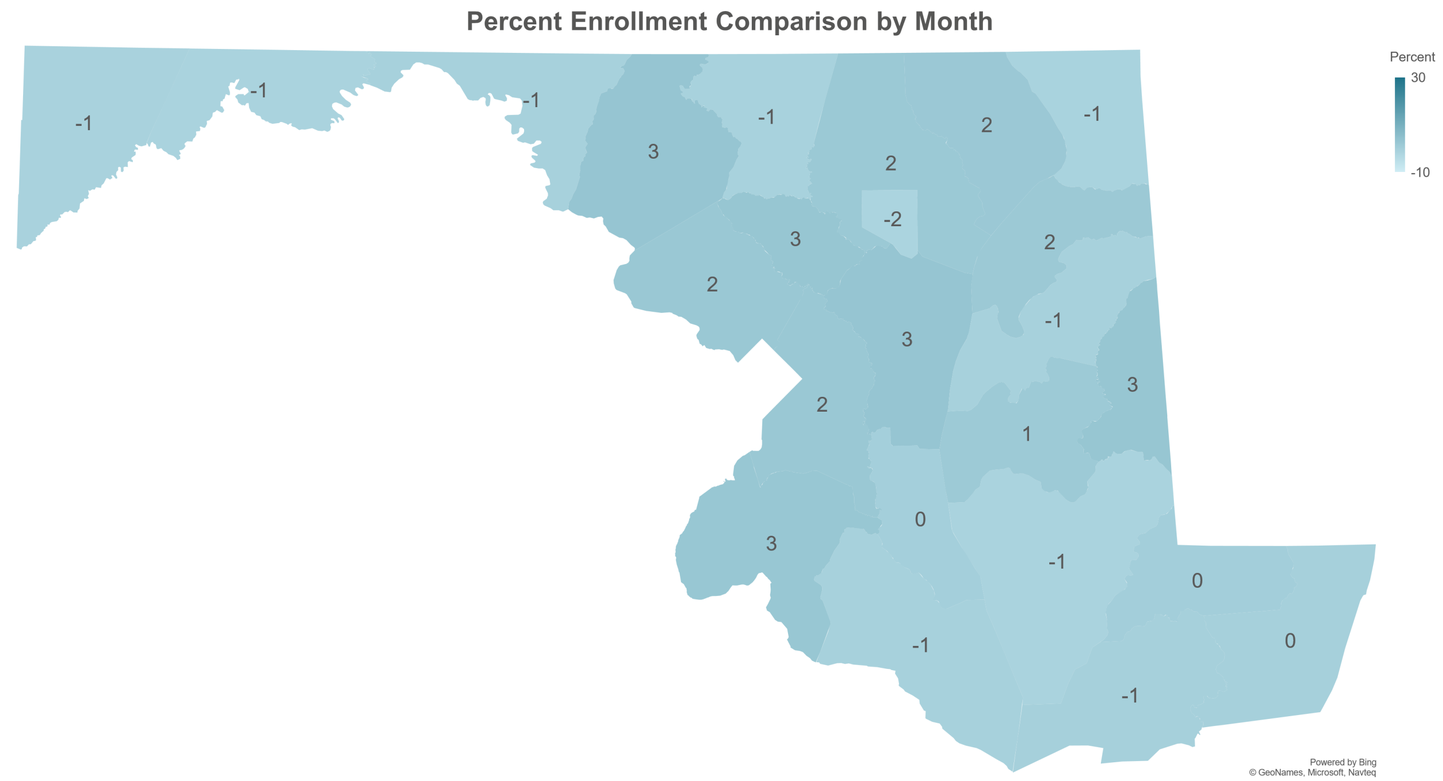
Anne Arundel

3% monthly growth

Smallest Growth by Month

Baltimore Citv

-2% monthly growth



Largest Growth by Year

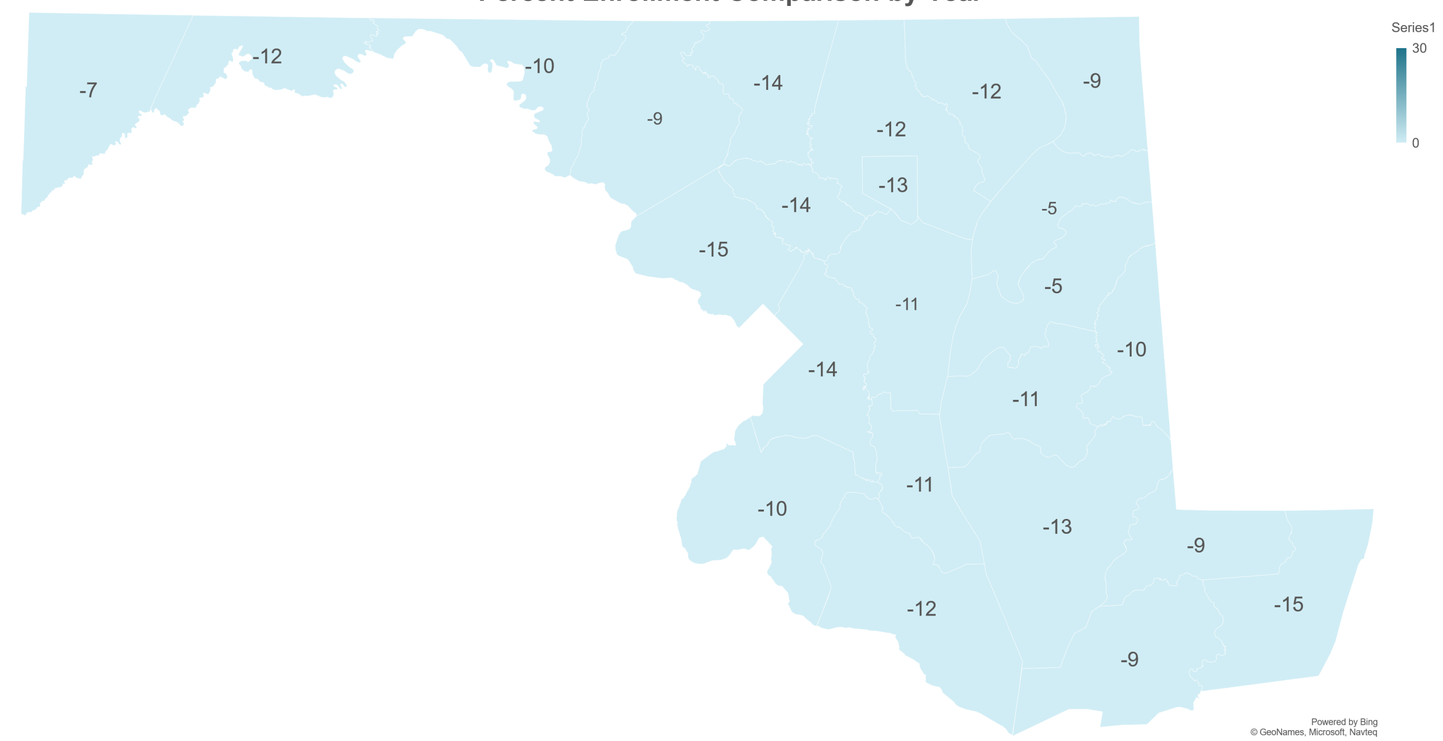
Kent

-5% yearly growth

Smallest Growth by Year:

Worcester

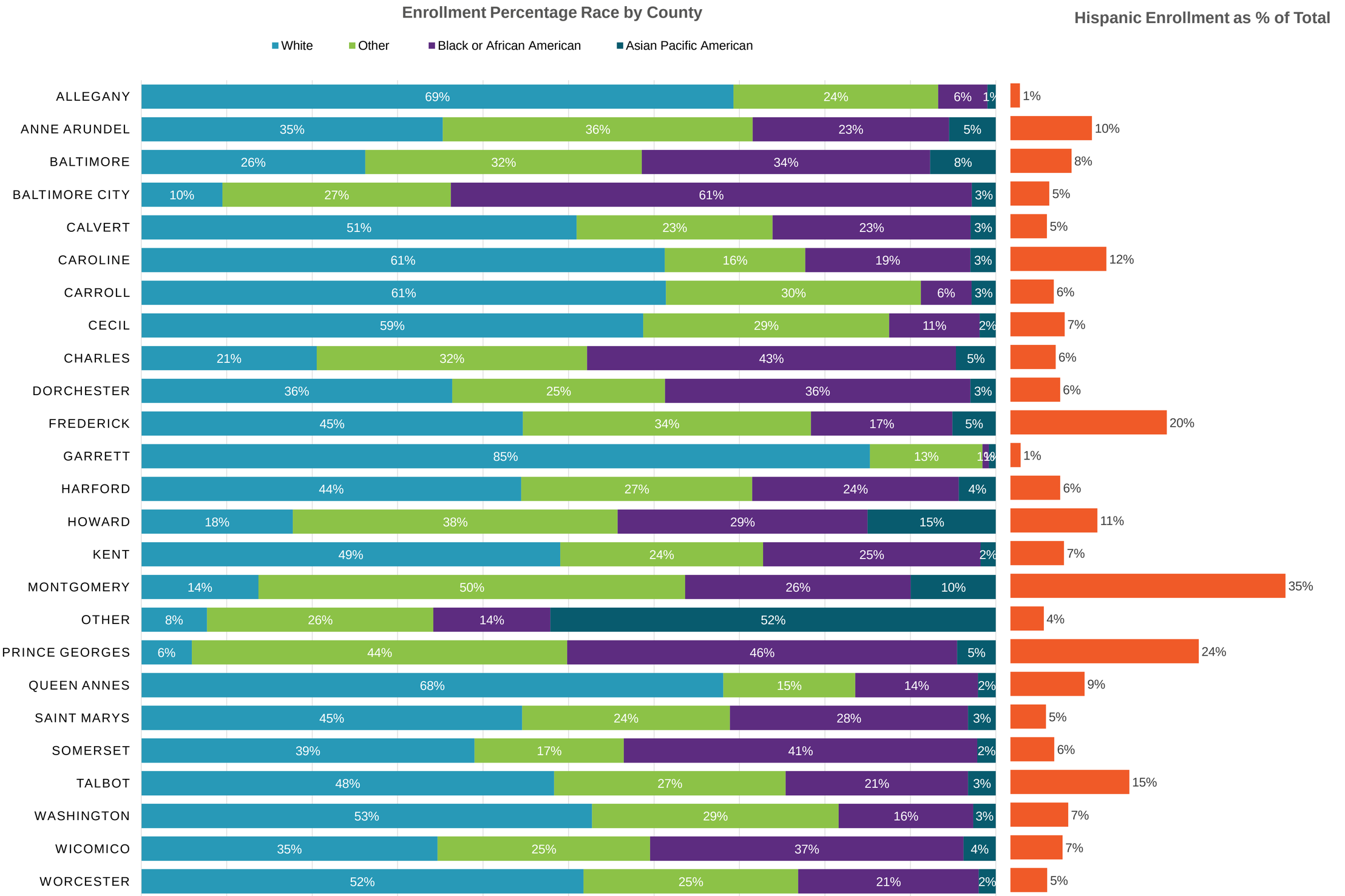
-15% yearly growth



County lines include bodies of water.

MEDICAID RACE AND ETHNICITY

Enrollment as of date on report cover..



Race/ethnicity is reported voluntarily.

Individuals reporting voluntarily as Hispanic by ethnicity are also counted under race as they reported it.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) ENROLLMENT

SHOP enrollments, which continue year-round, are as of Nov 30

aetna℠

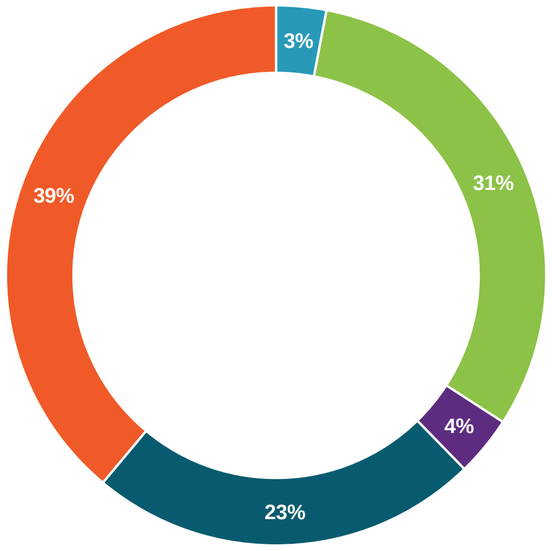
CareFirst BlueCross BlueShield

DOMINION NATIONAL

KAISER PERMANENTE®

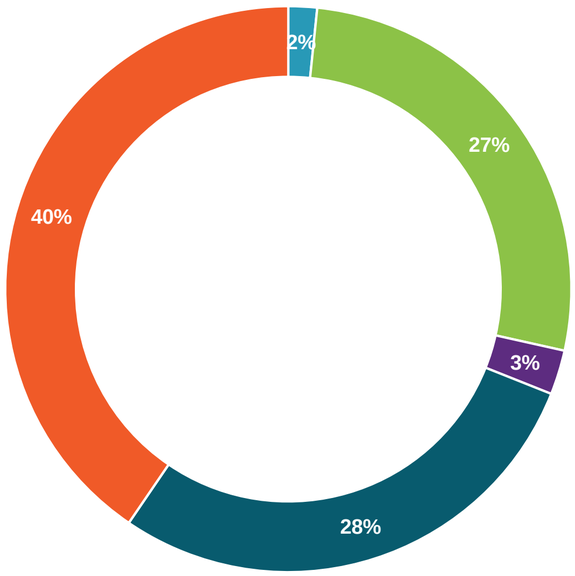
UnitedHealthcare®

SHOP % Employers by Carrier

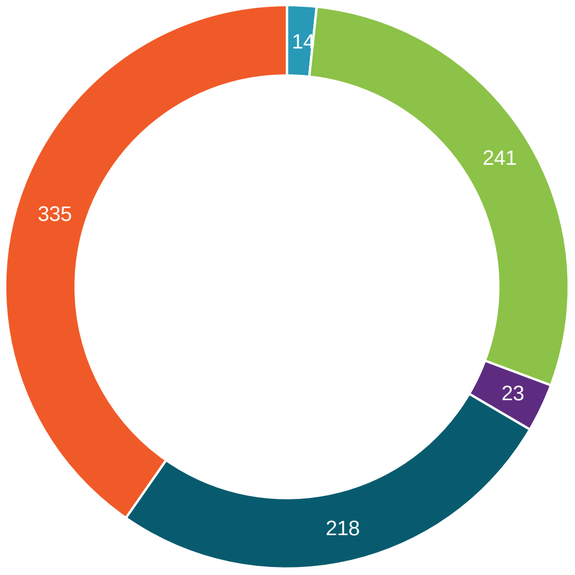


An employer may be enrolled in more than one carrier and dental

SHOP % Employees by Carrier



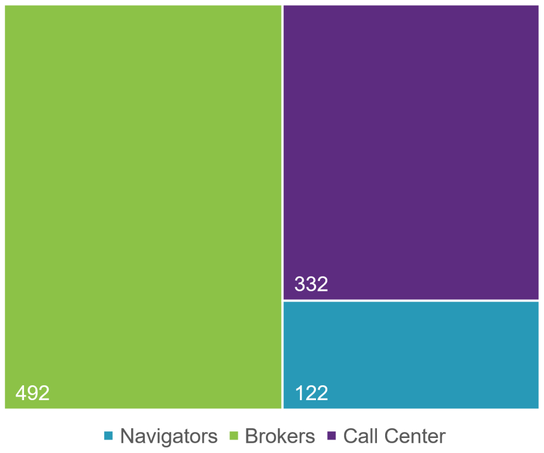
SHOP # Covered Lives by Carrier



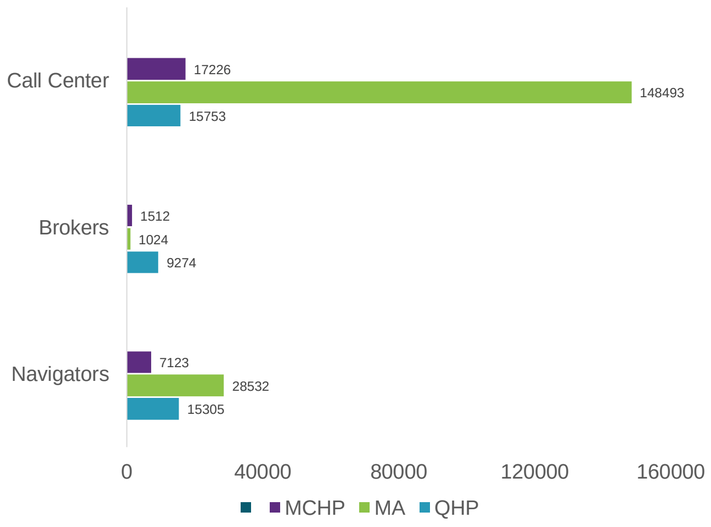
CONSUMER ASSISTANCE

Change compares period from start of open enrollment Nov. 1 to the end date on report cover with comparable time frame a year earlier (closest date available +/- 3 days).

Number of Consumer Assisters



QHP vs. Medicaid vs. CHIP Enrollments by Type of Consumer Assister



Calls Offered

167,159

-27% from previous year.

Average Speed Answer

0:07:0min

- 0:04 from previous year.

Average Hold Time

0:01:2 min

+ 0:00 from previous year.

Calls Handled Time

0:10:45min

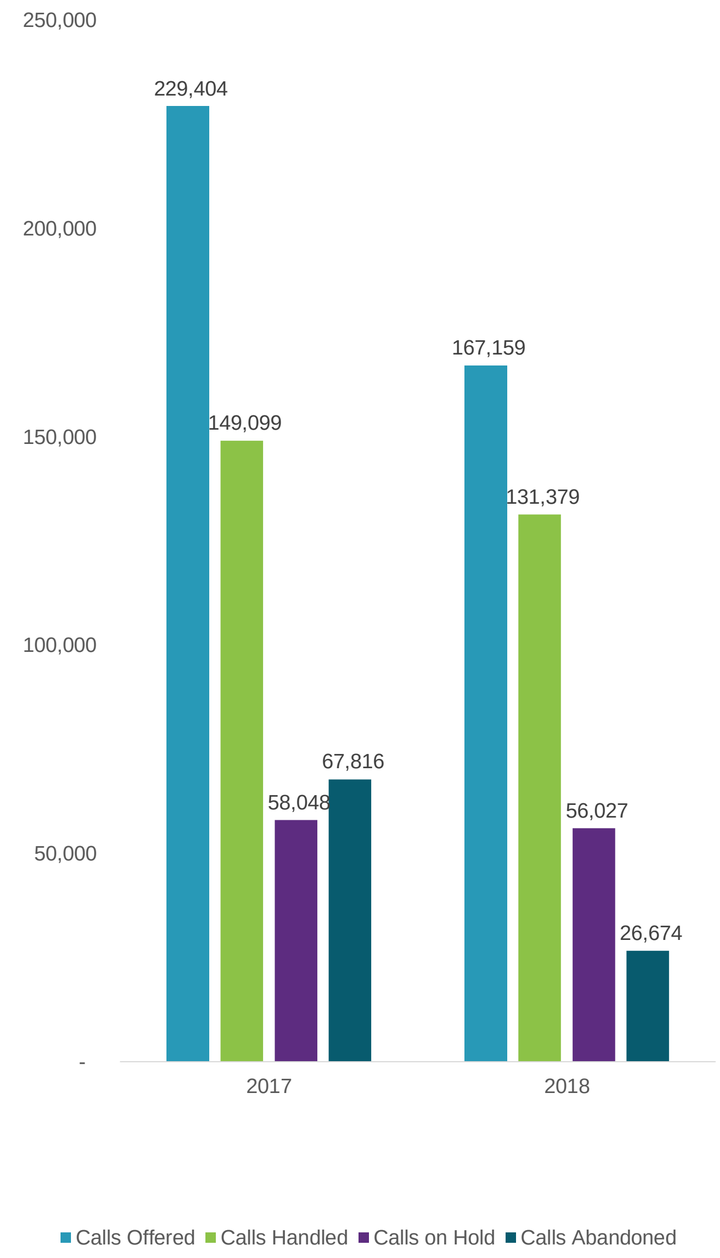
- 0:01 from previous year.

Average Quality Percent Rating

90%

3% from previous year.

Call Center Volumes



WEBSITE AND MOBILE

Period is from start of open enrollment Nov. 1 to the end date on report cover.

Website Visitors

251,001

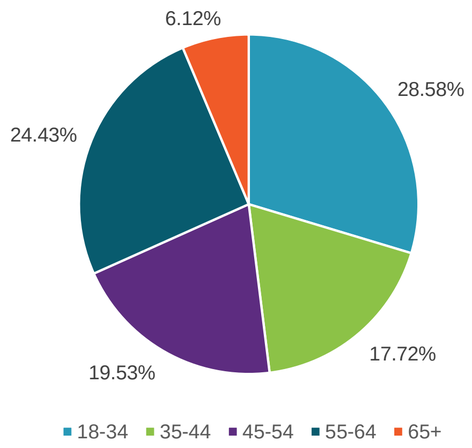
Mobile App Downloads

30,213

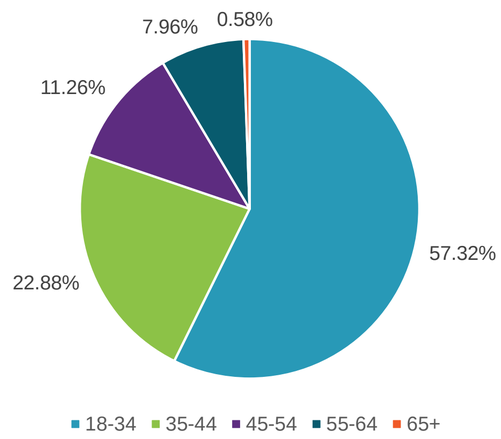
Enrollments Completed By Mobile App

7,814

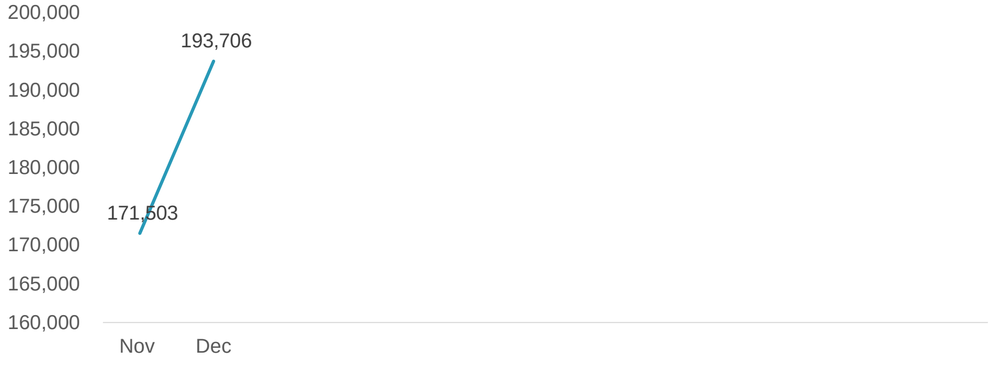
Website Enrollment By Age



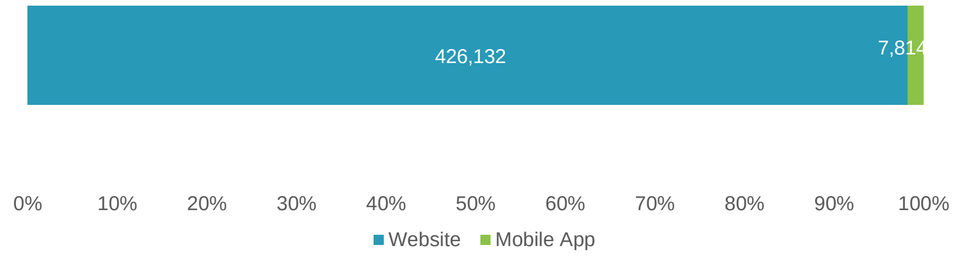
Mobile Enrollment By Age



Unique Website Visitors By Month



Website vs Mobile App Enrollment



Key Substance Use and Mental Health Indicators in the United States:

Results from the 2017 National Survey on Drug Use and Health

Substance Abuse and Mental Health Services Administration

SAMHSA

NSDUH

NATIONAL SURVEY ON DRUG USE AND HEALTH

Key Substance Use and Mental Health Indicators in the United States:
Results from the 2017 National Survey on Drug Use and Health

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Summary

This report summarizes key findings from the 2017 National Survey on Drug Use and Health (NSDUH) for national indicators of substance use and mental health among people aged 12 years old or older in the civilian, noninstitutionalized population of the United States. Results are provided for the overall category of individuals aged 12 or older and by age subgroups. The NSDUH questionnaire underwent a partial redesign in 2015 to improve the quality of the NSDUH data and to address the changing needs of policymakers and researchers. For measures that started a new baseline in 2015 due to this partial redesign, estimates are discussed only for 2017. Trends are provided for some of the estimates that were unaffected by the 2015 partial redesign.

Tobacco Use

In 2017, an estimated 48.7 million people aged 12 or older were current cigarette smokers, including 27.8 million people who were daily cigarette smokers and 11.4 million people who smoked approximately a pack or more of cigarettes per day. Although fewer than 1 in 6 people aged 12 or older were current cigarette smokers, cigarette use generally declined between 2002 and 2017 across all age groups.

Alcohol Use

NSDUH collects information on past month alcohol use, binge alcohol use, and heavy alcohol use. For men, binge alcohol use is defined in NSDUH as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. For women, binge drinking is defined as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days. Heavy alcohol use is defined as binge drinking on 5 or more days in the past 30 days.

In 2017, about 140.6 million Americans aged 12 or older were current alcohol users, 66.6 million were binge drinkers in the past month, and 16.7 million were heavy drinkers in the past month. About 7.4 million underage people aged 12 to 20 drank alcohol in the past month, which represents 1 in 5 individuals aged 12 to 20. About 1 in 8 underage individuals were binge drinkers in the past month. The percentage of underage drinkers in 2017 was lower than the percentages in 2002 through 2014, but it was similar to the percentages in 2015 and 2016.

Illicit Drug Use

In 2017, 30.5 million people aged 12 or older used an illicit drug in the past 30 days (i.e., current use), which corresponds to about 1 in 9 Americans (11.2 percent). About 1 in 4 young adults aged 18 to 25 were current illicit drug users. Regardless of age, the estimates of current illicit drug use for 2017 were driven primarily by marijuana use and the misuse of prescription pain relievers. Among the 30.5 million people aged 12 or older who were current illicit drug users, 26.0 million were current marijuana users and 3.2 million were current misusers of prescription pain relievers. Smaller numbers of people were current users of cocaine, hallucinogens, methamphetamine, inhalants, or heroin or were current misusers of prescription tranquilizers, stimulants, or sedatives.

The percentage of people aged 12 or older who were current marijuana users in 2017 was higher than the percentages in 2002 to 2016. The increase in marijuana use reflects increases in marijuana use among young adults aged 18 to 25 and adults aged 26 or older. Marijuana use among adolescents aged 12 to 17 was lower in 2017 than in most years from 2009 to 2014.

NSDUH also allows for estimation of opioid misuse, which is the use of heroin or the misuse of prescription pain relievers. In 2017, an estimated 11.4 million people misused opioids in the past year, including 11.1 million pain reliever misusers and 886,000 heroin users. Among people aged 12 or older who misused pain relievers in the past year, about 6 out of 10 people indicated that the main reason they misused pain relievers the last time they misused them was to relieve physical pain (62.6 percent), and about half (53.1 percent) obtained the last pain reliever they misused from a friend or relative.

Substance Use Initiation

In 2017, the substances with the largest number of recent (i.e., past year) initiates of use were alcohol (4.9 million new users), marijuana (3.0 million new users), prescription pain relievers (2.0 million new misusers), and cigarettes (1.9 million new users). The number of marijuana initiates aged 12 or older in 2017 was higher than the numbers in 2002 to 2016. For cigarettes, the number of initiates in 2017 was lower than the numbers in most years from 2004 to 2014, but it was similar to the numbers in 2015 and 2016.

Perceived Risk from Substance Use

Although more than 4 out of 5 people aged 12 or older in 2017 perceived great risk of harm from weekly use of cocaine or heroin, about one third of people perceived great risk of harm from weekly marijuana use. In 2017, about 2 out of 3 individuals aged 12 or older perceived great risk from having four or five drinks of alcohol nearly every day, and nearly 3 out of 4 individuals (71.6 percent) perceived great risk from smoking one or more packs of cigarettes per day.

Substance Use Disorders

In 2017, approximately 19.7 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year, including 14.5 million people who had an alcohol use disorder and 7.5 million people who had an illicit drug use disorder.[1] The most common illicit drug use disorder was for marijuana (4.1 million people). An estimated 2.1 million people had an opioid use disorder, which includes 1.7 million people with a prescription pain reliever use disorder and 0.7 million people with a heroin use disorder.

Major Depressive Episode

In 2017, 13.3 percent of adolescents aged 12 to 17 (3.2 million adolescents) and 13.1 percent of young adults aged 18 to 25 (4.4 million) had a major depressive episode (MDE) during the past year.[2] The percentage of adolescents in 2017 who had a past year MDE was higher than the percentages in 2004 to 2014, and the percentage of young adults in 2017 who had a past year MDE was higher than the percentages in 2005 to 2016. In contrast, the percentages of adults aged 26 to 49 and those aged 50 or older in 2017 with a past year MDE were similar to the percentages in most or all years from 2005 to 2016.

[1] People who met the criteria for dependence or abuse for alcohol or illicit drugs in the past 12 months based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), were defined as having an SUD. See the following reference: American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

[2] People who met the criteria for MDE based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), were defined as having an MDE. See the following reference: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5) (5th ed.). Arlington, VA: Author.

Mental Illness among Adults

In 2017, an estimated 46.6 million adults aged 18 or older (18.9 percent) had any mental illness (AMI) in the past year. An estimated 11.2 million adults in the nation had a serious mental illness (SMI) in the past year, representing 4.5 percent of all U.S. adults.[3] The percentage of adults in 2017 with AMI was similar to the percentage in 2016, but it was higher than the percentages in all but 3 years from 2008 to 2015. The percentage of adults in 2017 with SMI was higher than the percentages in most prior years. Percentages of young adults aged 18 to 25 in 2017 who had AMI or SMI were greater than the corresponding percentages in each year from 2008 to 2016.

Co-Occurring MDE and Substance Use among Adolescents

In 2017, the percentage of adolescents aged 12 to 17 who used illicit drugs in the past year was higher among those with a past year MDE than it was among those without a past year MDE (29.3 vs. 14.3 percent). An estimated 345,000 adolescents (1.4 percent of all adolescents) had an SUD and an MDE in the past year.

Co-Occurring Mental Illness and Substance Use Disorders among Adults

An estimated 8.5 million adults aged 18 or older (3.4 percent of all adults) had both AMI and at least one SUD in the past year, and 3.1 million adults (1.3 percent of all adults) had co-occurring SMI and an SUD in the past year.

Suicidal Thoughts and Behavior among Adults

In 2017, an estimated 10.6 million adults aged 18 or older had thought seriously about trying to kill themselves (4.3 percent of adults), 3.2 million had made suicide plans (1.3 percent), and 1.4 million made nonfatal suicide attempts (0.6 percent). The percentage of adults aged 18 or older in 2017 who had serious thoughts of suicide was higher than the percentages in 2008 to 2014, but it was similar to the percentages in 2015 and 2016. The percentage of young adults aged 18 to 25 in 2017 with serious thoughts

[3] Adults with AMI were defined as having any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental disorders and SUDs). Adults with AMI were defined as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. See footnote 1 for the reference for the DSM-IV criteria.

of suicide was higher than in 2008 to 2016. In contrast, the percentages of adults in 2017 who had serious thoughts of suicide were similar to those in most years from 2008 to 2016 for adults aged 26 to 49 and for those aged 50 or older.

Substance Use Treatment

In 2017, an estimated 20.7 million people aged 12 or older needed substance use treatment. This translates to about 1 in 13 people who needed treatment. Among young adults aged 18 to 25, however, about 1 in 7 people needed treatment. For NSDUH, people are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility in the past year.[4]

In 2017, 1.5 percent of people aged 12 or older (4.0 million people) received any substance use treatment in the past year, and 0.9 percent (2.5 million) received substance use treatment at a specialty facility. About 1 in 8 people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year (12.2 percent).

In 2017, among the estimated 18.2 million people aged 12 or older who needed substance use treatment but did not receive specialty treatment in the past year, about 1.0 million perceived they had a need for substance use treatment. About 2 in 5 people who perceived a need for treatment but did not receive treatment at a specialty facility were not ready to stop using, and about 1 in 3 had no health care coverage and were not able to afford the cost.

Treatment for Depression

Among the 3.2 million adolescents and 4.4 million young adults in 2017 who had a past year MDE, 1.3 million adolescents (41.5 percent) and 2.2 million young adults (50.7 percent) received treatment for depression. The percentages of adolescents and young adults in 2017 with a past year MDE who received treatment for their depression were similar to the percentages in most prior years.

[4] Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center.

Mental Health Service Use among Adults

In 2017, an estimated 36.4 million adults aged 18 or older (14.8 percent of adults) received mental health care during the past 12 months. Among the 46.6 million adults with AMI, 19.8 million (42.6 percent) received mental health services in the past year. About 7.5 million of the 11.2 million adults with past year SMI (66.7 percent) received mental health services in the past year. The percentages of adults with AMI or SMI who received mental health care in 2017 were similar to the corresponding percentages in most years from 2008 to 2016.

In 2017, an estimated 13.5 million adults aged 18 or older had a perceived unmet need for mental health care at any time in the past year, including 11.1 million adults with past year AMI and 4.9 million adults with past year SMI. The percentages of adults overall in 2017 and those with AMI who perceived an unmet need for mental health care in the past year were higher than the percentages in most prior years from 2008 to 2016. The percentage of adults in 2017 with SMI who perceived an unmet need for mental health care in the past year was higher than the percentages in most years from 2013 to 2016. In 2017, about 2 out of 5 adults with AMI (44.6 percent) and half of those with SMI (52.5 percent) who perceived an unmet need for mental health services did not receive services because they could not afford the cost of care.

Receipt of Services among Those with Co-Occurring Mental Illness and Substance Use

Among adolescents who had a co-occurring MDE and an SUD in the past year, 62.7 percent received either substance use treatment at a specialty facility or mental health services in the past year. About half of the adults with co-occurring AMI and an SUD in the past year did not receive either mental health care or specialty substance use treatment, and about 1 in 3 adults with co-occurring SMI and an SUD did not receive either type of care.

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Introduction

Substance use and mental health issues affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[1,2,3] The National Survey on Drug Use and Health (NSDUH) is the primary source for statistical information on illicit drug use, alcohol use, substance use disorders (SUDs), and mental health issues for the civilian, noninstitutionalized population of the United States. Information on mental health and substance use allows the Substance Abuse and Mental Health Services Administration (SAMHSA) and other policymakers to gauge progress toward improving the health of the nation.

This report summarizes findings for key substance use and mental health indicators from the 2017 National Survey on Drug Use and Health (NSDUH).

This report contains the first set of findings from the 2017 NSDUH for key substance use and mental health indicators in the United States. Comprehensive 2017 NSDUH detailed tables that show additional substance use and mental health-related outcomes, including data for various subpopulations covered in NSDUH, are available separately at https://www.samhsa.gov/data/.[4]

Survey Background

NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older.[5] The survey is sponsored by SAMHSA within the U.S. Department of Health and Human Services (HHS). The survey covers residents of households and individuals in noninstitutional group quarters (e.g., shelters, boarding houses, college dormitories, migratory workers' camps, halfway houses). The survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals.

NSDUH employs a stratified multistage area probability sample that is designed to be representative of both the nation as a whole and for each of the 50 states and the District of Columbia. The 2017 NSDUH annual target sample size of 67,500 interviews was distributed across three age groups, with 25 percent allocated to adolescents aged 12 to 17, 25 percent allocated to young adults aged 18 to 25, and 50 percent allocated to adults aged 26 or older. From 2002 through 2013, the NSDUH sample was allocated equally across these three age groups. Although the sample design changed in 2014, NSDUH had the same total target sample size per year of 67,500 interviews between 2002 and 2017.[6]

NSDUH is a face-to-face household interview survey that is conducted in two phases: the screening phase and the interview phase. The interviewer conducts a screening of the sampled household with an adult resident (aged 18 or older) in order to determine whether zero, one, or two residents aged 12 or older should be selected for the interview.[7] NSDUH collects data using audio computer-assisted self-interviewing (ACASI) in which respondents read or listen to the questions on headphones, then enter their answers directly into a NSDUH laptop computer. ACASI is designed for accurate reporting of information by providing respondents with a highly private and confidential mode for responding to questions about illicit drug use, mental health, and other sensitive behaviors. NSDUH also uses computer-assisted personal interviewing (CAPI) in which interviewers read less sensitive questions to respondents and enter the respondents' answers into a NSDUH laptop computer.

This report is based on data from 68,032 completed interviews from 2017 NSDUH respondents aged 12 or older.

In 2017, screening was completed at 138,061 addresses, and 68,032 completed interviews were obtained, including 17,033 interviews from adolescents aged 12 to 17 and 50,999 interviews from adults aged 18 or older. Weighted response rates for household screening and for interviewing were 75.1 and 67.1 percent, respectively, for an overall response rate of 50.4 percent for people aged 12 or older. The weighted interview response rates were 75.1 percent for adolescents and 66.3 percent for adults.[8] Further details about the 2017 NSDUH design and methods can be found on the web at https://www.samhsa.gov/data/.[9]

Data Presentation and Interpretation

This report focuses on substance use and mental health in the United States based on NSDUH data from 2017 and earlier years.[10] Estimates of substance use and substance use treatment are presented for individuals aged 12 or older, adolescents, and adults.[11] However, estimates of

mental health issues and mental health service use are not presented jointly for individuals aged 12 or older. Rather, these estimates are presented separately for adolescents aged 12 to 17 and adults aged 18 or older because adolescents and adults completed different sets of questions regarding mental health and mental health service utilization. All estimates (e.g., percentages and numbers) presented in the report are derived from NSDUH survey data that are subject to sampling errors. The estimates have met the criteria for statistical precision. Estimates that do not meet these criteria have been suppressed and are not shown.[12]

One of NSDUH's strengths is the stability in the sample and survey designs. This stability allows for the examination of trends across time. However, the benefit of using NSDUH data to assess trends has to be balanced with the periodic need to revise NSDUH content to address changes in society and emerging issues. Consequently, the NSDUH questionnaire underwent a partial redesign in 2015 to improve the quality of the NSDUH data and to address the changing needs of policymakers and researchers with regard to substance use and mental health issues. New baselines were started in 2015 for estimates that were affected by changes to the 2015 NSDUH questionnaire.[13,14,15]

Trends are presented in this report for estimates from the 2017 NSDUH that are assumed to have remained comparable with estimates from 2016 and prior years.[14,15] All trends that are presented in the report compare 2017 estimates with estimates from 3 or more prior years. When new baselines started in 2015 (e.g., substance use treatment), estimates are discussed only for 2017.[16] Most trend analyses focus on percentages because the percentages take into account any changes in the size of the total population and facilitate the comparison of estimates across years.[17] However, trend analyses for the initiation of substance use focus on the *number* of people who initiated substance use in the past year rather than on percentages. Therefore, care should be taken in interpreting increases over time in the estimated number of past year initiates because some of these increases could reflect growth in the size of the population.

Analyses of trends in this report focus on long-term trends in substance use and mental health issues.

Statistical tests also have been conducted for comparisons that appear in the text of the report. Statistically significant differences are described using terms such as "higher," "lower," "increased," or "decreased." Statements use terms such as "similar," "remained steady," or "stable" when a difference is not statistically significant. Analyses of long-term trends in this report summarize whether the 2017 estimates are different from or similar to estimates in most or all previous years,[18] while minimizing discussion of anomalous differences between any 2 years that can occur due to these estimates being based on samples.[19] Graphics and tables contain estimates that support the majority of statements in this report. For example, supplementary tables of estimates and standard errors are included in Appendix A. In some situations, estimates may be drawn only from the NSDUH detailed tables or from additional data analyses and are not presented in the appendix tables.

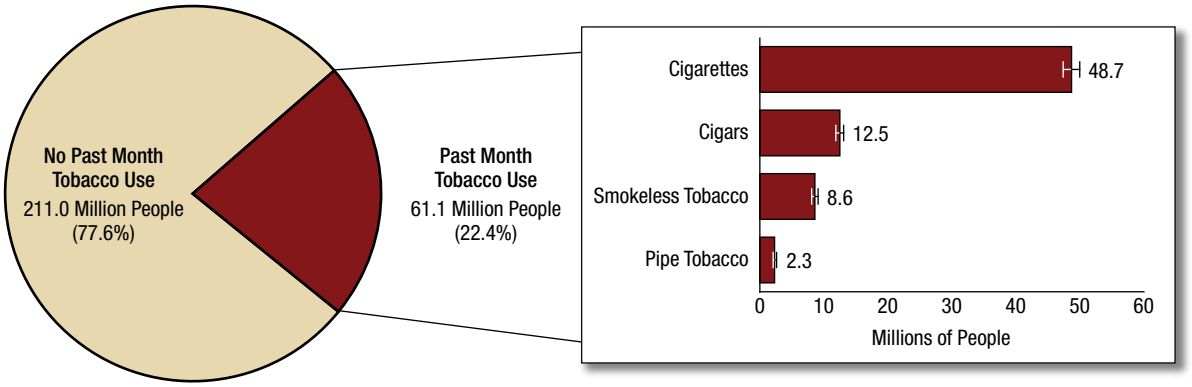
Tobacco Use in the Past Month

NSDUH data can be used not only to estimate the percentage of individuals who currently use tobacco products, but also to monitor changes in tobacco use over time. NSDUH asks respondents aged 12 or older about their tobacco use in the 30 days before the interview. Tobacco products include cigarettes, smokeless tobacco (such as snuff, dip, chewing tobacco, or "snus"), cigars, and pipe tobacco. Cigarette use is defined as smoking "part or all of a cigarette." A discussion of the estimates for daily cigarette smoking follows a presentation of the estimates for any cigarette smoking in the past month.

The majority of the 61.1 million current (i.e., past month) tobacco users in 2017 were current cigarette smokers (Figure 1), as has been the case historically.[20] Specifically, 48.7 million people aged 12 or older in 2017 were current cigarette smokers, 12.5 million people were current cigar smokers, 8.6 million people were current users of smokeless tobacco, and 2.3 million people currently smoked pipe tobacco.

Among current users of any tobacco product who were aged 12 or older, 65.2 percent smoked cigarettes but did not use other tobacco products, 14.6 percent smoked cigarettes and used some other type of tobacco product, and 20.3 percent used other tobacco products but not cigarettes (Table A.5B). This same pattern was observed in 2017 among young adults aged 18 to 25 and adults aged 26 or older, with most current tobacco users smoking only cigarettes. Specifically, more than half of young adults (53.2 percent) and more than two thirds of adults aged 26 or older (68.3 percent) who were current tobacco users smoked only cigarettes in

Figure 1. Numbers of Past Month Tobacco Users among People Aged 12 or Older: 2017



Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of current users of different tobacco products are not mutually exclusive because people could have used more than one type of tobacco product in the past month.

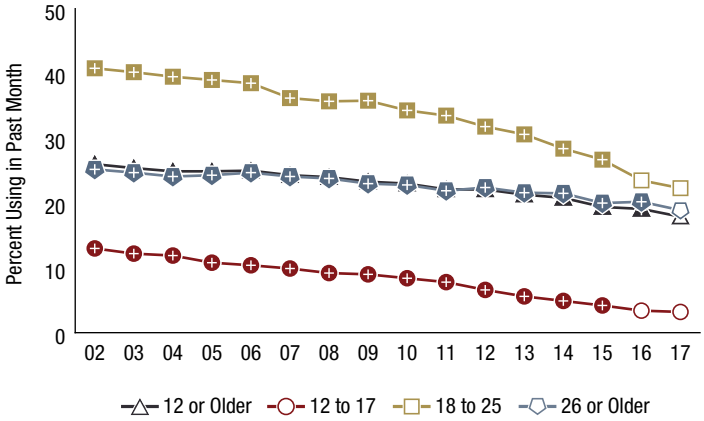
the past month. Among young adults and adults aged 26 or older who were current users of tobacco products, about one fifth did not smoke cigarettes (23.2 and 19.3 percent, respectively). In contrast, among adolescents who were current tobacco users, 35.3 percent used tobacco products other than cigarettes but did not smoke cigarettes. In addition, 29.3 percent of adolescents and 23.5 percent of young adults who were current tobacco users smoked cigarettes and used other tobacco products. Among adults aged 26 or older who were current tobacco users, about 1 in 8 (12.4 percent) were current cigarette smokers and current users of other tobacco products.

The remainder of this section on tobacco use focuses on cigarette smoking because most current tobacco users were cigarette smokers. More information on the use of cigars, pipe tobacco, and smokeless tobacco in the past month can be found in Tables A.1B to A.4B.

Cigarette Use

As noted previously, an estimated 48.7 million people aged 12 or older in 2017 were current cigarette smokers (Figure 1). This number of current cigarette smokers corresponds to 17.9 percent of the population (Figure 2). The percentage of people aged 12 or older who smoked cigarettes in the past month was lower in 2017 than in 2002 to 2016. Stated another way, fewer than 1 in 6 people aged 12 or older in 2017 were current cigarette smokers. In comparison, about 1 in 4 people aged 12 or older were current cigarette smokers in 2002 to 2008 (ranging from 24.0 to 26.0 percent). Although cigarette smoking has declined, some of this decline may reflect the use of electronic vaporizing devices for delivering nicotine, such as e-cigarettes. Future research on both cigarette use and e-cigarette use is needed to continue monitoring these developments; however, NSDUH does not currently ask separate questions about e-cigarette use.

Figure 2. Past Month Cigarette Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 2 Table. Past Month Cigarette Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	26.0+	25.4+	24.9+	24.9+	25.0+	24.3+	24.0+	23.3+	23.0+	22.1+	22.1+	21.3+	20.8+	19.4+	19.1+	17.9
12-17	13.0+	12.2+	11.9+	10.8+	10.4+	9.9+	9.2+	9.0+	8.4+	7.8+	6.6+	5.6+	4.9+	4.2+	3.4	3.2
18-25	40.8+	40.2+	39.5+	39.0+	38.5+	36.2+	35.7+	35.8+	34.3+	33.5+	31.8+	30.6+	28.4+	26.7+	23.5	22.3
≥26	25.2+	24.7+	24.1+	24.3+	24.7+	24.1+	23.8+	23.0+	22.8+	21.9+	22.4+	21.6+	21.5+	20.0+	20.2+	18.9

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Aged 12 to 17

In 2017, 787,000 adolescents aged 12 to 17 smoked cigarettes in the past month. This number of adolescents who were current cigarette smokers represents 3.2 percent of adolescents (Figure 2). The percentage of adolescents who were past month cigarette smokers declined from 13.0 percent in 2002 (or about 1 in 8 adolescents) to 3.2 percent in 2017 (or fewer than 1 in 30). The percentage of adolescents who were current cigarette smokers in 2017 was lower than the percentages in each year from 2002 to 2015, but it was similar to the percentage in 2016.

Aged 18 to 25

Among young adults aged 18 to 25 in 2017, 7.7 million individuals smoked cigarettes in the past month. This number of young adults who were current cigarette smokers represents about one fifth of young adults (22.3 percent) (Figure 2). The percentage of young adults who were current cigarette smokers in 2017 was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016.

Aged 26 or Older

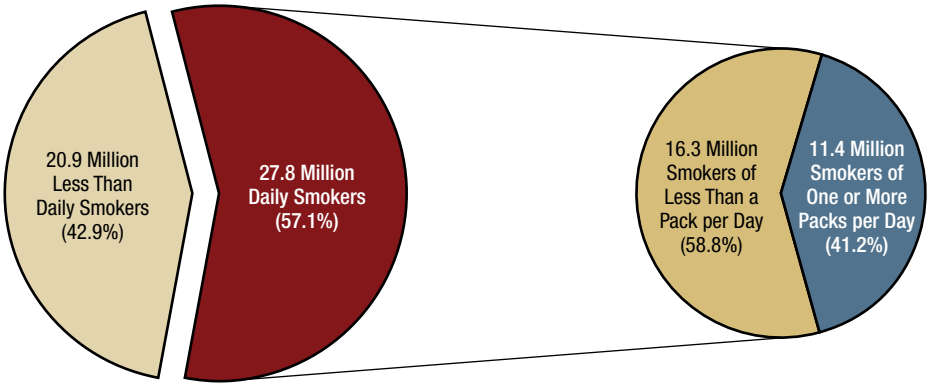
In 2017, 40.3 million adults aged 26 or older smoked cigarettes in the past month. Stated another way, about 1 in 5 adults aged 26 or older (18.9 percent) were current cigarette smokers in 2017 (Figure 2). The 2017 estimate for current cigarette smoking among adults 26 or older was lower than the estimates from 2002 to 2016.

Daily Cigarette Use

Among the 48.7 million current cigarette smokers aged 12 or older in 2017, 27.8 million were daily cigarette smokers. The 27.8 million daily smokers represent 57.1 percent of current cigarette smokers (Figure 3). Thus, nearly three fifths of current cigarette smokers in 2017 smoked cigarettes daily. The percentage of current smokers aged 12 or older in 2017 who smoked cigarettes daily was lower than the percentages in 2002 to 2013, but it was similar to the percentages in 2014 to 2016 (Table 1).

Among the 27.8 million daily smokers aged 12 or older in 2017, 11.4 million smoked 16 or more cigarettes per

Figure 3. Daily Cigarette Use among Past Month Cigarette Smokers Aged 12 or Older and Smoking of One or More Packs of Cigarettes per Day among Current Daily Smokers: 2017



Note: Current daily smokers with unknown data about the number of cigarettes smoked per day were excluded from the pie graph on the right.

Table 1. Daily Cigarette Use among Past Month Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
12 or Older	63.4+	62.9+	62.3+	63.0+	62.3+	61.3+	61.5+	61.0+	59.5+	60.7+	60.7+	59.6+	58.8	58.1	57.9	57.1
12 to 17	31.8+	29.7+	27.6+	25.8+	26.5+	26.4+	22.3+	23.0+	22.5+	22.7+	22.0+	19.4+	24.1+	20.0+	15.0	12.2
18 to 25	51.8+	52.7+	51.6+	50.1+	48.8+	49.2+	47.8+	45.3+	45.8+	45.3+	45.1+	43.1+	43.0+	42.0+	39.9	38.4
26 or Older	68.8+	68.0+	67.8+	68.9+	67.9+	66.3+	67.0+	67.2+	64.8+	66.5+	66.0+	64.9+	63.3	62.7	62.2	61.5

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

day (i.e., approximately one pack or more per day). Stated another way, about 2 out of 5 daily smokers (41.2 percent) smoked a pack or more of cigarettes per day (Figures 3 and 4). The percentage of daily smokers aged 12 or older who smoked one or more packs of cigarettes per day was lower in 2017 than the percentages in 2002 to 2011, but it was similar to the percentages in 2012 to 2016.

Aged 12 to 17

In 2017, about 96,000 adolescents aged 12 to 17 smoked cigarettes every day in the past month. This number corresponds to about 1 in 8 adolescent current smokers (12.2 percent) (Table 1). The 2017 percentage was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016. The percentage of adolescent daily smokers who smoked one or more packs of cigarettes per day was not reported for 2017 due to low precision.

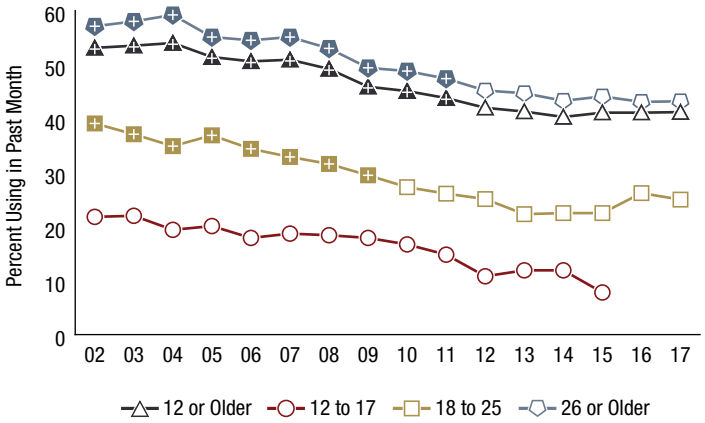
Aged 18 to 25

About 2.9 million young adults aged 18 to 25 in 2017 were daily cigarette smokers in the past month, or 38.4 percent of young adults who were current cigarette smokers (Table 1). Thus, nearly 2 in 5 young adults in 2017 who were current cigarette users smoked cigarettes daily. The percentage of young adult current smokers in 2017 who smoked cigarettes daily was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016. The percentage of young adult daily smokers in 2017 who smoked one or more packs of cigarettes per day (25.0 percent) was lower than the percentages in 2002 to 2009, but it was similar to the percentages in 2010 to 2016 (Figure 4).

Aged 26 or Older

In 2017, about 24.8 million adults aged 26 or older smoked cigarettes every day in the past month, which represents 61.5 percent of the adults aged 26 or older who were current smokers (Table 1). The percentage of current smokers aged 26 or older in 2017 who smoked cigarettes every day was lower than the percentages in 2002 to 2013, but it was similar to the percentages in 2014 to 2016. Despite the decline since 2002, when nearly 70 percent of current smokers aged 26 or older were daily smokers, about three fifths of current smokers in this age group in 2017 were daily smokers. Among daily smokers aged 26 or older, the percentage in 2017 who smoked one or more packs of cigarettes per day (43.2 percent) was lower than in 2002 to 2011. However, the percentage was stable between 2012 and 2017 (Figure 4).

Figure 4. Smokers of One or More Packs of Cigarettes per Day among Past Month Daily Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 4 Table. Smokers of One or More Packs of Cigarettes per Day among Past Month Daily Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	53.1+	53.5+	54.0+	51.4+	50.6+	50.9+	49.2+	45.9+	45.1+	43.8+	42.0	41.3	40.3	41.1	41.1	41.2
12-17	21.8	22.0	19.4	20.1	17.9	18.7	18.4	17.9	16.7	14.8	10.8	11.9	11.9	7.8	*	*
18-25	39.1+	37.1+	34.9+	36.9+	34.4+	32.9+	31.6+	29.5+	27.3	26.1	25.1	22.3	22.5	22.5	26.2	25.0
≥26	57.1+	58.0+	59.2+	55.1+	54.5+	55.1+	53.0+	49.4+	48.8+	47.4+	45.2	44.7	43.3	44.1	43.1	43.2

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.
* Low precision; no estimate reported.

Alcohol Use in the Past Month

NSDUH asks respondents aged 12 or older about their alcohol use in the 30 days before the interview. Current alcohol use is defined as any use of alcohol in the past 30 days. In addition to asking about any alcohol use, NSDUH collects information on binge alcohol use and heavy alcohol use. Until the 2015 NSDUH, the threshold for binge drinking was defined the same for males and females. Consistent with federal definitions[21] and other federal data collections, the NSDUH definition for binge alcohol use since 2015 differs for males and females. Binge drinking for males is defined as drinking five or more drinks[22] on the same occasion on at least 1 day in the past 30 days, which is unchanged from the threshold prior to 2015. Since 2015, binge alcohol use for females has been defined as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days. Heavy alcohol use is defined as binge drinking on 5 or more days in the past 30 days based on the thresholds that were described previously for males and females.

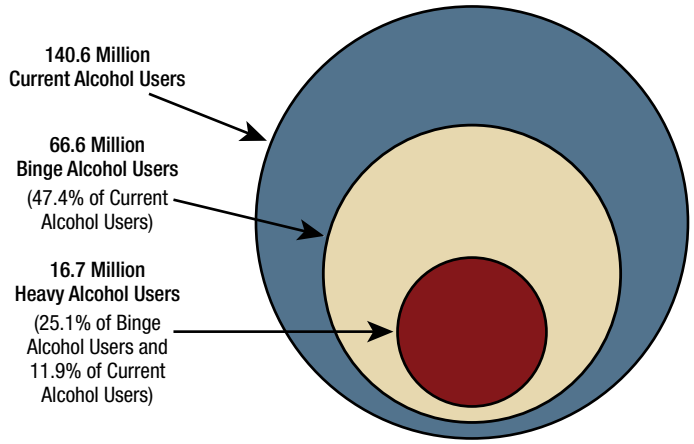
Any alcohol use, binge drinking, and heavy drinking are not mutually exclusive categories of use; heavy use is included in estimates of binge and current use, and binge use is included in estimates of current use (Figure 5). Because of the 2015 changes to the definition of binge alcohol use in NSDUH, estimates of past month binge and heavy alcohol use in 2017 are not comparable with estimates prior to 2015. Therefore, estimates of binge and heavy alcohol use are presented in this report only for 2017.[23]

In 2017, 140.6 million Americans aged 12 or older were current alcohol users, 66.6 million were binge drinkers in the past month, and 16.7 million were heavy drinkers in the past month (Figure 5). Thus, nearly half of current alcohol users were binge drinkers (47.4 percent), and 1 in 8 current alcohol users were heavy drinkers (11.9 percent). Among binge drinkers, about 1 in 4 (25.1 percent) were heavy drinkers.[24]

Any Alcohol Use

The 140.6 million current alcohol users aged 12 or older in 2017 (Figure 5) correspond to alcohol use in the past month by slightly more than half (51.7 percent) of people aged 12 or older (Figure 6). The 2017 estimate of past month alcohol use was similar to the estimates in most years between 2005 and 2015, but it was higher than the estimate in 2016 (50.7 percent).

Figure 5. Current, Binge, and Heavy Alcohol Use among People Aged 12 or Older: 2017



Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

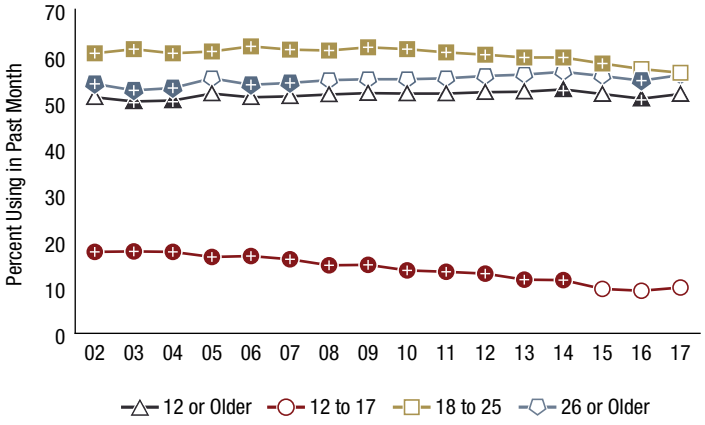
Aged 12 to 17

An estimated 9.9 percent of adolescents aged 12 to 17 in 2017 were current alcohol users (Figure 6), which corresponds to 2.5 million adolescents who drank alcohol in the past month. The percentage of adolescents who were current alcohol users in 2017 was lower than the percentages in 2002 through 2014, but it was similar to the percentages in 2015 and 2016. Although the estimate of current alcohol use among adolescents decreased between 2002 and 2017, about 1 in 10 adolescents were current alcohol users in 2017.

Aged 18 to 25

In 2017, 56.3 percent of young adults aged 18 to 25 were current alcohol users (Figure 6), which corresponds to about 19.3 million young adults. The percentage of young adults in 2017 who drank alcohol in the past month was similar to the percentage in 2016. Although the 2017 estimate was lower than the estimates in 2002 through 2015, more than half of young adults were current alcohol users in each year between 2002 and 2017 (ranging from 56.3 to 62.0 percent).

Figure 6. Past Month Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 6 Table. Past Month Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	51.0	50.1+	50.3+	51.8	51.0	51.2	51.6	51.9	51.8	51.8	52.1	52.2	52.7+	51.7	50.7+	51.7
12-17	17.6+	17.7+	17.6+	16.5+	16.7+	16.0+	14.7+	14.8+	13.6+	13.3+	12.9+	11.6+	11.5+	9.6	9.2	9.9
18-25	60.5+	61.4+	60.5+	60.9+	62.0+	61.3+	61.1+	61.8+	61.4+	60.7+	60.2+	59.6+	59.6+	58.3+	57.1	56.3
≥26	53.9+	52.5+	53.0+	55.1	53.7+	54.1+	54.7	54.9	54.9	55.1	55.6	55.9	56.5	55.6	54.6+	55.8

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

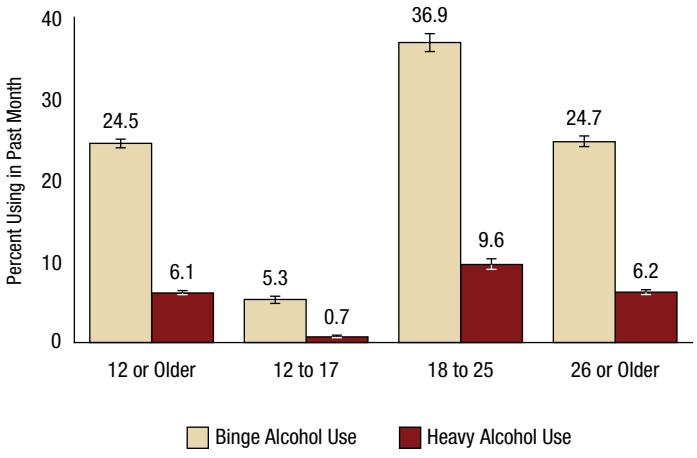
Aged 26 or Older

More than half of adults aged 26 or older in 2017 (55.8 percent) were current alcohol users (Figure 6). This percentage corresponds to about 118.8 million adults in this age group who drank alcohol in the past month. The percentage of adults aged 26 or older in 2017 who were current alcohol users was similar to the percentages in 2008 to 2015, but it was higher than the percentage in 2016 (54.6 percent). In each year between 2002 and 2017, slightly more than half of adults aged 26 or older were current alcohol users (ranging from 52.5 to 56.5 percent).

Binge Alcohol Use

In 2017, about 1 in 4 people aged 12 or older (24.5 percent) were current binge alcohol users (Figure 7). This percentage corresponds to about 66.6 million binge drinkers who were aged 12 or older (Figure 5). About 1.3 million adolescents aged 12 to 17 were past month binge drinkers, which corresponds to 5.3 percent of adolescents. Thus, about 1 in 20 adolescents aged 12 to 17 in 2017 were current binge drinkers. An estimated 36.9 percent of young adults aged 18 to 25 were binge drinkers in the past month, which corresponds to about 12.7 million young adults. Stated another way, more than a third of young adults in 2017 were current binge drinkers. About a quarter (24.7 percent) of adults aged 26 or older were current binge drinkers. This percentage corresponds to about 52.7 million adults in this age group who were binge drinkers.

Figure 7. Past Month Binge and Heavy Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2017



Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

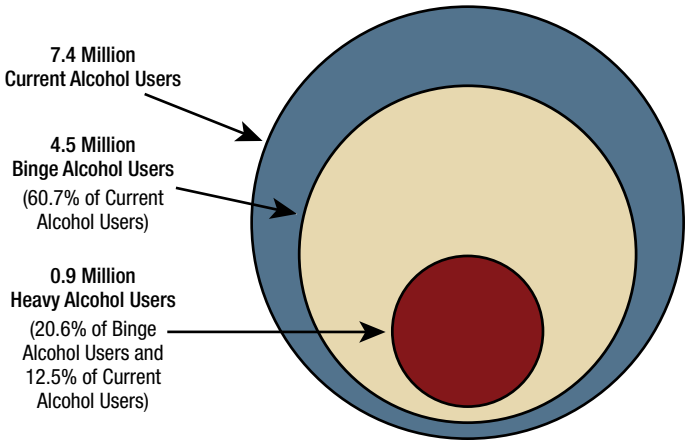
Heavy Alcohol Use

An estimated 16.7 million people aged 12 or older in 2017 who were heavy alcohol users in the past month (Figure 5), which represents 6.1 percent of the population aged 12 or older (Figure 7). In 2017, 174,000 adolescents aged 12 to 17 were current heavy drinkers. Stated another way, about 1 out of 140 adolescents (0.7 percent) engaged in binge drinking on 5 or more days in the past 30 days. About 1 out of every 10 young adults aged 18 to 25 (9.6 percent) were current heavy alcohol drinkers. This percentage corresponds to 3.3 million young adults who engaged in heavy drinking in the past month. An estimated 6.2 percent of adults aged 26 or older in 2017 were current heavy drinkers. This percentage corresponds to about 13.2 million adults aged 26 or older who engaged in heavy drinking in the past month.

Underage Alcohol Use

All 50 states and the District of Columbia currently prohibit the possession of alcoholic beverages by individuals younger than 21, and most prohibit underage consumption (i.e., consumption of alcoholic beverages prior to the age of 21).[25] In 2017, about 7.4 million people aged 12 to 20 drank alcohol in the past month, including 4.5 million who were binge drinkers and 932,000 who were heavy drinkers (Figure 8). Thus, about three fifths of underage current alcohol users (60.7 percent) were binge drinkers, and about 1 in 8 were heavy drinkers (12.5 percent). About one fifth of underage binge drinkers (20.6 percent) were heavy drinkers.[24]

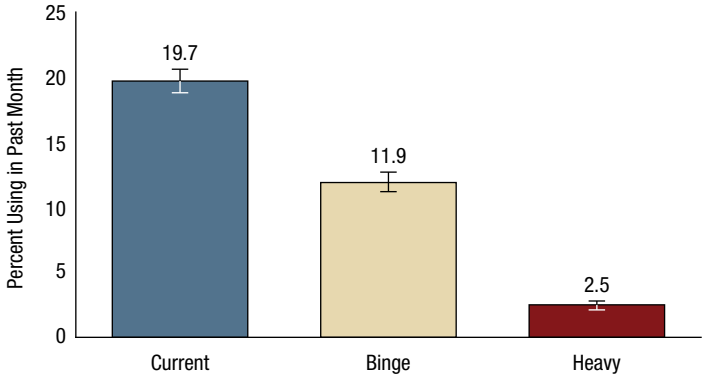
Figure 8. Current, Binge, and Heavy Alcohol Use among People Aged 12 to 20: 2017



Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

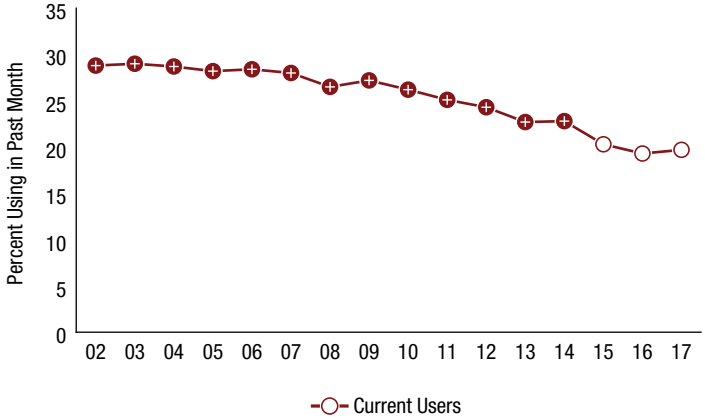
The estimate of 7.4 million underage people in 2017 who were current alcohol users represents 19.7 percent of 12 to 20 year olds (Figure 9). Among people aged 12 to 20 in 2017, 11.9 percent were binge drinkers, and 2.5 percent were heavy drinkers. The percentage of underage individuals who were current alcohol users in 2017 was lower than the percentages in 2002 through 2014, but it was similar to the percentages in 2015 and 2016 (Figure 10). Despite these declines over time, about 1 in 5 individuals aged 12 to 20 in 2017 drank alcohol in the past month.

Figure 9. Current, Binge, and Heavy Alcohol Use among People Aged 12 to 20: Percentages, 2017



Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

Figure 10. Current Alcohol Use among People Aged 12 to 20: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 10 Table. Current Alcohol Use among People Aged 12 to 20: Percentages, 2002-2017

Use	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
Current	28.8+	29.0+	28.7+	28.2+	28.4+	28.0+	26.5+	27.2+	26.2+	25.1+	24.3+	22.7+	22.8+	20.3	19.3	19.7

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Illicit Drug Use in the Past Month

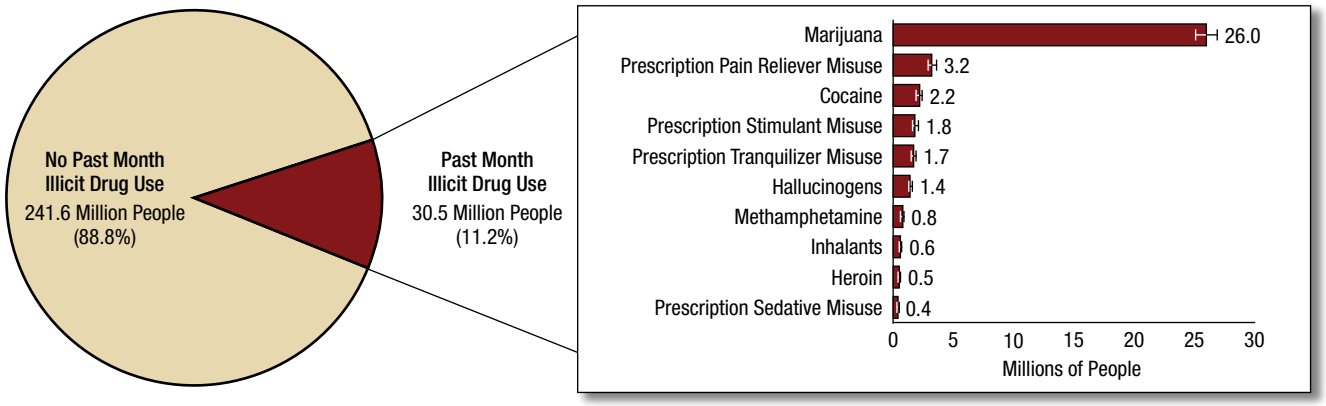
NSDUH obtains information on 10 categories of illicit drugs: marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives (see the section on the misuse of psychotherapeutic drugs for the definition of misuse). Estimates of "illicit drug use" reported from NSDUH reflect the data from these 10 drug categories. Because of changes in measurement in 2015 for 7 of the 10 illicit drug categories—hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives—estimates of use of any illicit drug and these 7 illicit drug categories in 2017 are not comparable with estimates prior to 2015. This report also describes the misuse of opioids in the past year (e.g., the misuse of prescription pain relievers or the use of heroin) in a later section.[26]

In 2017, an estimated 30.5 million Americans aged 12 or older were current illicit drug users, meaning that they had used an illicit drug in the past month (Figure 11). The most commonly used illicit drug in the past month was marijuana, which was used by 26.0 million people aged 12 or older. The second most common type of illicit drug use in the United States was the misuse of prescription pain relievers by an estimated 3.2 million people in the past month. Smaller numbers of people were current users of the other illicit drugs, as shown in Figure 11.[27]

Any Illicit Drug Use

The estimated 30.5 million people aged 12 or older who were current illicit drug users in 2017 represent 11.2 percent of the population aged 12 or older (Figures 11 and 12). Stated another way, 1 in 9 individuals aged 12 or older in the United States used illicit drugs in the past month. Approximately 2.0 million adolescents aged 12 to 17 in 2017 were current users of illicit drugs, which represents 7.9 percent of adolescents. Approximately 1 in 4 young adults aged 18 to 25 (24.2 percent) were current users of illicit drugs in 2017. This percentage corresponds to about 8.3 million young adults who were current users of illicit drugs. An estimated 9.5 percent of adults aged 26 or older were current users of illicit drugs, or about 20.2 million adults in this age group.

Figure 11. Numbers of Past Month Illicit Drug Users among People Aged 12 or Older: 2017



Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used or misused more than one type of illicit drug in the past month.

Marijuana Use

As noted in the illicit drug use section, an estimated 26.0 million Americans aged 12 or older in 2017 were current users of marijuana (Figure 11). This number of past month marijuana users corresponds to 9.6 percent of the population aged 12 or older (Figure 13). The percentage of people aged 12 or older who were current marijuana users in 2017 was higher than the percentages from 2002 to 2016. This increase in marijuana use among people aged 12 or older reflects increases in marijuana use among both young adults aged 18 to 25 and adults aged 26 or older.

Aged 12 to 17

In 2017, 6.5 percent of adolescents aged 12 to 17 were current users of marijuana (Figure 13). This means that approximately 1.6 million adolescents used marijuana in the past month. The percentage of adolescents in 2017 who were current marijuana users was lower than the percentages in most years from 2009 to 2014, but it was similar to the percentages in 2015 and 2016.

Figure 12. Past Month Illicit Drug Use among People Aged 12 or Older, by Age Group: 2017

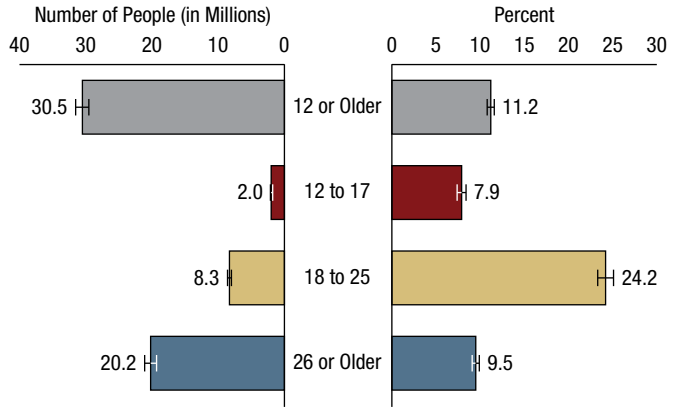
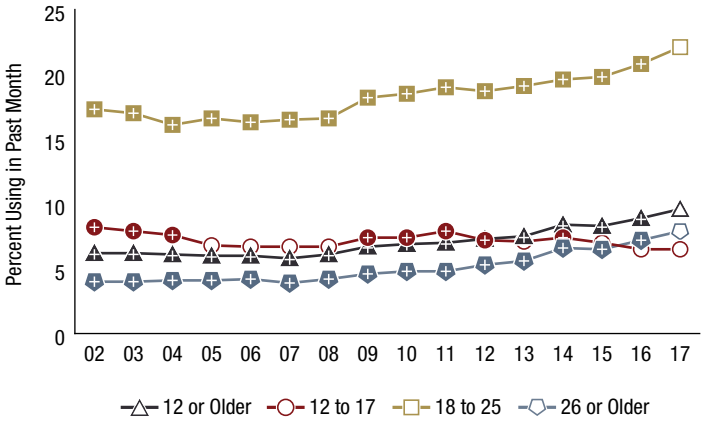


Figure 13. Past Month Marijuana Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 13 Table. Past Month Marijuana Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	6.2+	6.2+	6.1+	6.0+	6.0+	5.8+	6.1+	6.7+	6.9+	7.0+	7.3+	7.5+	8.4+	8.3+	8.9+	9.6
12-17	8.2+	7.9+	7.6+	6.8	6.7	6.7	6.7	7.4+	7.4+	7.9+	7.2+	7.1	7.4+	7.0	6.5	6.5
18-25	17.3+	17.0+	16.1+	16.6+	16.3+	16.5+	16.6+	18.2+	18.5+	19.0+	18.7+	19.1+	19.6+	19.8+	20.8+	22.1
≥26	4.0+	4.0+	4.1+	4.1+	4.2+	3.9+	4.2+	4.6+	4.8+	4.8+	5.3+	5.6+	6.6+	6.5+	7.2+	7.9

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Aged 18 to 25

In 2017, about 1 in 5 young adults aged 18 to 25 (22.1 percent) were current users of marijuana (Figure 13). This means that 7.6 million young adults used marijuana in the past month. The percentage of young adults who were current marijuana users in 2017 was higher than the percentages between 2002 and 2016.

Aged 26 or Older

In 2017, 7.9 percent of adults aged 26 or older were current users of marijuana (Figure 13), which represents about 16.8 million adults in this age group. The percentage of adults aged 26 or older who were current marijuana users in 2017 was higher than the percentages in 2002 to 2016.

Misuse of Psychotherapeutic Drugs

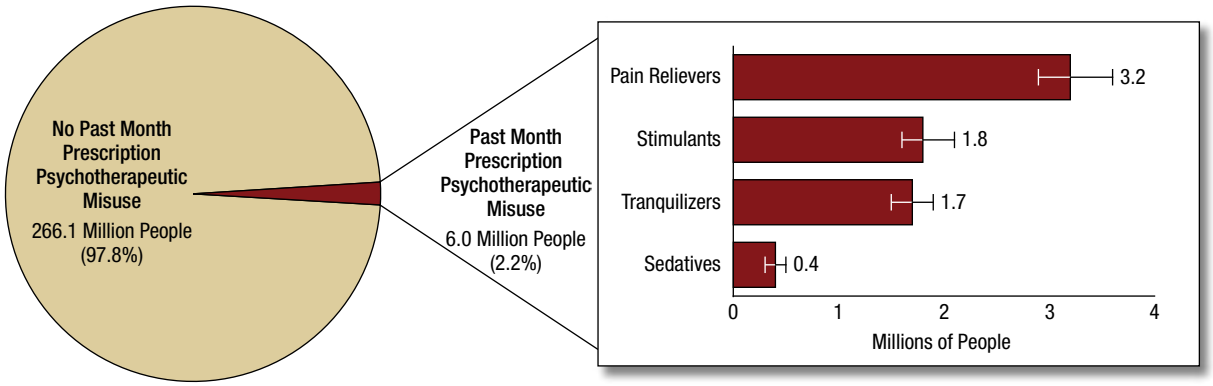
NSDUH collects data on four categories of prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) covering specific medications that currently are or have been available by prescription. NSDUH respondents are asked to report misuse of these drugs, defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. Misuse of over-the-counter drugs is not included. NSDUH reports combine the four prescription drug groups into a category referred to as "psychotherapeutics." Because the NDSUH prescription drug measures were revised in 2015, the 2017 estimates of prescription drug misuse are not comparable with estimates prior to 2015.

In this section, a summary of current misuse of any prescription psychotherapeutic drug is presented first, followed by sections on the current misuse of pain relievers, tranquilizers, stimulants, and sedatives. In 2017, an estimated 6.0 million Americans aged 12 or older misused psychotherapeutic drugs at least once in the past month, which represents 2.2 percent of the population aged 12 or older (Figure 14). Of the four categories of prescription drugs that are presented in this report, prescription pain relievers were the most commonly misused by people aged 12 or older. The 6.0 million people aged 12 or older who misused prescription psychotherapeutic drugs in the past month included 3.2 million who misused prescription pain relievers in that period. Approximately 1.7 million people aged 12 or older misused prescription tranquilizers in the past month. An estimated 1.8 million people aged 12 or older misused prescription stimulants, and 352,000 (0.4 million) misused prescription sedatives in the past month.

Pain Reliever Misuse

Several prescription drugs are grouped under the category of prescription pain relievers in NSDUH. These include hydrocodone products, oxycodone products, tramadol products, codeine products, morphine products, fentanyl products, buprenorphine products, oxymorphone products, Demerol®, hydromorphone products, methadone, or any other prescription pain reliever.[26]

Figure 14. Numbers of Past Month Prescription Psychotherapeutic Misusers among People Aged 12 or Older: 2017



Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of past month misusers of different prescription psychotherapeutics are not mutually exclusive because people could have misused more than one type of prescription psychotherapeutic in the past month.

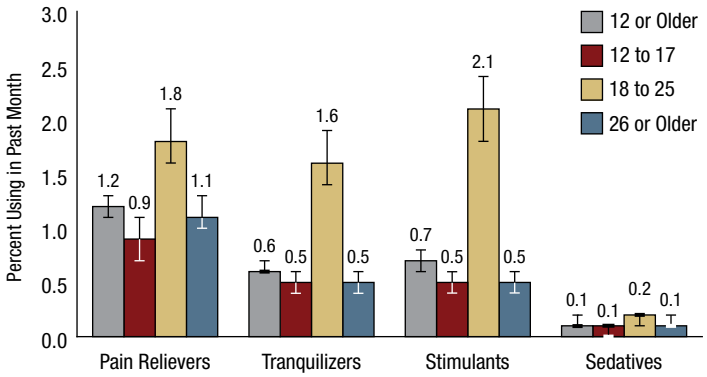
The estimated 3.2 million people aged 12 or older in 2017 described previously who were current misusers of pain relievers represents 1.2 percent of the population aged 12 or older (Figures 14 and 15). In 2017, an estimated 214,000 adolescents aged 12 to 17 were current misusers of pain relievers, which corresponds to 0.9 percent of adolescents (Figure 15). An estimated 634,000 young adults aged 18 to 25 misused pain relievers in the past month, which represents 1.8 percent of young adults. An estimated 2.4 million adults aged 26 or older were current misusers of pain relievers, which corresponds to 1.1 percent of adults aged 26 or older.

Tranquilizer Misuse

Several prescription drugs are grouped under the category of prescription tranquilizers in NSDUH. These include benzodiazepine tranquilizers (including alprazolam products, lorazepam products, clonazepam products, or diazepam products), muscle relaxants, or any other prescription tranquilizer.

The estimate of 1.7 million people aged 12 or older in 2017 that was described previously who were current misusers of tranquilizers represents 0.6 percent of people aged 12 or older (Figures 14 and 15). In 2017, an estimated 128,000 adolescents aged 12 to 17 were current misusers of tranquilizers, which represents 0.5 percent of adolescents (Figure 15). An estimated 552,000 young adults aged 18 to 25 misused tranquilizers in the past month, which represents 1.6 percent of young adults. An estimated 1.0 million adults aged 26 or older were current misusers of tranquilizers, which corresponds to 0.5 percent of adults in this age group.

Figure 15. Past Month Prescription Psychotherapeutic Misuse among People Aged 12 or Older, by Age Group: Percentages, 2017



Stimulant Misuse

Several prescription drugs are grouped under the category of prescription stimulants in NSDUH. These include amphetamine products, methylphenidate products, anorectic (weight-loss) stimulants, Provigil®, or any other prescription stimulant. The amphetamine and methylphenidate products that are included in the NSDUH questionnaire are primarily prescribed for the treatment of attention-deficit/hyperactivity disorder (ADHD). Since 2015, methamphetamine has not been included as a prescription stimulant, unless respondents specified the prescription form of methamphetamine (Desoxyn®) as some other stimulant that they had misused in the past year.[28]

The estimate of 1.8 million people aged 12 or older in 2017 that was described previously who were current misusers of stimulants represents 0.7 percent of people aged 12 or older (Figures 14 and 15). In 2017, about 123,000 adolescents aged 12 to 17 were current misusers of stimulants, corresponding to about 0.5 percent of adolescents (Figure 15). There were about 715,000 young adults aged 18 to 25 who misused stimulants in the past month, which corresponds to about 2.1 percent of young adults. An estimated 1.0 million adults aged 26 or older were current misusers of stimulants, which represents 0.5 percent of this age group.

Sedative Misuse

Several prescription drugs are grouped under the category of prescription sedatives in NSDUH. These include zolpidem products, eszopiclone products, zaleplon products, benzodiazepine sedatives (including flurazepam, temazepam products, or triazolam products), barbiturates, or any other prescription sedative.

The estimate of 352,000 people aged 12 or older in 2017 that was described previously who were current misusers of sedatives rounds to the 0.4 million people shown in Figure 14. This number represents 0.1 percent of the population aged 12 or older (Figure 15). There were an estimated 19,000 adolescents in 2017 who were current misusers of sedatives (0.1 percent of adolescents). An estimated 52,000 young adults aged 18 to 25 misused sedatives in the past month (0.2 percent of young adults). An estimated 281,000 adults aged 26 or older were current misusers of sedatives (0.1 percent of adults aged 26 or older).

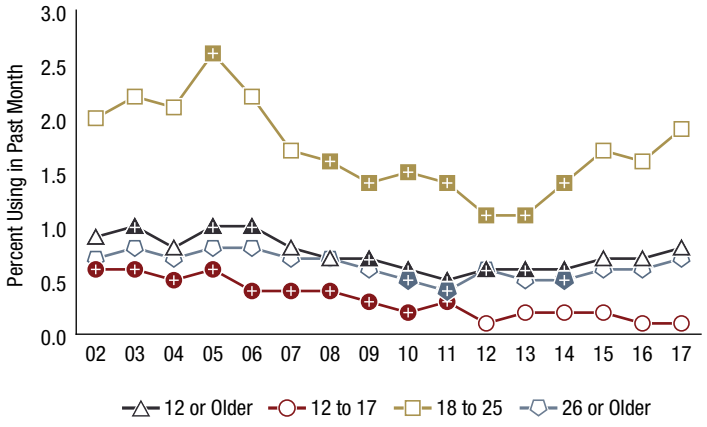
Cocaine Use

In this report, estimates of the use of cocaine include use of crack cocaine. Estimates also are presented separately for crack use. In 2017, an estimated 2.2 million people aged 12 or older were current users of cocaine (Figure 11), including about 473,000 current users of crack. These numbers correspond to about 0.8 percent of the population aged 12 or older who were current users of cocaine (Figure 16) and 0.2 percent who were current users of crack (Table A.7B). The 2017 estimate for current cocaine use was higher than the estimates in 2009 to 2014, but it was similar to the estimates in 2015 and 2016. The 2017 estimate of current cocaine use showed no clear pattern of differences compared with estimates in 2002 to 2008. The 2017 estimate of current crack use was similar to the estimates in most years from 2002 to 2016.

Aged 12 to 17

There were 26,000 adolescents aged 12 to 17 who were current users of cocaine in 2017. This number represents 0.1 percent of adolescents (Figure 16). The 2017 estimate for current cocaine use among adolescents was similar to the estimates between 2012 and 2016, but the 2017 estimate was lower than the estimates in 2002 to 2011. There was not sufficient precision to report the estimate of crack use among adolescents in 2017.

Figure 16. Past Month Cocaine Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 16 Table. Past Month Cocaine Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	0.9	1.0+	0.8	1.0+	1.0+	0.8	0.7	0.7+	0.6+	0.5+	0.6+	0.6+	0.6+	0.7	0.7	0.8
12-17	0.6+	0.6+	0.5+	0.6+	0.4+	0.4+	0.4+	0.3+	0.2+	0.3+	0.1	0.2	0.2	0.2	0.1	0.1
18-25	2.0	2.2	2.1	2.6+	2.2	1.7	1.6+	1.4+	1.5+	1.4+	1.1+	1.1+	1.4+	1.7	1.6	1.9
≥26	0.7	0.8	0.7	0.8	0.8	0.7	0.7	0.6	0.5+	0.4+	0.6	0.5	0.5+	0.6	0.6	0.7

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Aged 18 to 25

An estimated 1.9 percent of young adults aged 18 to 25 were current users of cocaine in 2017 (Figure 16), and 0.1 percent used crack in the past month (Table A.9B). These percentages represent 665,000 young adults who used cocaine, including 24,000 who used crack. The 2017 percentage of young adults who were current cocaine users was higher than the percentages in 2008 through 2014, and it was similar to the percentages in 2015 and 2016. The estimate of current crack use among young adults in 2017 was lower than estimates in most years between 2002 and 2010, but it was similar to the estimates in 2011 to 2016.

Aged 26 or Older

In 2017, 0.7 percent of adults aged 26 or older were current users of cocaine (Figure 16), and 0.2 percent used crack in the past month (Table A.10B). These percentages represent 1.5 million adults aged 26 or older who currently used cocaine, including 448,000 who currently used crack. The 2017 estimates of current cocaine use and current crack use among adults aged 26 or older were similar to the estimates in most years between 2002 and 2016.

Heroin Use

About 494,000 people aged 12 or older were current heroin users in 2017, which rounds to the 0.5 million people shown in Figure 11. This number corresponds to about 0.2 percent of the population aged 12 or older (Table A.7B).

The percentage of current heroin users aged 12 or older in 2017 was slightly higher than the percentages in most years between 2002 and 2015, but it was similar to the percentage in 2016. Even when there was a statistically significant difference between the 2017 estimate and estimates in prior years, however, the estimates ranged between 0.1 and 0.2 percent.

Aged 12 to 17

In 2017, less than 0.1 percent of adolescents aged 12 to 17 were current heroin users (Table A.8B), or about 2,000 adolescents. The 2017 estimate of heroin use in the past month among adolescents was either lower than or similar to the estimates in 2002 to 2016. Even when there

was a statistically significant difference between the 2017 estimate and estimates in prior years, however, the estimates in any given year were 0.1 percent or less.

Aged 18 to 25

Among young adults aged 18 to 25 in 2017, 0.3 percent were current heroin users (Table A.9B). This percentage represents 102,000 young adults who were current users of heroin. The percentage of young adults in 2017 who were current heroin users was higher than the percentages in most years between 2002 through 2007, but it was similar to the percentages in 2008 through 2016.

Aged 26 or Older

In 2017, 0.2 percent of adults aged 26 or older were current heroin users (Table A.10B). This percentage represents 390,000 adults aged 26 or older who were current users of heroin. The percentage of adults aged 26 or older in 2017 who were current heroin users (0.2 percent) was higher than the percentages for most years between 2002 and 2015 (ranging from less than 0.1 to 0.2 percent), but it was similar to the percentage in 2016.

Hallucinogen Use

Several drugs are grouped under the category of hallucinogens, including LSD, PCP, peyote, mescaline, psilocybin mushrooms, "Ecstasy" (MDMA or "Molly"), ketamine, DMT/AMT/"Foxy," and *Salvia divinorum*.[29] In 2015, the NSDUH estimate of any hallucinogen use was expanded to include the use of ketamine, DMT/AMT/"Foxy," and *Salvia divinorum*. "Molly" also was added as a term for Ecstasy. Because of these changes in 2015, the 2017 estimates of hallucinogen use are not comparable with estimates prior to 2015.

In 2017, an estimated 1.4 million people aged 12 or older were current users of hallucinogens (Figure 11), representing 0.5 percent of the population aged 12 or older (Figure 17). An estimated 143,000 adolescents aged 12 to 17 were current users of hallucinogens, or 0.6 percent of adolescents. An estimated 1.7 percent of young adults aged 18 to 25 were current users of hallucinogens, which represents 594,000 young adults who used hallucinogens. An estimated 0.3 percent of adults aged 26 or older were current users of hallucinogens, which represents 701,000 individuals in this age group who were current users of hallucinogens.

Inhalant Use

Inhalants include a variety of substances, such as nitrous oxide, amyl nitrite, cleaning fluids, gasoline, spray paint, computer keyboard cleaner, other aerosol sprays, felt-tip pens, and glue. Respondents are asked to report the use of inhalants to get high but not to include accidental inhalation of a substance. In 2015, the NSDUH estimate of inhalant use was expanded to include the use of felt-tip pens or computer keyboard cleaner to get high. Because of this 2015 change, the 2017 estimates of inhalant use are not comparable with estimates prior to 2015.

In 2017, approximately 556,000 people aged 12 or older were current users of inhalants, which rounds to the estimate of 0.6 million people shown in Figure 11. This number represents 0.2 percent of the population aged 12 or older (Figure 18). Current use of inhalants in 2017 was more common among adolescents aged 12 to 17 and among young adults aged 18 to 25 than among adults aged 26 or older. In 2017, 0.6 percent of adolescents, 0.5 percent of young adults aged 18 to 25, and 0.1 percent of adults aged 26 or older were current users of inhalants. About 153,000

Figure 17. Past Month Hallucinogen Use among People Aged 12 or Older, by Age Group: Percentages, 2017

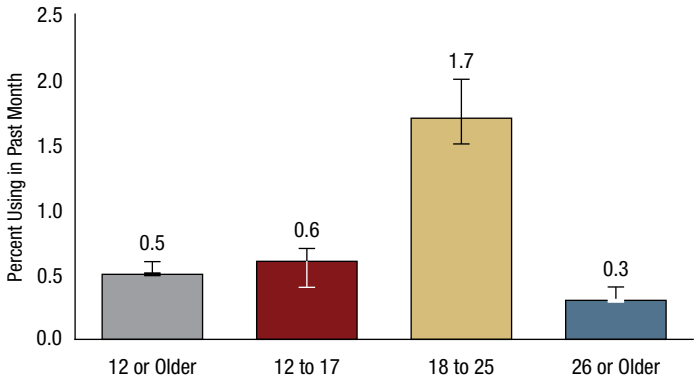
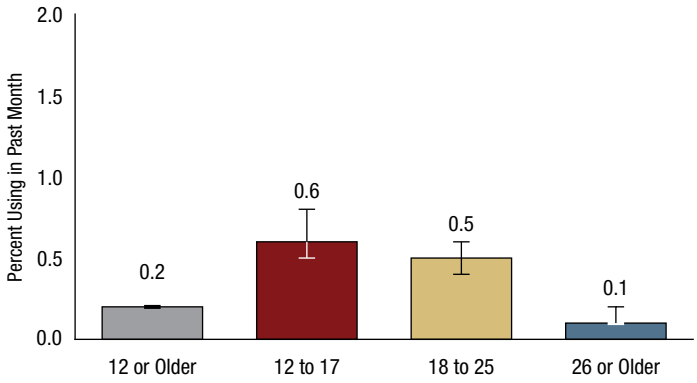


Figure 18. Past Month Inhalant Use among People Aged 12 or Older, by Age Group: Percentages, 2017



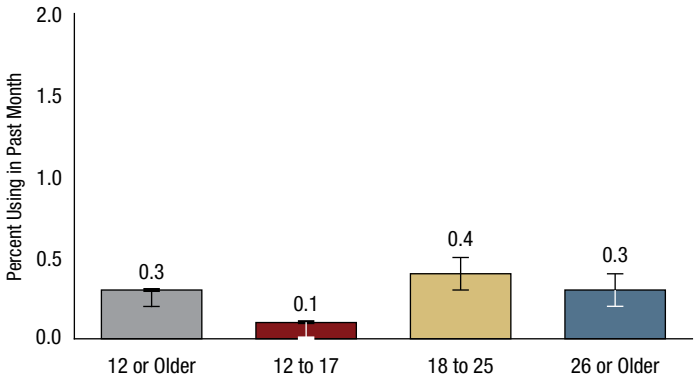
adolescents, 168,000 young adults, and 235,000 adults aged 26 or older were current users of inhalants; the number of adults aged 26 or older who were current users of inhalants reflects the larger number of people in this age group.

Methamphetamine Use

Prior to 2015, questions about methamphetamine use were asked in the context of questions about the misuse of prescription stimulants because methamphetamine is legally available by prescription (Desoxyn®). However, most methamphetamine that is used in the United States is produced and distributed illicitly rather than through the pharmaceutical industry. Therefore, for 2015, a new set of questions specific to methamphetamine use was created and administered separately from the questions about the misuse of prescription stimulants. Because of these 2015 changes, the 2017 estimates of methamphetamine use are not comparable with estimates prior to 2015.

In 2017, approximately 774,000 people aged 12 or older were current users of methamphetamine, which rounds to the estimate of 0.8 million people shown in Figure 11. This number represents 0.3 percent of the population aged 12 or older (Figure 19). About 16,000 adolescents aged 12 to 17 were current methamphetamine users. This number corresponds to 0.1 percent of adolescents being current methamphetamine users. There were about 151,000 young adults aged 18 to 25 who used methamphetamine in the past month, which corresponds to about 0.4 percent of young adults. An estimated 607,000 adults aged 26 or older used methamphetamine, which represents 0.3 percent of adults in this age group.

Figure 19. Past Month Methamphetamine Use among People Aged 12 or Older, by Age Group: Percentages, 2017



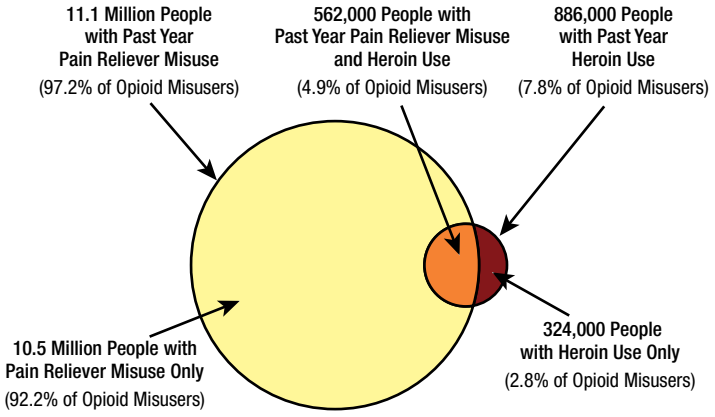
Opioid Misuse in the Past Year

Opioids are a group of chemically similar drugs that include heroin and prescription pain relievers, such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin®), and morphine. In this report, opioid misuse includes the misuse of prescription pain relievers or the use of heroin. Prescription pain relievers could include some nonopioids because respondents could specify that they misused other pain relievers that are not opioids.[26] In 2017, there were 11.4 million past year opioid misusers aged 12 or older in the United States, the vast majority of whom misused prescription pain relievers (Figure 20). Specifically, 11.1 million people aged 12 or older in 2017 misused prescription pain relievers in the past year compared with 886,000 people who used heroin. The majority of prescription pain reliever misusers had misused only prescription pain relievers in the past year but had not used heroin (10.5 million). Approximately 562,000 people had misused prescription pain relievers and used heroin in the past year. About 324,000 people used heroin in the past year but had not misused prescription pain relievers. Although 5.1 percent of prescription pain reliever misusers also used heroin in the past year, 63.5 percent of heroin users also misused pain relievers in the past year.[24]

Past Year Opioid Misuse

This section presents additional 2017 estimates for past year opioid misuse, heroin use, and pain reliever misuse. Because most opioid misuse involves the misuse of prescription pain

Figure 20. Past Year Opioid Misuse among People Aged 12 or Older: 2017



Note: Opioid misuse is defined as heroin use or prescription pain reliever misuse.
Note: The percentages do not add to 100 percent due to rounding.

relievers, this section also provides further details on the misuse of pain relievers in the past year. Specifically, 2017 estimates are presented for the subtypes of prescription pain relievers that people misused, where people obtained the prescription pain relievers that they most recently misused, and the main reason for the most recent misuse of prescription pain relievers in the past year.

As noted previously, approximately 11.4 million people aged 12 or older in 2017 misused opioids in the past year (Figures 20 and 21). This number represents 4.2 percent of the population aged 12 or older. About 769,000 adolescents aged 12 to 17 misused opioids in the past year, which rounds to the estimate of 0.8 million people shown in Figure 21. This number corresponds to 3.1 percent of adolescents who misused opioids in the past year. About 2.5 million young adults aged 18 to 25 misused opioids in the past year, which corresponds to about 7.3 percent of young adults. An estimated 8.1 million adults aged 26 or older misused opioids in the past year, which represents 3.8 percent of adults in this age group.

Past Year Heroin Use

As noted previously, an estimated 886,000 people aged 12 or older in 2017 used heroin in the past year (Figure 20). The estimate of past year heroin use in 2017 (0.3 percent) was higher than the estimates for most years between 2002 and 2011, but it was similar to the estimates in 2012 to 2015 (Figure 22).

Aged 12 to 17

In 2017, 0.1 percent of adolescents aged 12 to 17 were past year heroin users (Figure 22). This percentage represents 14,000 adolescents who used heroin in the past year. The percentage of adolescents in 2017 who were past year heroin users was similar to or slightly lower than the percentages in 2002 through 2016.

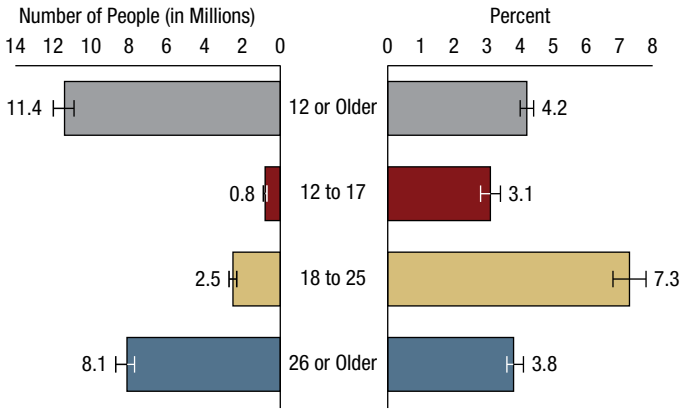
Aged 18 to 25

Among young adults aged 18 to 25 in 2017, 0.6 percent were past year heroin users (Figure 22). This percentage represents 214,000 young adults who used heroin in the past year. The percentage of young adults in 2017 who were past year heroin users was similar to the percentages between 2005 and 2016 (ranging from 0.4 to 0.8 percent), but it was slightly higher than the percentages in 2002 through 2004 (ranging from 0.3 to 0.4 percent).

Aged 26 or Older

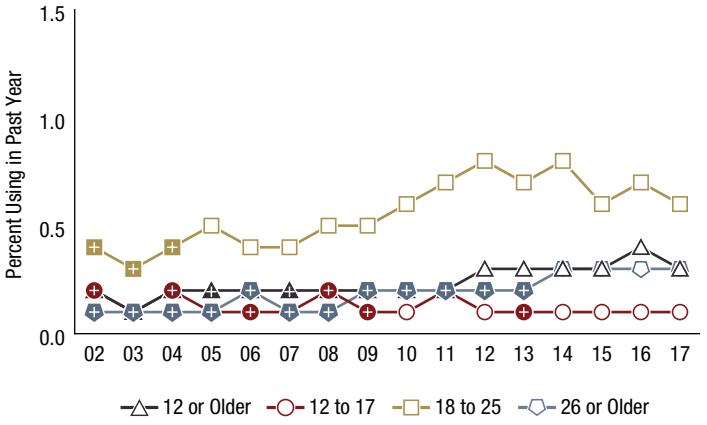
In 2017, 0.3 percent of adults aged 26 or older were past year heroin users (Figure 22). This percentage represents 658,000 adults aged 26 or older who used heroin in the past year. The percentage of adults aged 26 or older in 2017 who were past year heroin users was similar to the percentages in 2014 to 2016, but it was slightly higher than the percentages in all years from 2002 to 2013.

Figure 21. Past Year Opioid Misuse among People Aged 12 or Older, by Age Group: 2017



Note: Opioid misuse is defined as heroin use or prescription pain reliever misuse.

Figure 22. Past Year Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 22 Table. Past Year Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	0.2+	0.1+	0.2+	0.2+	0.2+	0.2+	0.2+	0.2+	0.2	0.2+	0.3	0.3	0.3	0.3	0.4	0.3
12-17	0.2+	0.1+	0.2+	0.1+	0.1+	0.1	0.2+	0.1+	0.1	0.2+	0.1	0.1+	0.1	0.1	0.1	0.1
18-25	0.4+	0.3+	0.4+	0.5	0.4	0.4	0.5	0.5	0.6	0.7	0.8	0.7	0.8	0.6	0.7	0.6
≥26	0.1+	0.1+	0.1+	0.1+	0.2+	0.1+	0.1+	0.2+	0.2+	0.2+	0.2+	0.2+	0.3	0.3	0.3	0.3

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Past Year Pain Reliever Misuse

As noted previously, approximately 11.1 million people in 2017 misused prescription pain relievers in the past year (Figure 20), representing 4.1 percent of the population aged 12 or older (Figure 23). Among youths aged 12 to 17, 3.1 percent misused prescription pain relievers, corresponding to 767,000 youths, which rounds to the estimate of 0.8 million shown in Figure 23. There were about 2.5 million young adults aged 18 to 25 who misused pain relievers in the past year, which corresponds to about 7.2 percent of young adults. An estimated 7.8 million adults aged 26 or older misused pain relievers in the past year, which represents 3.7 percent of adults in this age group.

Misuse of Subtypes of Pain Relievers

NSDUH asked respondents in 2017 to identify the specific prescription pain relievers that they used in the past year. For each specific pain reliever that respondents reported using in the past 12 months, respondents were asked whether they misused that pain reliever in that period. The specific pain relievers that individuals misused in the past year were categorized into subtypes, such as hydrocodone products. For example, respondents who reported the misuse of the pain relievers Vicodin® or hydrocodone were classified as misusers of hydrocodone products. This section presents estimates of the subtypes of pain relievers that were misused by individuals aged 12 or older.

In 2017, hydrocodone products were the most commonly misused subtype of prescription pain relievers, including Vicodin®, Lortab®, Norco®, Zohydro® ER, and generic hydrocodone (Figure 24). An estimated 6.3 million people aged 12 or older misused these products in the past year, representing 2.3 percent of the population. An estimated 3.7 million people misused oxycodone products in the past year; this number represents 1.4 percent of people aged 12 or older. Oxycodone products include OxyContin®, Percocet®, Percodan®, Roxicodone®, and generic oxycodone. An estimated 0.3 percent of people aged 12 or older misused buprenorphine products in the past year, which represents 766,000 people. About 261,000 people aged 12 or older (0.1 percent) misused methadone.

There were 245,000 people in 2017 who misused prescription fentanyl products, representing 0.1 percent of the population (Figure 24). Because NSDUH respondents were asked about the misuse of only prescription forms of fentanyl, however, this estimate for fentanyl misuse may underrepresent people who misused fentanyl that was illicitly manufactured in clandestine laboratories[30] (i.e., as opposed to the misuse of diverted fentanyl that was produced by the pharmaceutical industry). This estimate of fentanyl misuse also may not include people who misused illicitly manufactured fentanyl that was mixed with heroin or sold as heroin (but contained only illicitly manufactured fentanyl).

Main Reasons for the Last Misuse of Pain Relievers

Respondents in the 2017 NSDUH who reported prescription pain reliever misuse in the past year were asked to recall the last prescription pain reliever that they misused in the past year. Respondents were then asked to report their reasons for misusing this prescription pain reliever that last time. Respondents who reported more than one reason for misusing the last prescription pain reliever were asked to report the main

Figure 23. Past Year Prescription Pain Reliever Misuse among People Aged 12 or Older, by Age Group: 2017

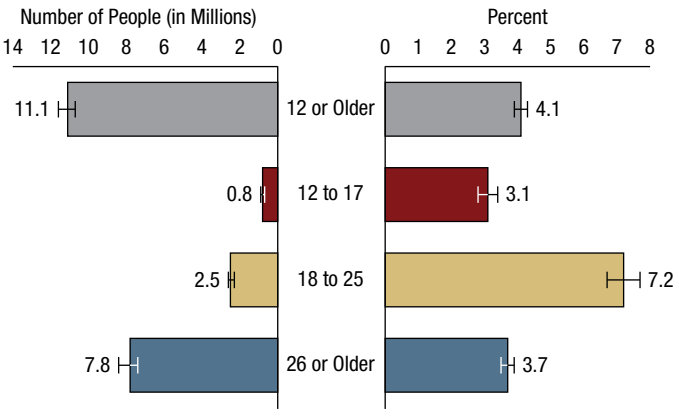
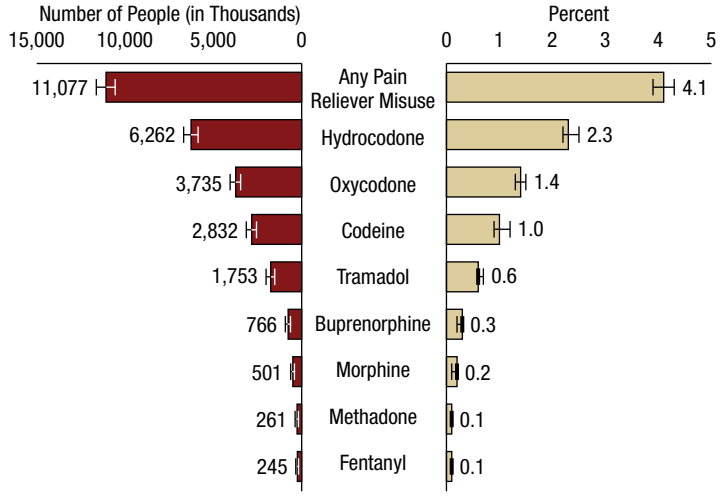


Figure 24. Past Year Misuse of Prescription Pain Reliever Subtypes among People Aged 12 or Older: 2017



Note: The figure does not show all pain reliever subtypes from the NSDUH questionnaire.

reason for pain reliever misuse. If respondents reported only one reason for misusing their last prescription pain reliever, then that reason was their main reason for pain reliever misuse.

Among people aged 12 or older in 2017 who misused prescription pain relievers in the past year, the most common main reason for their last misuse of a pain reliever was to relieve physical pain (62.6 percent) (Figure 25). According to the NSDUH definition, use without a prescription of one's own or use at a higher dosage or more often than prescribed are both classified as misuse even if it was for the purpose of pain relief. Other common reasons were to feel good or get high (13.2 percent) and to relax or relieve tension (8.4 percent). Less common reasons among past year misusers of pain relievers included to help with sleep (5.4 percent), to help with feelings or emotions (3.6 percent), to experiment or see what the drug was like (2.8 percent), because they were "hooked" or needed to have the drug (2.2 percent), and to increase or decrease the effects of other drugs (0.7 percent). Some other reason was the main reason for misuse among 1.0 percent of past year misusers of pain relievers.

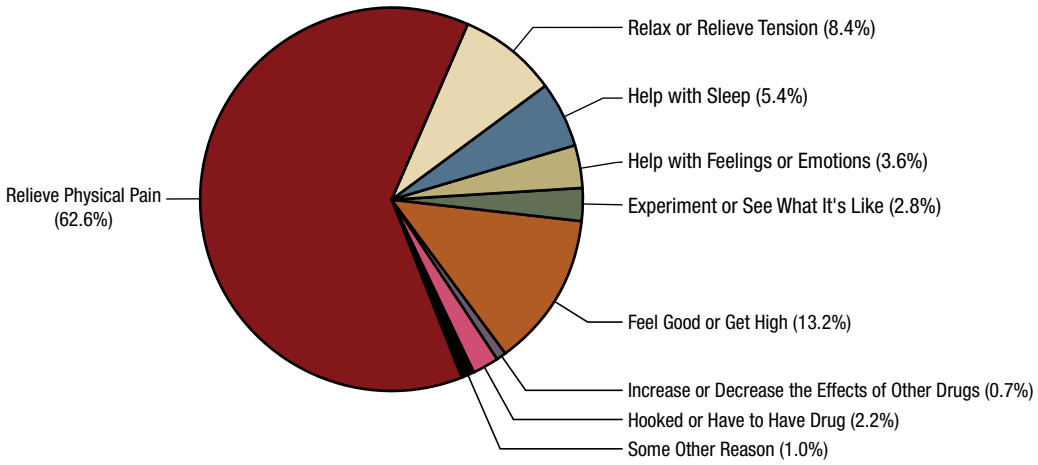
Source of the Last Pain Reliever That Was Misused

Among people aged 12 or older in 2017 who misused prescription pain relievers in the past year, the most common source for the last pain reliever they misused was from a friend or relative (Figure 26). More than half (53.1 percent) of people who misused pain relievers in the past year obtained the pain relievers the last time from a friend or relative. Specifically, 38.5 percent of people who misused pain relievers in the past year obtained pain relievers the last time by getting them from a friend or relative for free, 10.6 percent bought their last pain reliever from a friend or relative, and 4.0 percent took their last pain reliever from a friend or relative without asking. About one third of people who misused pain relievers in the past year (36.6 percent) obtained pain relievers the last time through prescription(s) or stole pain relievers from a health care provider, typically getting the pain relievers through a prescription from one doctor (34.6 percent). About 1 in 18 people who misused pain relievers in the past year (5.7 percent) bought the last pain reliever they misused from a drug dealer or other stranger.

Initiation of Substance Use

NSDUH includes questions that measure the initiation of substance use, that is, the first use of particular substances.[31] This report presents estimates of the number of recent substance use initiates or prescription drug misuse initiates.[32] Recent initiates were defined as substance users or prescription drug misusers who reported first using or misusing, respectively, a particular substance in the prior 12 months.[33,34] More information about the methods for measuring and estimating the initiation of substance use and prescription drug misuse in NSDUH can be found in Section B.4.2 of the 2017 NSDUH's methodological summary and definitions report.[14]

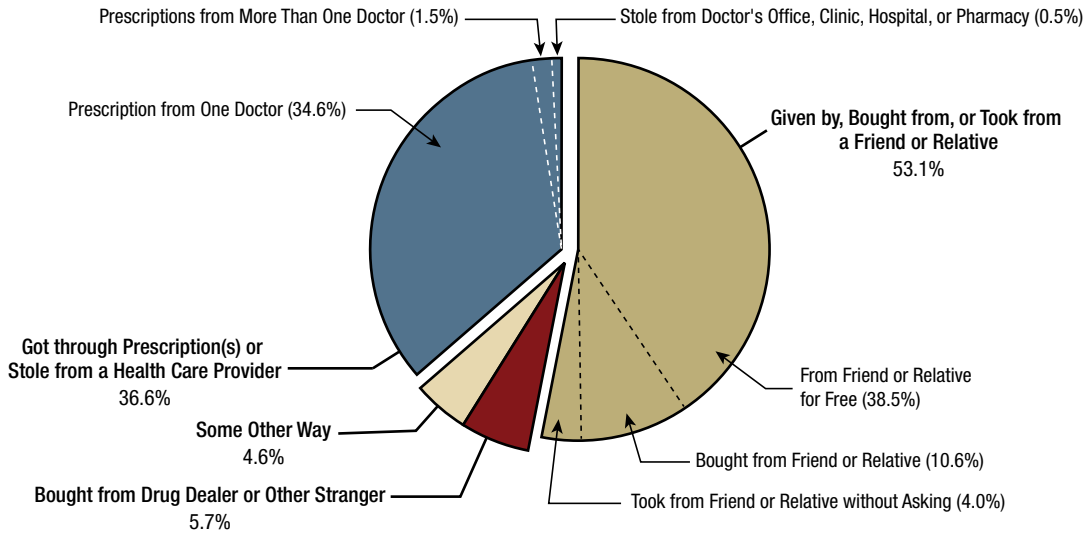
Figure 25. Main Reason for the Most Recent Prescription Pain Reliever Misuse among People Aged 12 or Older Who Misused Prescription Pain Reliever in the Past Year: Percentages, 2017



11.1 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: The percentages do not add to 100 percent due to rounding.

Figure 26. Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages, 2017



Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.

Unlike previous sections, this section focuses on the *numbers* of people who were recent initiates (e.g., the number of people aged 12 or older who were recent initiates of marijuana use) rather than on percentages. However, care should be taken in interpreting increases over time in the estimated number of past year initiates because some of these increases could reflect growth in the size of the population over time. Because of changes to the 2015 NSDUH questionnaire, initiation estimates for prescription drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives), methamphetamine, hallucinogens, inhalants, and smokeless tobacco are shown only for 2017; estimates in 2017 for the numbers of past year initiates for these substances are not comparable with estimates prior to 2015.

Figure 27 provides an overview of the numbers of individuals aged 12 or older in 2017 who were past year initiates for the substances that are discussed in this section. The illicit drugs in 2017 with the largest number of recent initiates were marijuana (3.0 million new users), prescription pain relievers (2.0 million new misusers), prescription tranquilizers (1.4 million new misusers), hallucinogens (1.2 million new users), prescription stimulants (1.2 million new misusers), and cocaine (1.0 million new users). In addition, there were 4.9 million new users of alcohol and 1.9 million people who tried a cigarette for the first time in the past year.[35]

Initiation of Cigarette Use

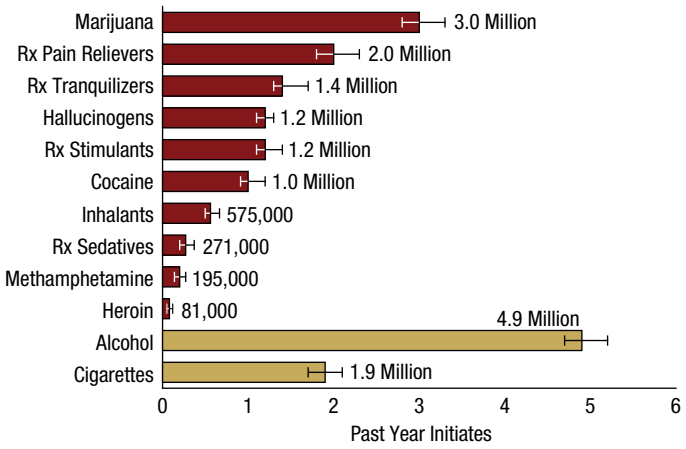
In 2017, about 1.9 million people aged 12 or older smoked part or all of a cigarette for the first time in the past 12 months (Figure 27). This number averages to about 5,200 people each day who initiated cigarette smoking (Table A.19A). The total number of initiates of cigarette smoking who were aged 12 or older in 2017 was lower than the numbers in most years from 2004 to 2014, but it was similar to the numbers in 2015 and 2016 (Table A.15A).

By Age Group

In 2017, an estimated 604,000 adolescents aged 12 to 17 smoked part or all of a cigarette for the first time in the past year (Table A.16A). This number of recent initiates among adolescents averages to approximately 1,700 adolescents each day who initiated cigarette smoking (Table A.19A). Also, 1.2 million young adults aged 18 to 25 initiated cigarette use in the past year (Table A.17A), which translates to about 3,200 young adults who initiated cigarette use each day. An estimated 142,000 adults aged 26 or older initiated cigarette use in the past year (Table A.18A).

Among adolescents aged 12 to 17 in 2017, the number of recent initiates of any cigarette smoking was lower than the numbers in each year between 2002 and 2016 (Table A.16A). About 1.2 million to 1.3 million adolescents each year from 2002 to 2011 initiated cigarette smoking in the past year. The number of initiates among adolescents

Figure 27. Numbers of Past Year Initiates of Substances among People Aged 12 or Older: 2017



Rx = prescription.

Note: Estimates for prescription pain relievers, prescription tranquilizers, prescription stimulants, and prescription sedatives are for the initiation of misuse.

decreased to 1.0 million in 2012 and to fewer than 1.0 million in subsequent years.

Among young adults aged 18 to 25 in 2017, the number of recent initiates of any cigarette smoking was higher than the numbers in 2016 and most years from 2002 to 2007. The number in 2017 was similar to the numbers in 2008 to 2015 (Table A.17A). The number of recent cigarette initiates who were aged 26 or older in 2017 was similar to the numbers in most years from 2002 to 2016 (Table A.18A). These data for cigarette initiation show a consistent pattern over time that relatively few people try cigarettes for the first time after age 25.

Initiation of Alcohol Use

About 4.9 million people aged 12 or older in 2017 used alcohol for the first time in the past year, not counting sips from another person's drink (Figure 27). This number averages to approximately 13,500 initiates per day (Table A.19A). The total number of past year initiates aged 12 or older in 2017 for alcohol use was higher than the numbers in 2002 to 2009, but it was similar to the numbers in most years from 2010 to 2016 (Table A.15A).

By Age Group

In 2017, an estimated 2.3 million adolescents aged 12 to 17 used alcohol for the first time in the past year (Table A.16A), which averages to approximately 6,400 adolescents each day who initiated alcohol use (Table A.19A). Also, 2.4 million young adults aged 18 to 25 (Table A.17A) and 143,000 adults aged 26 or older (Table A.18A) in 2017 initiated alcohol use in the past year.

The number of adolescents aged 12 to 17 in 2017 who recently initiated alcohol use was lower than the numbers in most years from 2002 to 2011, but it was similar to the numbers in 2012 to 2016 (Table A.16A). Among young adults aged 18 to 25, the number of recent initiates in 2017 was higher than the numbers in most years from 2002 to 2016 (Table A.17A). For adults aged 26 or older, the number of initiates in 2017 was similar to the numbers in all years from 2002 to 2016 (Table A.18A). As was the case with cigarette initiation, these data show a consistent pattern that relatively few people start to use alcohol after age 25.

Initiation of Marijuana Use

In 2017, about 3.0 million people aged 12 or older used marijuana for the first time in the past 12 months (Figures 27 and 28). This number averages to about 8,300 new marijuana users each day (Table A.19A). The 2017 estimate for the number of past year initiates for marijuana was higher than the estimates in 2002 to 2016.

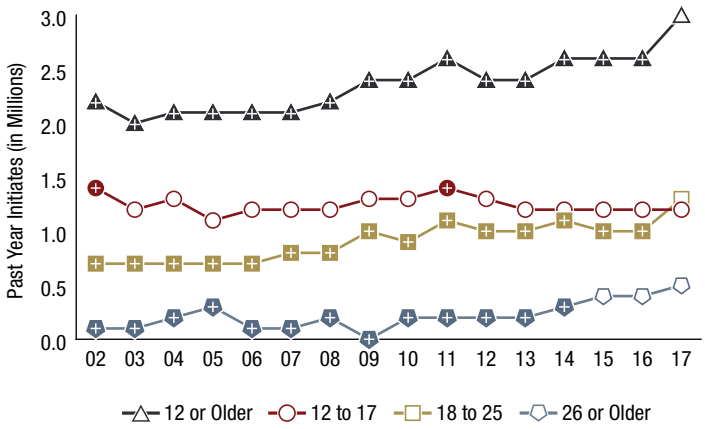
By Age Group

In 2017, an estimated 1.2 million adolescents aged 12 to 17 used marijuana for the first time in the past year (Figure 28), which translates to approximately 3,300 adolescents each day who initiated marijuana use (Table A.19A). About 1.1 million to 1.4 million adolescents per year in 2002 to 2016 were recent marijuana initiates. The 2017 estimate was similar to the estimates in most years from 2002 to 2016.

In 2017, 1.3 million young adults aged 18 to 25 initiated marijuana use in the past year (Figure 28), or an average of about 3,600 recent initiates per day in this age group (Table A.19A). The 2017 estimate for the number of young adults who initiated marijuana use in the past year was higher than the estimates in all years from 2002 to 2016.

An estimated 525,000 adults aged 26 or older in 2017 initiated marijuana use in the past year, which rounds to the estimate of 0.5 million initiates in this age group in Figure 28. This number averages to about 1,400 recent initiates per day in this age group (Table A.19A). The number of recent marijuana initiates in this age group in 2017 was higher than the numbers of initiates in all years from 2002 to 2014, but it was similar to the numbers in 2015 and 2016. Consistent with the pattern for cigarette and alcohol use, the majority of people in 2017 who initiated marijuana use in the past year were aged 12 to 25.

Figure 28. Past Year Marijuana Initiates among People Aged 12 or Older, by Age Group (in Millions): 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 28 Table. Past Year Marijuana Initiates among People Aged 12 or Older, by Age Group (in Millions): 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	2.2+	2.0+	2.1+	2.1+	2.1+	2.1+	2.2+	2.4+	2.4+	2.6+	2.4+	2.4+	2.6+	2.6+	2.6+	3.0
12-17	1.4+	1.2	1.3	1.1	1.2	1.2	1.2	1.3	1.3	1.4+	1.3	1.2	1.2	1.2	1.2	1.2
18-25	0.7+	0.7+	0.7+	0.7+	0.7+	0.8+	0.8+	1.0+	0.9+	1.1+	1.0+	1.0+	1.1+	1.0+	1.0+	1.3
≥26	0.1+	0.1+	0.2+	0.3+	0.1+	0.1+	0.2+	0.0+	0.2+	0.2+	0.2+	0.2+	0.3+	0.4	0.4	0.5

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Estimates of less than 0.1 million round to 0.0 million when shown to the nearest tenth of a million.

Initiation of Prescription Pain Reliever Misuse

The 2017 NSDUH questionnaire includes questions about the first misuse of prescription pain relievers. Because a new baseline was established in 2015, the 2017 NSDUH estimates of the initiation of prescription pain reliever misuse are not comparable with estimates prior to 2015.

In 2017, the number of recent initiates of prescription pain reliever misuse (2.0 million) was the second highest among the illicit drugs, after the number of marijuana initiates (Figure 27). The number of people aged 12 or older who misused prescription pain relievers for the first time in the past year averages to about 5,500 initiates per day (Table A.19A).

In 2017, approximately 316,000 adolescents aged 12 to 17 misused prescription pain relievers for the first time in the past year (Table A.16A). This number averages to approximately 900 adolescents each day who initiated prescription pain reliever misuse (Table A.19A). An estimated 465,000 young adults aged 18 to 25 and 1.2 million adults aged 26 or older initiated prescription pain reliever misuse in the past year (Tables A.17A and A.18A, respectively). These numbers average to about 1,300 young adults and about 3,400 adults aged 26 or older each day who initiated prescription pain reliever misuse. Unlike the patterns for cigarette, alcohol, and marijuana use, the majority of the people in 2017 who initiated prescription pain reliever misuse were aged 26 or older.

Initiation of Prescription Tranquilizer Misuse

The 2017 NSDUH questionnaire includes questions about the first misuse of prescription tranquilizers. Because a new baseline was established in 2015, the 2017 NSDUH estimates of the initiation of prescription tranquilizer misuse are not comparable with estimates prior to 2015.

About 1.4 million people aged 12 or older in 2017 misused prescription tranquilizers for the first time in the past year (Figure 27). This number averages to about 4,000 initiates per day (Table A.19A).

Approximately 223,000 adolescents aged 12 to 17, 473,000 young adults aged 18 to 25, and 749,000 adults aged 26 or older in 2017 misused prescription tranquilizers for the first time in the past year (Tables A.16A, A.17A, and A.18A, respectively). Thus, about 600 adolescents, 1,300 young adults, and 2,100 adults aged 26 or older each day initiated prescription tranquilizer misuse (Table A.19A).

Initiation of Prescription Stimulant Misuse

The 2017 NSDUH questionnaire includes questions about the first misuse of prescription stimulants. Because a new baseline was established in 2015, the 2017 NSDUH estimates of the initiation of prescription stimulant misuse are not comparable with estimates prior to 2015.

In 2017, approximately 1.2 million people aged 12 or older misused prescription stimulants for the first time in the past year (Figure 27). This estimated number of initiates averages to about 3,300 initiates per day for prescription stimulant misuse (Table A.19A).

Approximately 217,000 adolescents aged 12 to 17, 581,000 young adults aged 18 to 25, and 394,000 adults aged 26 or older in 2017 misused prescription stimulants for the first time in the past year (Tables A.16A, A.17A, and A.18A, respectively). Thus, in 2017, about 600 adolescents, 1,600 young adults, and 1,100 adults aged 26 or older each day initiated prescription stimulant misuse (Table A.19A).

Initiation of Prescription Sedative Misuse

The 2017 NSDUH questionnaire includes questions about the first misuse of prescription sedatives. Because a new baseline was established in 2015, the 2017 NSDUH estimates of the initiation of prescription sedative misuse are not comparable with estimates prior to 2015.

In 2017, approximately 271,000 people aged 12 or older misused prescription sedatives for the first time in the past year (Figure 27). This estimated number of initiates averages to about 740 initiates per day for prescription sedative misuse (Table A.19A).

In 2017, approximately 34,000 adolescents aged 12 to 17, 51,000 young adults aged 18 to 25, and 186,000 adults aged 26 or older misused prescription sedatives for the first time in the past year (Tables A.16A, A.17A, and A.18A, respectively). Thus, about 90 adolescents, 140 young adults, and 510 adults aged 26 or older each day initiated prescription sedative misuse (Table A.19A).

Initiation of Cocaine Use

In 2017, 1.0 million people aged 12 or older used cocaine for the first time in the past year (Figures 27 and 29). This number averages to approximately 2,800 cocaine initiates per day (Table A.19A). The number of past year initiates in 2017 for cocaine use was higher than the estimated numbers in 2008 to 2014, but it was similar to the numbers in 2015 and 2016.[36] This increase in the number of past year cocaine initiates in recent years indicates a need to monitor trends in cocaine initiation to assess whether the annual numbers of initiates in future years will stabilize at the level in 2015 to 2017, show further increases, or again decrease to levels similar to those in 2008 to 2014.

By Age Group

In 2017, an estimated 98,000 adolescents aged 12 to 17 used cocaine for the first time in the past year (Figure 29). Among adolescents in 2017, the number of cocaine initiates was lower than the numbers in all years from 2002 to 2011, but it was similar to the numbers in 2012 to 2016.

Also in 2017, 729,000 young adults aged 18 to 25 and 210,000 adults aged 26 or older initiated cocaine use in the past year (Figure 29). The number of young adults who initiated cocaine use each day averages to about 2,000 young adults (Table A.19A). Among young adults in 2017, the total number of cocaine initiates was higher than the numbers in each year from 2002 to 2014, but it did not differ significantly from the numbers in 2015 and 2016. Among adults aged 26 or older in 2017, the number of cocaine initiates was higher than the numbers in most years from 2005 to 2013, but it was similar to the numbers in 2014 to 2016 and in 2002 to 2004.

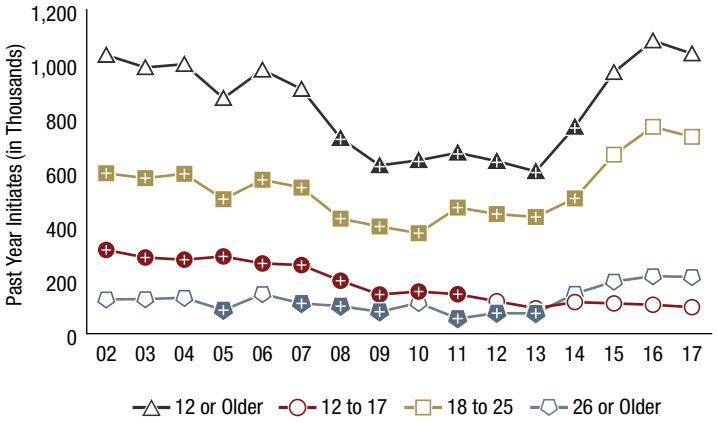
Initiation of Heroin Use

In 2017, 81,000 people aged 12 or older used heroin for the first time in the past year (Figures 27 and 30). On average, this represents about 220 people each day who initiated heroin use (Table A.19A). Among people aged 12 or older in 2017, the number of past year heroin initiates was lower than the numbers in most years from 2009 to 2016, but it was similar to the numbers of recent heroin initiates in 2002 to 2008.

By Age Group

In 2017, an estimated 9,000 adolescents aged 12 to 17, 46,000 young adults aged 18 to 25, and 26,000 adults aged 26 or older used heroin for the first time in the past year (Figure 30). The number of adolescents in 2017 who were recent heroin initiates was similar to the numbers in most years between 2005 and 2016, but it was lower than the

Figure 29. Past Year Cocaine Initiates among People Aged 12 or Older, by Age Group (in Thousands): 2002-2017



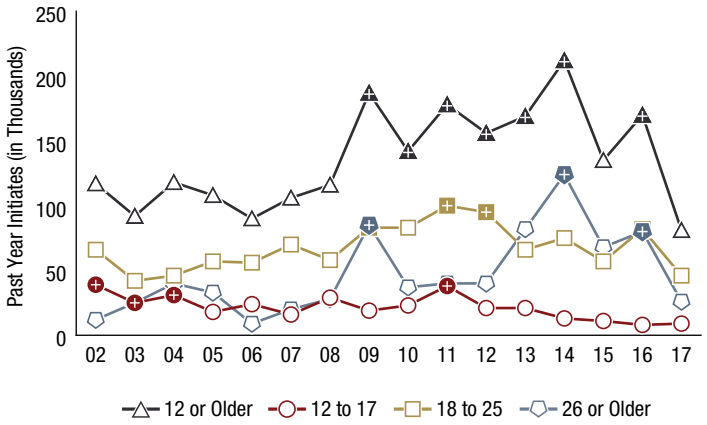
+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 29 Table. Past Year Cocaine Initiates among People Aged 12 or Older, by Age Group (in Thousands): 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	1,032	986	998	872	977	906	724+	623+	642+	670+	639+	601+	766+	968	1,085	1,037
12-17	310+	282+	274+	286+	260+	254+	196+	145+	156+	146+	120	94	117	112	107	98
18-25	594+	576+	592+	498+	570+	541+	426+	397+	372+	467+	443+	432+	501+	663	766	729
≥26	127	128	133	87+	147	112+	102+	81+	114	56+	76+	75+	148	193	213	210

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 30. Past Year Heroin Initiates among People Aged 12 or Older, by Age Group (in Thousands): 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 30 Table. Past Year Heroin Initiates among People Aged 12 or Older, by Age Group (in Thousands): 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	117	92	118	108	90	106	116	187+	142+	178+	156+	169+	212+	135	170+	81
12-17	39+	25+	31+	18	24	16	29	19	23	38+	21	21	13	11	8	9
18-25	66	42	46	57	56	70	58	83+	83	100+	95+	66	75	57	82	46
≥26	12	25	40	33	9	20	28	85+	37	40	40	82	124+	68	80+	26

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

numbers in 2002 to 2004. The number of young adults aged 18 to 25 in 2017 who were past year heroin initiates was similar to the numbers in most years from 2002 to 2016, although the number in 2017 was lower than the numbers in 2009, 2011, and 2012. Among adults aged 26 or older in 2017, the number of past year heroin initiates was similar to the numbers in most years from 2002 to 2015, but it was lower than the estimate in 2016. Caution is advised in interpreting the fluctuations in the numbers of heroin initiates in single years because the relatively small numbers of recent initiates per year can contribute to these fluctuations.[37]

Initiation of Hallucinogen Use

Because a new baseline was established in 2015, the 2017 NSDUH estimates of hallucinogen use initiation are not comparable with estimates prior to 2015. In 2017, 1.2 million people aged 12 or older used hallucinogens for the first time in the past year (Figure 27).[38] This number averages to about 3,300 new hallucinogen users each day (Table A.19A). An estimated 344,000 adolescents aged 12 to 17, 683,000 young adults aged 18 to 25, and 167,000 adults aged 26 or older used hallucinogens for the first time in the past year (Tables A.16A, A.17A, and A.18A, respectively).

Initiation of Inhalant Use

Because a new baseline was established in 2015, the 2017 NSDUH estimates of inhalant initiation are not comparable with estimates prior to 2015. In 2017, 575,000 people aged 12 or older had used inhalants for the first time in the past 12 months (Figure 27), which averages to about 1,600 people per day who initiated inhalant use (Table A.19A).

In 2017, inhalants were more commonly used by adolescents aged 12 to 17 and by young adults aged 18 to 25 than by adults aged 26 or older, which is reflected in the number of inhalant initiates by age group. An estimated 289,000 adolescents used inhalants for the first time in the past year (Table A.16A). This number averages to approximately 790 adolescents each day who initiated inhalant use (Table A.19A). There were 212,000 young adults aged 18 to 25 who initiated inhalant use in the past year (Table A.17A), or an average of 580 young adults each day who initiated inhalant use. An estimated 75,000 adults aged 26 or older used inhalants for the first time in the past year (Table A.18A), or an average of about 210 initiates per day in this age group.

Initiation of Methamphetamine Use

Because of changes in the NSDUH questionnaire, estimates of methamphetamine initiation in 2017 are not comparable with estimates prior to 2015. In 2017, 195,000 people aged 12 or older initiated methamphetamine use in the past year (Figure 27), which averages to about 530 people per day who initiated methamphetamine use (Table A.19A). An estimated 27,000 adolescents aged 12 to 17, 95,000 young adults aged 18 to 25, and 73,000 adults aged 26 or older used methamphetamine for the first time in the past year (Tables A.16A, A.17A, and A.18A, respectively).

Perceived Risk from Substance Use

One factor that can influence whether individuals will use tobacco, alcohol, or illicit drugs is the extent to which they believe that using these substances might cause them harm. In 2017, NSDUH respondents were asked how much they thought people risk harming themselves physically and in other ways when they use various substances in certain amounts or frequencies. Response choices for these items were "great risk," "moderate risk," "slight risk," or "no risk." Depending on the substance, respondents were asked about

their perceived risk of harm from trying the substance, using it daily, using it once a month (subsequently referred to as monthly use), or using it once or twice a week (subsequently referred to as weekly use). Only estimates from 2017 are presented for estimates of the perceived risk of harm because a new baseline was established in 2015 for these estimates.

Figure 31 presents the percentages of people aged 12 or older in 2017 who perceived great risk of harm from the use of various substances. In this report, risk perceptions across substances are not compared because there are variations in the quantity and frequency of use across these substances.[39]

Perceived Risk from Smoking a Pack or More of Cigarettes Daily

In 2017, 71.6 percent of people aged 12 or older perceived great risk of harm from smoking one or more packs of cigarettes per day (Figure 31). Perceptions of risk varied by age, with adults aged 26 or older (73.0 percent) being more likely than adolescents aged 12 to 17 (67.2 percent) and young adults aged 18 to 25 (66.6 percent) to perceive great risk from smoking one or more packs of cigarettes per day (Table A.20B). Nevertheless, about two thirds or more of people in each age group perceived great risk from smoking a pack or more of cigarettes per day.

Perceived Risk from Binge Alcohol Use

In 2017, about 2 out of 3 individuals aged 12 or older (68.9 percent) perceived great risk of harm from having four or five drinks of alcohol nearly every day (Figure 31).

Less than half of individuals aged 12 or older (44.6 percent) perceived great risk from having five or more drinks of alcohol once or twice a week. For brevity, these levels of alcohol consumption on a single day are subsequently referred to as "binge drinking" in this section.[22,23]

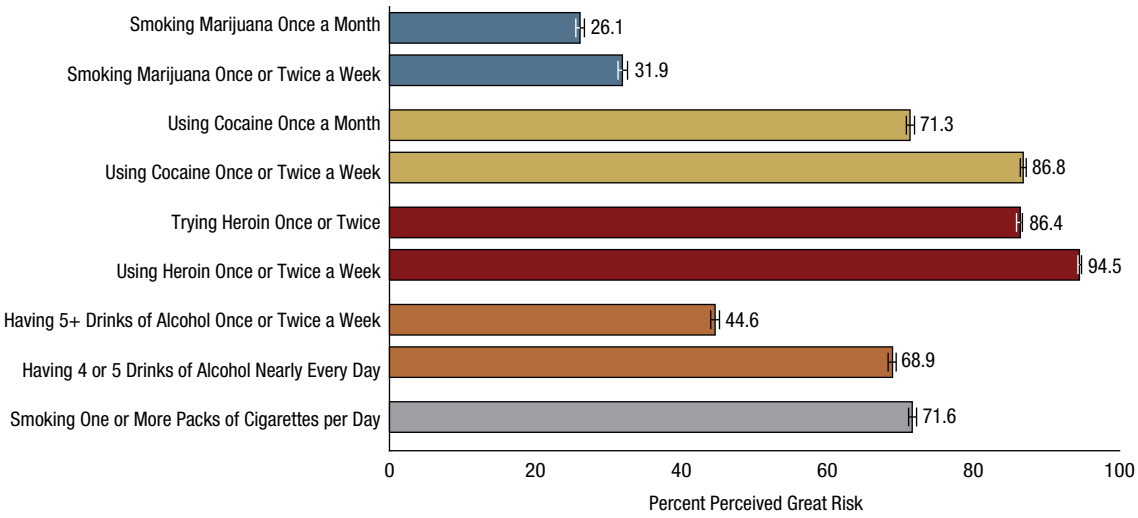
Perceptions of risk from binge alcohol use varied by age in 2017. Percentages of people who perceived great risk of harm from weekly binge drinking were lowest among young adults aged 18 to 25 (37.9 percent), followed by adolescents aged 12 to 17 (43.6 percent), then by adults aged 26 or older (45.8 percent) (Table A.20B). Similarly, young adults were least likely to perceive great risk from binge drinking nearly every day (63.2 percent), followed by adolescents (65.2 percent), then by adults aged 26 or older (70.2 percent).

Perceived Risk from Marijuana Use

In 2017, about one fourth of people aged 12 or older (26.1 percent) perceived great risk of harm from smoking marijuana once a month (Figure 31). About one third of people aged 12 or older (31.9 percent) perceived great risk from smoking marijuana once or twice a week.

Perceptions of risk of harm from smoking marijuana varied by age in 2017, with young adults aged 18 to 25 being less likely than adolescents aged 12 to 17 or adults aged 26 or older to perceive great risk from smoking marijuana monthly or weekly (Table A.20B). About one fourth of adolescents aged 12 to 17 (24.4 percent) perceived great risk of harm from smoking marijuana monthly, and about 2 in 5

Figure 31. Perceived Great Risk from Substance Use among People Aged 12 or Older: Percentages, 2017



adolescents perceived great risk from smoking marijuana weekly (37.7 percent). An estimated 12.3 percent of young adults aged 18 to 25 perceived great risk from smoking marijuana monthly, and 15.4 percent perceived great risk from smoking marijuana weekly. Among adults aged 26 or older, 28.5 percent perceived great risk from smoking marijuana monthly, and 34.0 percent perceived great risk from smoking marijuana weekly.

Perceived Risk from Cocaine Use

In 2017, most individuals aged 12 or older perceived great risk of harm from using cocaine either once a month or once or twice a week (Figure 31). An estimated 71.3 percent of individuals aged 12 or older perceived great risk of harm from monthly cocaine use, and 86.8 percent perceived great risk of harm from weekly use of this drug.

Perceptions of risk of harm varied by age in 2017, with adolescents aged 12 to 17 being less likely than young adults aged 18 to 25 or adults aged 26 or older to perceive great risk from using cocaine either monthly or weekly (Table A.20B). More than half of adolescents perceived great risk of harm from monthly cocaine use (55.6 percent), and about 4 out of 5 adolescents (80.1 percent) perceived great risk from weekly cocaine use. Nearly 2 out of 3 young adults aged 18 to 25 perceived great risk from monthly cocaine use (63.0 percent), and more than 4 out of 5 perceived great risk from weekly cocaine use (83.3 percent). About 3 out of 4 adults aged 26 or older perceived great risk from monthly cocaine use (74.5 percent), and 88.2 percent perceived great risk from weekly cocaine use. Additional data on finer age group categories that can be found in the 2017 detailed tables (available at https://www.samhsa.gov/data/) indicate that the lower likelihood of adolescents than adults to perceive great risk of harm from cocaine use may reflect a general lack of knowledge about cocaine among adolescents, as younger adolescents aged 12 or 13 tended to have lower perceptions of the risk of harm compared with older adolescents or adults.

Perceived Risk from Heroin Use

In 2017, most individuals aged 12 or older perceived great risk of harm from trying heroin once or twice or from using heroin weekly (Figure 31). An estimated 86.4 percent of individuals aged 12 or older perceived great risk of harm from trying heroin once or twice, and 94.5 percent perceived great risk of harm from weekly use.

Perceptions of risk varied by age group in 2017, with adolescents aged 12 to 17 being less likely than young adults aged 18 to 25 or adults aged 26 or older to perceive great risk from trying heroin once or twice or using it weekly (Table A.20B). The lower perceptions of the risk of harm from heroin use among adolescents relative to older age groups were most evident in the percentage who perceived great risk of harm from trying heroin once or twice. About two thirds of adolescents aged 12 to 17 perceived great risk from trying heroin once or twice (66.3 percent). In comparison, 82.6 percent of young adults aged 18 to 25 and 89.3 percent of adults aged 26 or older perceived great risk from trying heroin once or twice. An estimated 84.0 percent of adolescents perceived great risk from weekly heroin use compared with 93.9 percent of young adults and 95.8 percent of adults aged 26 or older.

As with risk perceptions for cocaine use, estimates from the 2017 detailed tables indicate that younger adolescents aged 12 or 13 were less likely than older adolescents or adults to perceive great risk from heroin use. Thus, the lower likelihood of adolescents than adults to perceive great risk of harm from heroin use may be attributable to a general lack of knowledge about heroin among adolescents, especially among younger adolescents.

Substance Use Disorders in the Past Year

Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. NSDUH includes a series of questions to estimate the percentage of the population aged 12 or older who had at least one SUD in the past 12 months (subsequently referred to as "an SUD" or "a past year SUD," except when "SUDs" refers to more than one substance, such as SUDs for the misuse of prescription drugs). Respondents were asked SUD questions if they previously reported use in the past 12 months of alcohol or illicit drugs. Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). These SUD questions classify people as having an SUD in the past 12 months and are based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV).[40,41]

Because of changes that were described previously to the questions for the misuse of prescription drugs, use of methamphetamine, and use of hallucinogens and inhalants, the 2017 estimates for overall SUD (i.e., for alcohol or illicit drugs), any illicit drug use disorder, and SUDs for the misuse of prescription drugs are not comparable with the estimates from years prior to 2015.[42] The questions did not change for identifying past year users of alcohol, marijuana, cocaine, and heroin. Therefore, estimates of SUDs for these substances in 2017 remained comparable with estimates from earlier years.

This section presents SUD estimates for the most common disorders among the population aged 12 or older. Less common SUD estimates are not discussed in this report (e.g., inhalant use disorder) but are available in Tables A.21B through A.24B.

Alcohol Use Disorder

Alcohol use disorder was defined as meeting DSM-IV criteria for either dependence or abuse for alcohol. Respondents who used alcohol on 6 or more days in the past 12 months were defined as having dependence if they met three or more of the following seven dependence criteria:

1. spent a lot of time engaging in activities related to alcohol use,
2. used alcohol in greater quantities or for a longer time than intended,
3. developed tolerance,
4. made unsuccessful attempts to cut down on use,
5. continued use despite physical health or emotional problems associated with alcohol use,
6. reduced or eliminated participation in other activities because of alcohol use, and
7. experienced withdrawal symptoms when cutting back or stopping use.

Respondents who used alcohol on 6 or more days in the past 12 months and did not meet criteria for alcohol dependence were defined as having abuse if they reported one or more of the following:

1. problems at work, home, and school because of alcohol use;
2. regularly using alcohol and then doing something physically dangerous;
3. repeated trouble with the law because of alcohol use; and
4. continued use of alcohol despite problems with family or friends.

An estimated 14.5 million people aged 12 or older in 2017 had an alcohol use disorder, which represents 5.3 percent of people aged 12 or older (Figure 32), or about 1 in 19 people aged 12 or older. The percentage of people aged 12 or older in 2017 with an alcohol use disorder was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016.

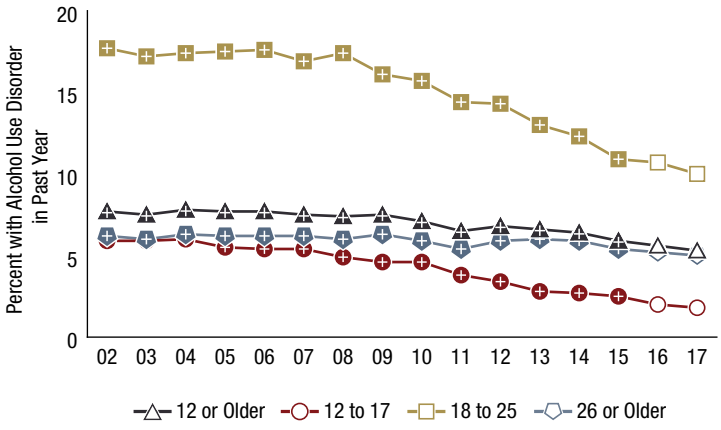
Aged 12 to 17

An estimated 443,000 adolescents aged 12 to 17 in 2017 had a past year alcohol use disorder, or 1.8 percent of adolescents (Figure 32). The percentage of adolescents in 2017 with an alcohol use disorder was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016.

Aged 18 to 25

Approximately 3.4 million young adults aged 18 to 25 in 2017 had an alcohol use disorder in the past year. This number of young adults with an alcohol use disorder represents 10.0 percent of young adults (Figure 32). The percentage of young adults in 2017 with an alcohol use

Figure 32. Alcohol Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 32 Table. Alcohol Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	7.7+	7.5+	7.8+	7.7+	7.7+	7.5+	7.4+	7.5+	7.1+	6.5+	6.8+	6.6+	6.4+	5.9+	5.6	5.3
12-17	5.9+	5.9+	6.0+	5.5+	5.4+	5.4+	4.9+	4.6+	4.6+	3.8+	3.4+	2.8+	2.7+	2.5+	2.0	1.8
18-25	17.7+	17.2+	17.4+	17.5+	17.6+	16.9+	17.4+	16.1+	15.7+	14.4+	14.3+	13.0+	12.3+	10.9+	10.7	10.0
≥26	6.2+	6.0+	6.3+	6.2+	6.2+	6.2+	6.0+	6.3+	5.9+	5.4+	5.9+	6.0+	5.9+	5.4+	5.2	5.0

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

disorder was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016. Nevertheless, 1 in 10 young adults in 2017 had an alcohol use disorder.

Aged 26 or Older

In 2017, approximately 10.6 million adults aged 26 or older had an alcohol use disorder in the past year, which represents 5.0 percent of the adults in this age group (Figure 32). The percentage of adults aged 26 or older in 2017 with an alcohol use disorder was lower than the percentages in 2002 to 2015, but it was similar to the percentage in 2016.

Illicit Drug Use Disorder

This section presents overall estimates for illicit drug use disorder and then provides SUD estimates for selected specific illicit drugs. Illicit drug use disorder is defined as meeting DSM-IV criteria for either dependence or abuse for one or more of the following illicit drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs that were misused (i.e., pain relievers, tranquilizers, stimulants, and sedatives).[43] There are seven possible dependence criteria for specific illicit drugs:

1. spent a lot of time engaging in activities related to use of the drug,
2. used the drug in greater quantities or for a longer time than intended,
3. developed tolerance to the drug,
4. made unsuccessful attempts to cut down on use of the drug,
5. continued to use the drug despite physical health or emotional problems associated with use,
6. reduced or eliminated participation in other activities because of use of the drug, and
7. experienced withdrawal symptoms when respondents cut back or stopped using the drug.

For most illicit drugs, dependence is defined as meeting three or more of these seven criteria. However, experiencing withdrawal symptoms is not included as a criterion for some illicit drugs based on DSM-IV criteria. For these substances, dependence is defined as meeting three or more of the first six criteria.

Respondents who used (or misused) a specific illicit drug in the past 12 months and did not meet the dependence criteria for that drug were defined as having abuse for that drug if they reported one or more of the following:

1. problems at work, home, and school because of use of the drug;
2. regularly using the drug and then doing something physically dangerous;
3. repeated trouble with the law because of use of the drug; and
4. continued use of the drug despite problems with family or friends.

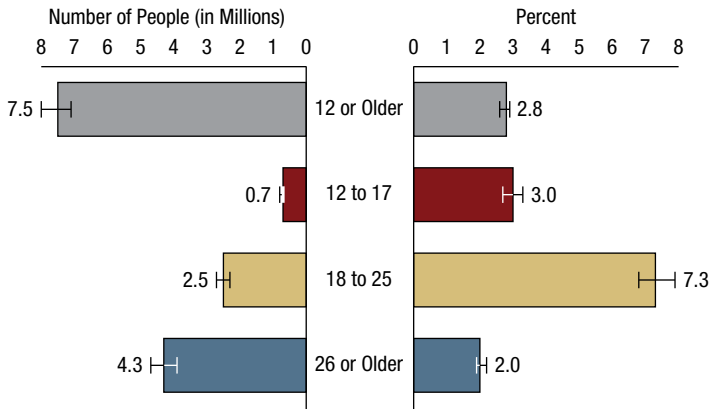
Application of these criteria is discussed briefly in the respective SUD sections for specific illicit drugs. Detailed definitions for SUDs for specific illicit drugs also can be found in a glossary of key definitions for the 2017 NSDUH.[2]

In 2017, an estimated 7.5 million people aged 12 or older had at least one illicit drug use disorder (Figure 33). This number represents 2.8 percent of people aged 12 or older. An estimated 3.0 percent of adolescents aged 12 to 17 had an illicit drug use disorder, or about 741,000 adolescents. Approximately 2.5 million young adults aged 18 to 25 had an illicit drug use disorder in the past year, which represents 7.3 percent of young adults. Approximately 4.3 million adults aged 26 or older had an illicit drug use disorder in the past year, which represents 2.0 percent of adults in this age group.

Marijuana Use Disorder

Marijuana use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of marijuana, including health problems, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who used

Figure 33. Illicit Drug Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: 2017



marijuana on 6 or more days in the past 12 months were categorized as having a marijuana use disorder if they met the DSM-IV criteria for either dependence or abuse for marijuana. Dependence and abuse criteria for illicit drugs (including marijuana) were described previously.

Approximately 4.1 million people aged 12 or older in 2017 had a marijuana use disorder in the past year, which represents 1.5 percent of people aged 12 or older (Figure 34). The percentage of the population aged 12 or older in 2017 with a marijuana use disorder was lower than the percentages in most years between 2002 and 2010, and it was similar to the percentages from 2011 to 2016.

Aged 12 to 17

In 2017, 2.2 percent of adolescents aged 12 to 17 had a marijuana use disorder in the past year (Figure 34), or about 557,000 adolescents. The percentage of adolescents in 2017 with a marijuana use disorder was lower than the percentages in 2002 to 2014, but it was similar to the percentages in 2015 and 2016.

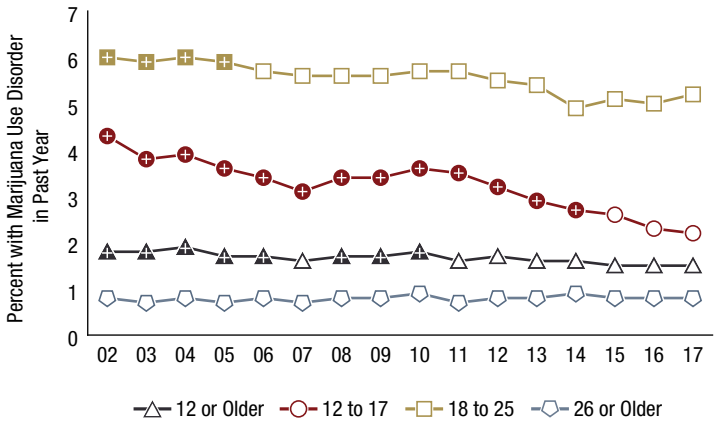
Aged 18 to 25

Approximately 1.8 million young adults aged 18 to 25 in 2017 had a marijuana use disorder in the past year, or 5.2 percent of young adults (Figure 34). The percentage of young adults in 2017 with a marijuana use disorder was lower than the percentages in 2002 through 2005, but it was similar to the percentages in all years from 2006 to 2016.

Aged 26 or Older

In 2017, approximately 1.7 million adults aged 26 or older had a marijuana use disorder in the past year, or 0.8 percent of adults in this age group (Figure 34). The 2017 percentage of adults aged 26 or older with a marijuana use disorder was similar to the percentages in all years between 2002 and 2016.

Figure 34. Marijuana Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 34 Table. Marijuana Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	1.8+	1.8+	1.9+	1.7+	1.7+	1.6	1.7+	1.7+	1.8+	1.6	1.7	1.6	1.6	1.5	1.5	1.5
12-17	4.3+	3.8+	3.9+	3.6+	3.4+	3.1+	3.4+	3.4+	3.6+	3.5+	3.2+	2.9+	2.7+	2.6	2.3	2.2
18-25	6.0+	5.9+	6.0+	5.9+	5.7	5.6	5.6	5.6	5.7	5.7	5.5	5.4	4.9	5.1	5.0	5.2
≥26	0.8	0.7	0.8	0.7	0.8	0.7	0.8	0.8	0.9	0.7	0.8	0.8	0.9	0.8	0.8	0.8

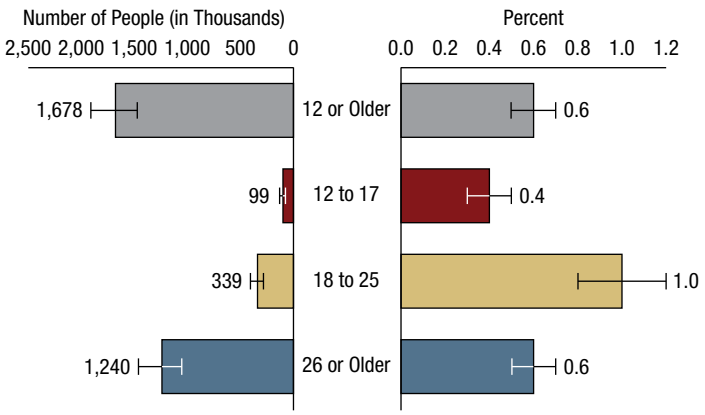
+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Pain Reliever Use Disorder

Pain reliever use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of pain relievers, including health problems, physical withdrawal, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who misused pain relievers in the past 12 months were categorized as having a pain reliever use disorder if they met the DSM-IV criteria for either dependence or abuse for pain relievers. Dependence and abuse criteria for illicit drugs (including misused pain relievers) were described previously.

In 2017, an estimated 1.7 million people aged 12 or older had a pain reliever use disorder, which corresponds to 0.6 percent of people aged 12 or older (Figure 35). An estimated 0.4 percent of adolescents aged 12 to 17 had a pain reliever use disorder in the past year, which represents about 99,000 adolescents. Approximately 339,000 young adults aged 18 to 25 and 1.2 million adults aged 26 or older had a pain reliever

Figure 35. Pain Reliever Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: 2017



use disorder in the past year. These numbers of adults with a pain reliever use disorder correspond to 1.0 percent of young adults and 0.6 percent of adults aged 26 or older.

Tranquilizer Use Disorder

Tranquilizer use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of tranquilizers, including health problems, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who misused tranquilizers in the past 12 months were categorized as having a tranquilizer use disorder if they met the DSM-IV criteria for either dependence or abuse for tranquilizers. Dependence and abuse criteria for illicit drugs (including misused tranquilizers) were described previously.

In 2017, an estimated 739,000 people aged 12 or older had a tranquilizer use disorder. This number represents 0.3 percent of people aged 12 or older (Table A.21B). An estimated 0.3 percent of adolescents aged 12 to 17 had a tranquilizer use disorder in the past year (Table A.22B), which represents about 80,000 adolescents. Approximately 278,000 young adults aged 18 to 25 and 380,000 adults aged 26 or older had a tranquilizer use disorder in the past year. These numbers correspond to 0.8 percent of young adults (Table A.23B) and 0.2 percent of adults aged 26 or older (Table A.24B).

Stimulant Use Disorder

Stimulant use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of prescription stimulants, including health problems, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who misused stimulants in the past 12 months were categorized as having a stimulant use disorder if they met the DSM-IV criteria for either dependence or abuse for stimulants. Dependence and abuse criteria for illicit drugs (including misused stimulants) were described previously. Respondents who met criteria for methamphetamine use disorder were not classified as having a stimulant use disorder unless they also met the criteria for stimulant use disorder based on their misuse of prescription stimulants.

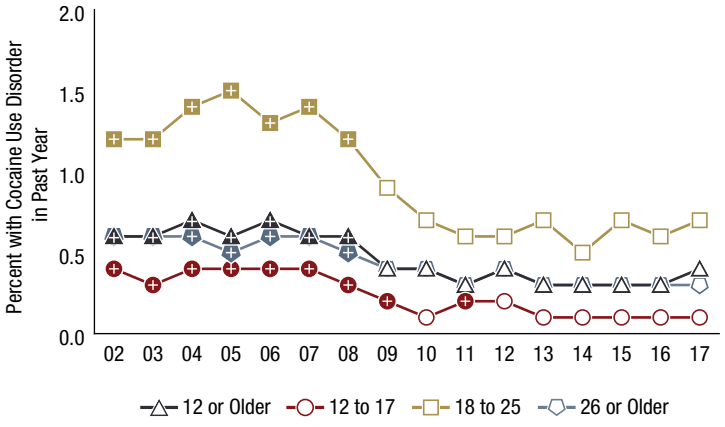
In 2017, an estimated 572,000 people aged 12 or older had a stimulant use disorder in the past year. This number of people with a stimulant use disorder represents 0.2 percent of people aged 12 or older (Table A.21B). An estimated 0.2 percent of adolescents aged 12 to 17 had a stimulant use disorder in the past year (Table A.22B), which represents about 62,000 adolescents. Approximately 187,000 young adults aged 18 to 25 and 323,000 adults aged 26 or older had a stimulant use disorder in the past year. These numbers correspond to 0.5 percent of young adults (Table A.23B) and 0.2 percent of adults aged 26 or older (Table A.24B).

Cocaine Use Disorder

Cocaine use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of cocaine, including health problems, physical withdrawal, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who used cocaine or crack in the past 12 months were categorized as having a cocaine use disorder if they met the DSM-IV criteria for either dependence or abuse for cocaine. Dependence and abuse criteria for illicit drugs (including cocaine) were described previously.

About 966,000 people aged 12 or older in 2017 had a cocaine use disorder in the past year. This number of people with a cocaine use disorder represents 0.4 percent of the population aged 12 or older (Figure 36). The percentage of

Figure 36. Cocaine Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 36 Table. Cocaine Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	0.6+	0.6+	0.7+	0.6+	0.7+	0.6+	0.6+	0.4	0.4	0.3	0.4	0.3	0.3	0.3	0.3	0.4
12-17	0.4+	0.3+	0.4+	0.4+	0.4+	0.4+	0.3+	0.2+	0.1	0.2+	0.2	0.1	0.1	0.1	0.1	0.1
18-25	1.2+	1.2+	1.4+	1.5+	1.3+	1.4+	1.2+	0.9	0.7	0.6	0.6	0.7	0.5	0.7	0.6	0.7
≥26	0.6+	0.6+	0.6+	0.5+	0.6+	0.6+	0.5+	0.4	0.4	0.3	0.4	0.3	0.3	0.3	0.3	0.3

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

the population aged 12 or older in 2017 with a cocaine use disorder was similar to the percentages in 2009 to 2016, but it was lower than the percentages from 2002 to 2008.

Aged 12 to 17

An estimated 0.1 percent of adolescents aged 12 to 17 in 2017 had a cocaine use disorder in the past year (Figure 36), or about 19,000 adolescents. The percentage of adolescents in 2017 with a cocaine use disorder was lower than the percentages in most years from 2002 to 2011, but it was similar to the percentages from 2012 to 2016.

Aged 18 to 25

Approximately 243,000 young adults aged 18 to 25 in 2017 had a cocaine use disorder in the past year. This number represents 0.7 percent of young adults (Figure 36). The percentage of young adults in 2017 with a cocaine use disorder was lower than the percentages in 2002 to 2008, but it was similar to the percentages from 2009 to 2016.

Aged 26 or Older

In 2017, approximately 703,000 adults aged 26 or older had a cocaine use disorder in the past year, which represents 0.3 percent of adults in this age group (Figure 36). The percentage of adults aged 26 or older in 2017 with a cocaine use disorder was lower than the percentages from 2002 to 2008, but it remained steady when compared with the percentages in all years between 2009 and 2016.

Heroin Use Disorder

Heroin use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of heroin, including health problems, physical withdrawal, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who used heroin in the past 12 months were categorized as having a heroin use disorder if they met the DSM-IV criteria for either dependence or abuse for heroin. Dependence and abuse criteria for illicit drugs (including heroin) were described previously.

About 652,000 people aged 12 or older in 2017 had a heroin use disorder. This number of people with a heroin use disorder represents 0.2 percent of people aged 12 or older (Figure 37). The percentage of people aged 12 or older in 2017 with a heroin use disorder was higher than the percentages in 2002 to 2011, but it was similar to the percentages from 2012 to 2016. Although there are significant differences, all percentages from 2002 to 2017 were 0.2 percent or less.

Aged 12 to 17

Less than 0.1 percent of adolescents aged 12 to 17 in 2017 had a heroin use disorder in the past year (Figure 37), which corresponds to about 4,000 adolescents. The percentage of adolescents in 2017 with a heroin use disorder was similar to the estimates in most years from 2002 to 2016.

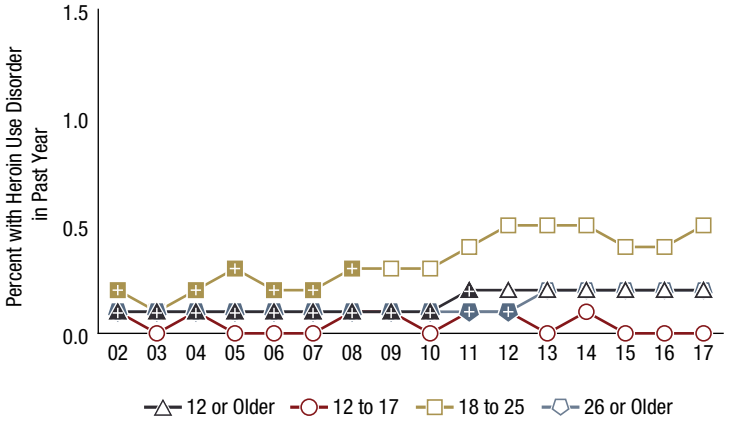
Aged 18 to 25

Approximately 165,000 young adults aged 18 to 25 in 2017 had a heroin use disorder in the past year, which represents 0.5 percent of young adults (Figure 37). The percentage of young adults in 2017 with a heroin use disorder was greater than the percentages in 2002 to 2008, but it was similar to the percentages from 2009 to 2016.

Aged 26 or Older

In 2017, approximately 483,000 adults aged 26 or older had a heroin use disorder in the past year, which represents 0.2 percent of adults in this age group (Figure 37). Between 2002 and 2017, 0.1 to 0.2 percent of adults aged 26 or older had a heroin use disorder in the past year. The 2017 estimate was higher than the estimates in 2002 to 2012, but it remained steady when compared with the percentages between 2013 and 2016.

Figure 37. Heroin Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 37 Table. Heroin Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2017

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
≥12	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.2+	0.2	0.2	0.2	0.2	0.2	0.2
12-17	0.1	0.0	0.1+	0.0	0.0	0.0	0.1+	0.1+	0.0	0.1+	0.1	0.0	0.1	0.0	0.0	0.0
18-25	0.2+	0.1+	0.2+	0.3+	0.2+	0.2+	0.3+	0.3	0.3	0.4	0.5	0.5	0.5	0.4	0.4	0.5
≥26	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.2	0.2	0.2	0.2	0.2

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Estimates of less than 0.1 percent round to 0.0 percent when shown to the nearest tenth of a percent.

Methamphetamine Use Disorder

Respondents were asked questions about SUD symptoms that they attributed specifically to their use of methamphetamine. Methamphetamine use disorder does not include stimulant use disorder based on the misuse of prescription stimulants because, starting in 2015, these concepts were measured and reported separately.

Methamphetamine use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of methamphetamine, including health problems, physical withdrawal, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. NSDUH respondents who used methamphetamine in the past 12 months were categorized as having a methamphetamine use disorder if they met the DSM-IV criteria for either dependence or abuse for methamphetamine. Dependence and abuse criteria for illicit drugs (including methamphetamine) were described previously.

In 2017, an estimated 964,000 people aged 12 or older had a methamphetamine use disorder. This number represents about 0.4 percent of people aged 12 or older (Table A.21B). An estimated 0.1 percent of adolescents aged 12 to 17 had a methamphetamine use disorder in the past year (Table A.22B), which represents about 24,000 adolescents. Approximately 188,000 young adults aged 18 to 25 and 751,000 adults aged 26 or older had a methamphetamine use disorder in the past year. These numbers of adults with a methamphetamine use disorder in the past year correspond to 0.5 percent of young adults aged 18 to 25 (Table A.23B) and 0.4 percent of adults aged 26 or older (Table A.24B).

Opioid Use Disorder

Misuse of opioids include two categories of drugs: the use of heroin and the misuse of prescription pain relievers. NSDUH collects dependence and abuse information for these two categories of drugs. A respondent was classified as having an opioid use disorder if he or she met DSM-IV criteria for heroin use disorder or pain reliever use disorder, as described previously.

In 2017, an estimated 2.1 million people aged 12 or older had an opioid use disorder, or 0.8 percent of people aged 12 or older (Figure 38). An estimated 0.4 percent of adolescents aged 12 to 17 had an opioid use disorder in the past year, which represents about 103,000 adolescents. About 445,000 young adults aged 18 to 25 had an opioid use disorder in the past year. This number corresponds to 1.3 percent of young adults. An estimated 1.6 million adults aged 26 or older had an opioid use disorder, which corresponds to 0.7 percent of adults in this age group.

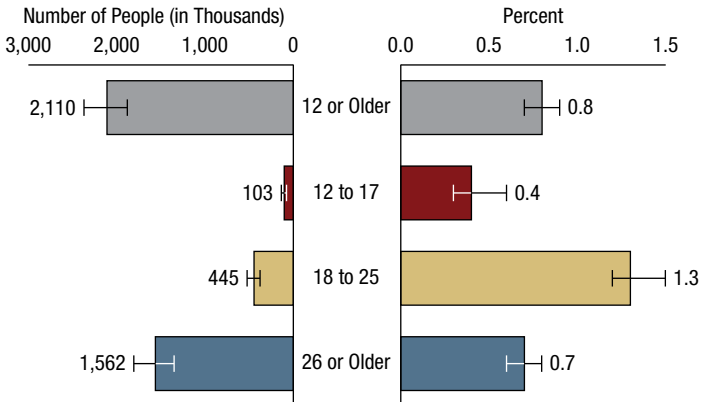
Substance Use Disorder (Alcohol or Illicit Drugs)

NSDUH's overall estimates of SUD include people who met the DSM-IV criteria for either dependence or abuse for alcohol or illicit drugs. In 2017, approximately 19.7 million people aged 12 or older had an SUD in the past year, including 14.5 million people who had an alcohol use disorder and 7.5 million people who had an illicit drug use disorder (Figure 39). Among the 7.5 million people aged 12 or older who had an illicit drug use disorder, the most common disorders were for marijuana (4.1 million people) and misuse of prescription pain relievers (1.7 million people).

The estimated 14.5 million people aged 12 or older in 2017 who had an alcohol use disorder in the past year represent nearly 3 out of 4 people who had an SUD (73.6 percent) (Figure 40).[24] The 7.5 million people who had an illicit drug use disorder represent about 2 out of 5 people who had an SUD (38.3 percent). An estimated 2.3 million people had both an alcohol use disorder and an illicit drug use disorder in the past year, or about 1 in 8 people who had a past year SUD (11.9 percent).

In 2017, the 19.7 million people with a past year SUD represented 7.2 percent of people aged 12 or older

Figure 38. Opioid Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: 2017



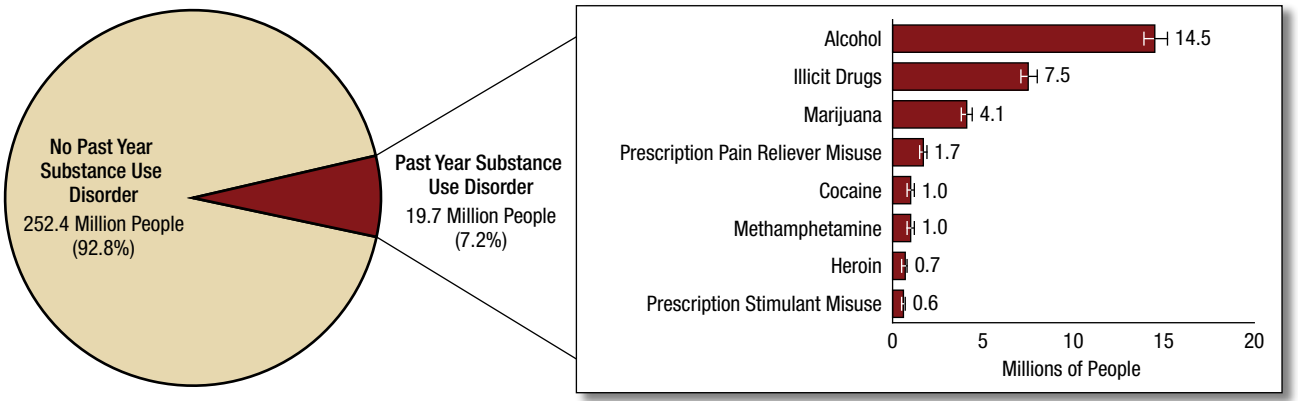
Note: Opioid use disorder is defined as meeting DSM-IV criteria for heroin use disorder or pain reliever use disorder in the past 12 months.

(Figure 41). This percentage of people who had an SUD corresponds to about 1 in 14 people aged 12 or older. An estimated 992,000 adolescents aged 12 to 17 had an SUD, which represents 4.0 percent of adolescents. An estimated 5.1 million young adults aged 18 to 25 had an SUD. This number represents 14.8 percent of young adults. An estimated 13.6 million adults aged 26 or older had an SUD, which represents 6.4 percent of adults in this age group. Stated another way, about 1 in 25 adolescents, 1 in 7 young adults, and 1 in 16 adults aged 26 or older had an SUD in the past year.

Major Depressive Episode in the Past Year

Mental disorders, such as major depressive episode (MDE), are characterized by changes in mood, thought, or behavior. They can make carrying out daily activities difficult and can impair an individual's ability to work or function in school, interact with family, and fulfill other major life functions. Adults aged 18 or older and adolescents aged 12 to 17 were defined as having had at least one MDE in the past 12 months (subsequently referred to as "an MDE" or "a past year MDE") if they had a period of 2 weeks or longer in that period when they experienced a depressed mood or loss

Figure 39. Numbers of People Aged 12 or Older with a Past Year Substance Use Disorder: 2017



Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

Figure 40. Alcohol Use Disorder and Illicit Drug Use Disorder in the Past Year among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD): 2017

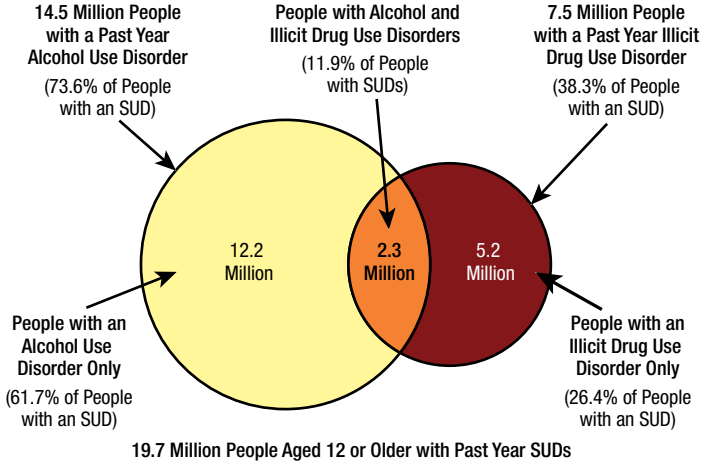
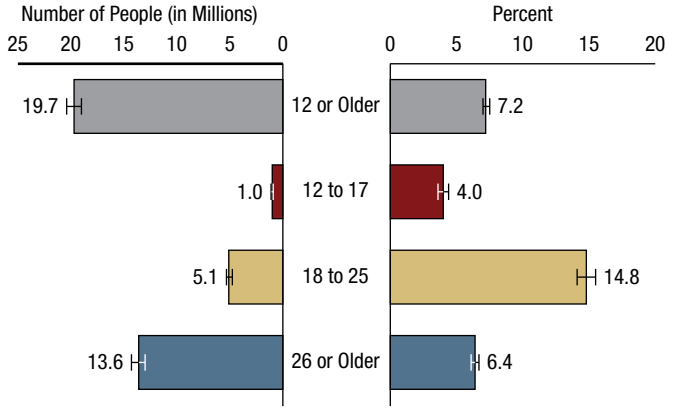


Figure 41. Substance Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: 2017



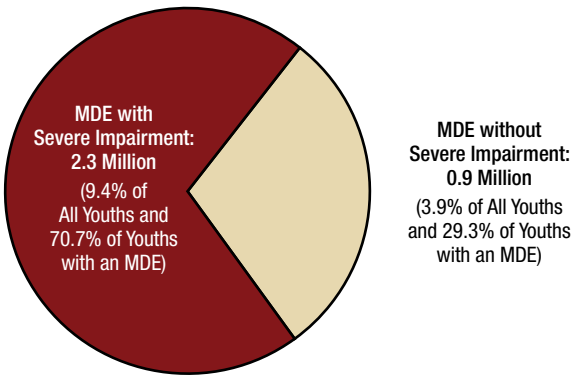
of interest or pleasure in daily activities, and they had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, or self-worth. MDE questions are based on diagnostic criteria from DSM-5.[44] Some of the wordings of depression questions for adolescents and adults differed slightly to make the questions more developmentally appropriate for adolescents. Therefore, the adult and youth estimates for MDE are not directly comparable and are presented separately.[45]

NSDUH also collects data on impairment in four major life activities or role domains because of an MDE in the past year. These domains are defined separately for adults and youths to reflect the different roles associated with the two age groups. Adults were defined as having an MDE with severe impairment if their depression caused severe problems with their ability to manage at home, manage well at work, have relationships with others, or have a social life.[46] Adolescents were defined as having an MDE with severe impairment if their depression caused severe problems with their ability to do chores at home, do well at work or school, get along with their family, or have a social life.[47]

MDE and MDE with Severe Impairment among Adolescents

In 2017, 13.3 percent of adolescents aged 12 to 17 (3.2 million adolescents) had an MDE in the past year, and 9.4 percent of adolescents (2.3 million adolescents) had a past year MDE with severe impairment (Figure 42). Thus, adolescents in 2017 who had an MDE with severe impairment represented more than two thirds (70.7 percent) of adolescents who had a past year MDE.[24,48]

Figure 42. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: 2017



3.2 Million Youths with a Past Year MDE (13.3% of All Youths)

Note: Youth respondents with unknown past year MDE data or unknown impairment data were excluded.

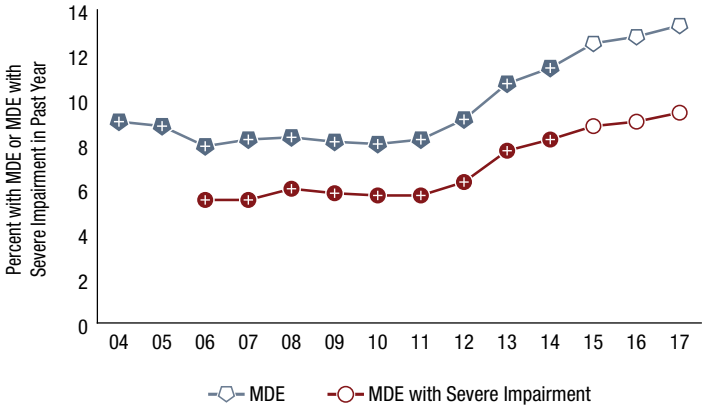
The percentage of adolescents aged 12 to 17 in 2017 who had a past year MDE was higher than the percentages in 2004 to 2014, but it was similar to the estimates in 2015 and 2016 (Figure 43). The percentage of adolescents in 2017 who had a past year MDE with severe impairment was higher than the percentages in 2006 to 2014, which ranged from 5.5 to 8.2 percent. However, the 2017 estimate for MDE with severe impairment among adolescents was similar to the estimates in 2015 and 2016.

MDE and MDE with Severe Impairment among Adults

In 2017, 7.1 percent of adults aged 18 or older (17.3 million adults) had at least one MDE in the past year, and 4.5 percent of adults (11.0 million adults) had an MDE with severe impairment in the past year (Figure 44). Adults in 2017 who had an MDE with severe impairment represented nearly two thirds (63.8 percent) of adults who had a past year MDE.[24,48]

The percentage of adults aged 18 or older in 2017 who had a past year MDE was similar to the percentages in most years from 2010 to 2016 (Figure 45). The percentage of adults in 2017 with a past year MDE with severe impairment was similar to the percentages in most years between 2009 and 2016 (Figure 46).

Figure 43. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: Percentages, 2004-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 43 Table. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: Percentages, 2004-2017

MDE Status	04	05	06	07	08	09	10	11	12	13	14	15	16	17
MDE	9.0+	8.8+	7.9+	8.2+	8.3+	8.1+	8.0+	8.2+	9.1+	10.7+	11.4+	12.5	12.8	13.3
MDE with Severe Impairment	N/A	N/A	5.5+	5.5+	6.0+	5.8+	5.7+	5.7+	6.3+	7.7+	8.2+	8.8	9.0	9.4

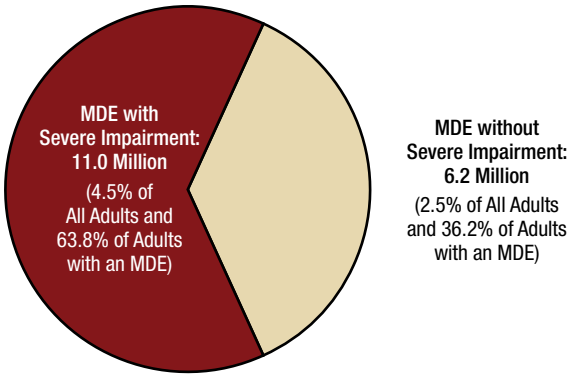
N/A = not available.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Aged 18 to 25

In 2017, an estimated 4.4 million young adults aged 18 to 25 had a past year MDE, or 13.1 percent of young adults (Figure 45). The percentage of young adults with a past year MDE was greater in 2017 than in the years from 2005 to 2016.

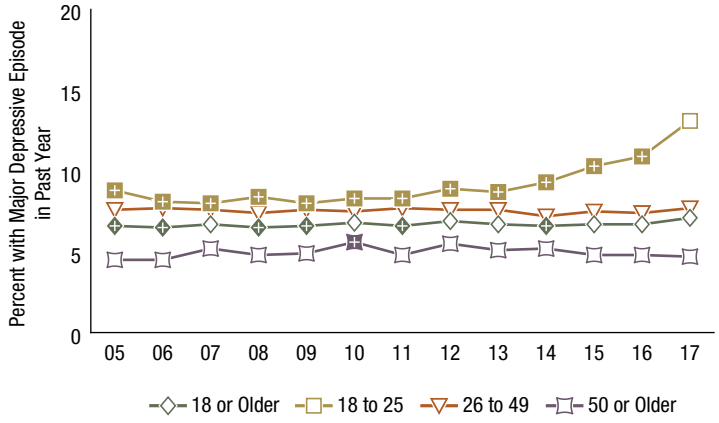
Figure 44. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Adults Aged 18 or Older: 2017



17.3 Million Adults with a Past Year MDE (7.1% of All Adults)

Note: Adult respondents with unknown past year MDE data or unknown impairment data were excluded.

Figure 45. Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2005-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 45 Table. Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2005-2017

Age Group	05	06	07	08	09	10	11	12	13	14	15	16	17
18 or Older	6.6+	6.5+	6.7	6.5+	6.6+	6.8	6.6+	6.9	6.7	6.6+	6.7	6.7	7.1
18 to 25	8.8+	8.1+	8.0+	8.4+	8.0+	8.3+	8.3+	8.9+	8.7+	9.3+	10.3+	10.9+	13.1
26 to 49	7.6	7.7	7.6	7.4	7.6	7.5	7.7	7.6	7.6	7.2	7.5	7.4	7.7
50 or Older	4.5	4.5	5.2	4.8	4.9	5.6+	4.8	5.5	5.1	5.2	4.8	4.8	4.7

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

An estimated 2.9 million young adults aged 18 to 25 in 2017 had a past year MDE with severe impairment, or 8.5 percent of young adults (Figure 46). The percentage of young adults with a past year MDE with severe impairment was greater in 2017 than in 2009 to 2016.

Aged 26 to 49

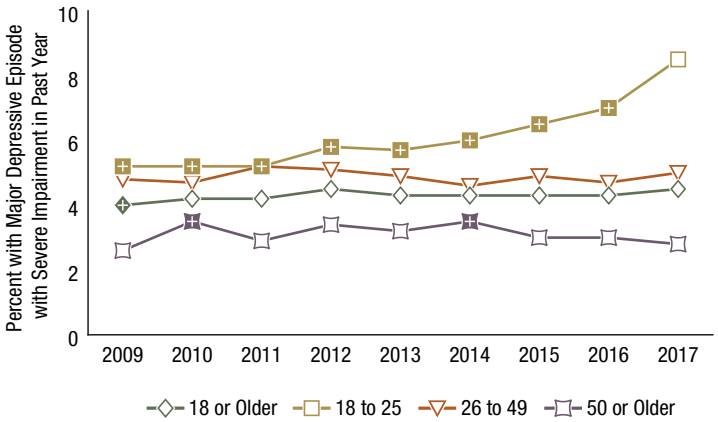
In 2017, an estimated 7.6 million adults aged 26 to 49 had a past year MDE, or 7.7 percent of adults in this age group (Figure 45). The percentage of adults aged 26 to 49 in 2017 who had a past year MDE was similar to the corresponding percentages in 2005 to 2016.

An estimated 5.0 million adults aged 26 to 49 in 2017 had a past year MDE with severe impairment, or 5.0 percent of adults in this age group (Figure 46). The percentage of adults aged 26 to 49 in 2017 who had a past year MDE with severe impairment was similar to the percentages in 2009 to 2016.

Aged 50 or Older

In 2017, an estimated 5.2 million adults aged 50 or older had a past year MDE, or 4.7 percent of adults in this age group (Figure 45). The percentage of adults aged 50 or

Figure 46. Major Depressive Episode with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2009-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 46 Table. Major Depressive Episode with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2009-2017

Age Group	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	4.0+	4.2	4.2	4.5	4.3	4.3	4.3	4.3	4.5
18 to 25	5.2+	5.2+	5.2+	5.8+	5.7+	6.0+	6.5+	7.0+	8.5
26 to 49	4.8	4.7	5.2	5.1	4.9	4.6	4.9	4.7	5.0
50 or Older	2.6	3.5+	2.9	3.4	3.2	3.5+	3.0	3.0	2.8

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

older in 2017 who had a past year MDE was similar to the corresponding percentages in most years from 2005 to 2016.

An estimated 3.1 million adults aged 50 or older in 2017 had a past year MDE with severe impairment, or 2.8 percent of adults in this age group (Figure 46). The percentage of adults aged 50 or older in 2017 who had a past year MDE with severe impairment was similar to the percentages in most years from 2009 to 2016.

Mental Illness among Adults in the Past Year

NSDUH provides estimates of any mental illness (AMI) and serious mental illness (SMI) for adults aged 18 or older.[49] Except for MDE, NSDUH does not include questions or methods for estimating the occurrence of mental disorders among adolescents. Therefore, NSDUH does not include any measure for adolescents that is equivalent to AMI or SMI for adults.

Adults with AMI were defined as having any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental disorders and SUDs).[40,50] Adults with AMI were defined as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. AMI and SMI are not mutually exclusive categories; adults with SMI are included in estimates of adults with AMI. Adults with AMI who do not meet the criteria for having SMI are categorized as having AMI excluding SMI. This section includes past year estimates of adults with AMI, SMI, and AMI excluding SMI.

Mental Illness among All Adults

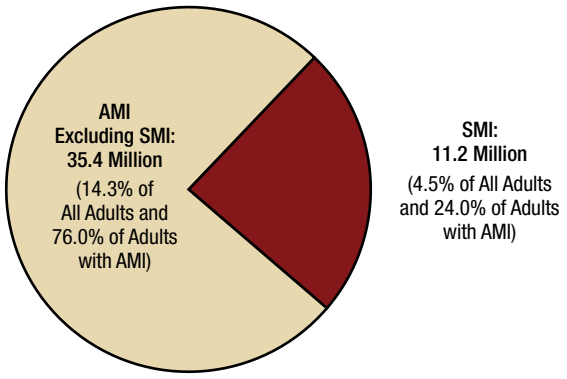
In 2017, an estimated 46.6 million adults aged 18 or older had AMI in the past year (Figure 47). This number represents 18.9 percent of adults in the United States. An estimated 11.2 million adults in the nation had SMI in the past year, and 35.4 million adults had AMI excluding SMI in the past year. The number of adults with SMI represents 4.5 percent of adults, and the number of adults with AMI excluding SMI represents 14.3 percent of adults. Among adults with AMI in the past year, 24.0 percent had SMI, and 76.0 percent did not have SMI.[24,51,52]

The percentage of adults in 2017 with AMI was similar to the percentage in 2016, but it was higher than percentages in all but 3 years from 2008 to 2015 (Figure 48). The percentage of adults in 2017 with SMI was higher than percentages in most years from 2008 to 2016. In contrast, the percentage of adults in 2017 who had AMI excluding SMI was similar to the percentages from 2008 to 2016 (Figures 49 and 50).

Aged 18 to 25

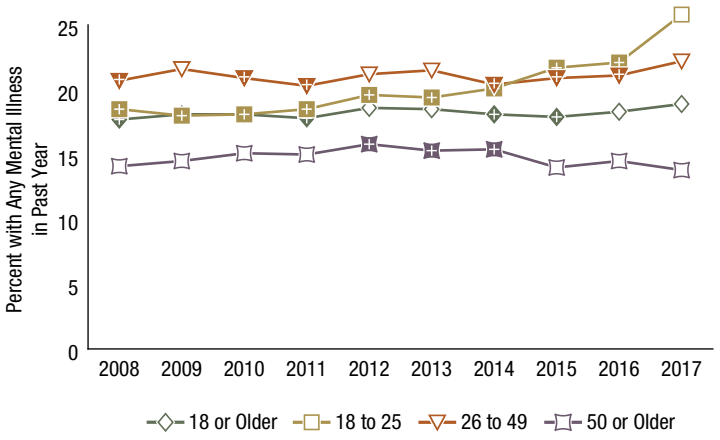
In 2017, an estimated 8.8 million young adults aged 18 to 25 (25.8 percent) had AMI in the past year (Figure 48).

Figure 47. Any Mental Illness (AMI), Serious Mental Illness (SMI), and AMI Excluding SMI in the Past Year among Adults Aged 18 or Older: 2017



46.6 Million Adults with AMI in the Past Year (18.9% of All Adults)

Figure 48. Any Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 48 Table. Any Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	17.7+	18.1	18.1+	17.8+	18.6	18.5	18.1+	17.9+	18.3	18.9
18 to 25	18.5+	18.0+	18.1+	18.5+	19.6+	19.4+	20.1+	21.7+	22.1+	25.8
26 to 49	20.7+	21.6	20.9+	20.3+	21.2	21.5	20.4+	20.9+	21.1+	22.2
50 or Older	14.1	14.5	15.1	15.0	15.8+	15.3+	15.4+	14.0	14.5	13.8

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

An estimated 2.6 million young adults (7.5 percent) had SMI in the past year (Figure 49). An estimated 6.3 million young adults (18.3 percent) had AMI excluding SMI in the past year (Figure 50).

Percentages of young adults aged 18 to 25 in 2017 who had AMI, SMI, or AMI excluding SMI were greater than the corresponding percentages in each year from 2008 to 2016. For example, the percentages of young adults with AMI ranged from 18.0 to 22.1 percent in 2008 to 2016 compared with 25.8 percent of young adults in 2017.

Aged 26 to 49

In 2017, 22.3 million adults aged 26 to 49 (22.2 percent) had AMI in the past year (Figure 48), and an estimated 5.6 million adults aged 26 to 49 (5.6 percent) had SMI in the past year (Figure 49). An estimated 16.7 million adults aged 26 to 49 (16.6 percent) had AMI excluding SMI in the past year (Figure 50).

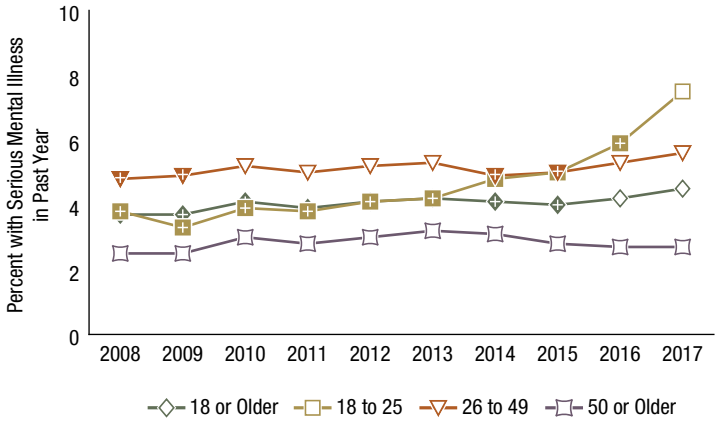
The 2017 estimate of AMI among adults aged 26 to 49 was higher than the estimates between 2014 and 2016, but it was similar to the estimates in 2012 and 2013. The estimate of SMI among adults aged 26 to 49 in 2017 was higher than the estimates in 2014 and 2015, but it was similar to the estimates in 2010 to 2013 and in 2016. The estimate of AMI excluding SMI among adults aged 26 to 49 in 2017 was higher than the estimates in 2014 and 2016, but it was similar to the estimates in most years between 2008 and 2013 and in 2015.

Aged 50 or Older

In 2017, an estimated 15.5 million adults aged 50 or older (13.8 percent) had AMI in the past year (Figure 48), and an estimated 3.0 million adults aged 50 or older (2.7 percent) had SMI in the past year (Figure 49). An estimated 12.5 million adults aged 50 or older (11.1 percent) had AMI excluding SMI in the past year (Figure 50).

The 2017 estimate of AMI among adults aged 50 or older was similar to estimates in 2015 and 2016, but it was lower than the estimates in 2012 to 2014. The percentages of adults aged 50 or older in 2017 with past year SMI and with past year AMI excluding SMI were similar to the percentages in most or all years from 2008 to 2016.

Figure 49. Serious Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



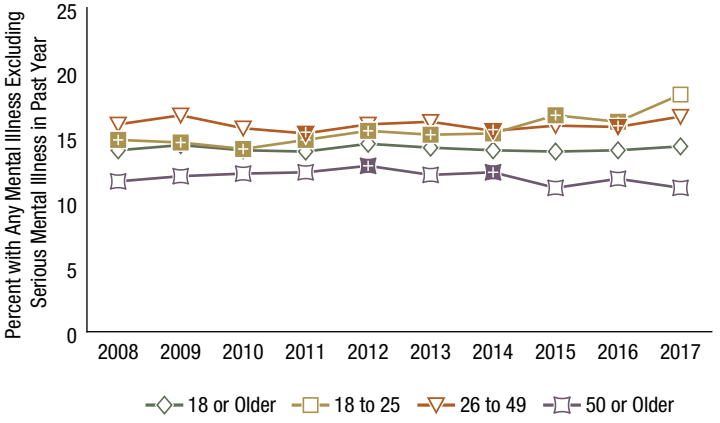
+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 49 Table. Serious Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	3.7+	3.7+	4.1+	3.9+	4.1+	4.2	4.1+	4.0+	4.2	4.5
18 to 25	3.8+	3.3+	3.9+	3.8+	4.1+	4.2+	4.8+	5.0+	5.9+	7.5
26 to 49	4.8+	4.9+	5.2	5.0	5.2	5.3	4.9+	5.0+	5.3	5.6
50 or Older	2.5	2.5	3.0	2.8	3.0	3.2	3.1	2.8	2.7	2.7

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 50. Any Mental Illness Excluding Serious Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 50 Table. Any Mental Illness Excluding Serious Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	14.0	14.4	14.0	13.9	14.5	14.2	14.0	13.9	14.0	14.3
18 to 25	14.8+	14.6+	14.1+	14.8+	15.5+	15.2+	15.3+	16.7+	16.2+	18.3
26 to 49	16.0	16.7	15.7	15.3+	16.0	16.2	15.5+	15.9	15.8+	16.6
50 or Older	11.6	12.0	12.2	12.3	12.8+	12.1	12.3+	11.1	11.8	11.1

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Co-Occurring Substance Use and Mental Health Issues

Individuals with both a mental health issue (i.e., MDE, AMI, SMI) and an SUD (i.e., illicit drug use disorder or alcohol use disorder) in the past year are defined as having a co-occurring mental health issue and an SUD. This section summarizes the co-occurrence of mental health and substance use issues in the population overall, the prevalence of substance use issues among those who have a mental health issue, and the prevalence of a mental health issue among those with a substance use issue. Estimates are presented separately for adults aged 18 or older and youths aged 12 to 17 due to the differences in the measurement of mental health issues across these age groups. Also, the order of onset of SUDs and symptoms of mental disorders cannot be established in the NSDUH data for adolescents or adults (e.g., whether the onset of SUDs preceded the onset of symptoms of mental disorders, or vice versa).

Co-Occurring MDE and Substance Use among Adolescents

This section describes co-occurring MDE and substance use and co-occurring MDE and SUDs among adolescents aged 12 to 17. Estimates of co-occurring MDE and SUDs are presented among all adolescents. Additionally, this section presents estimates of having a past year MDE among adolescents with SUDs. This section also presents estimates of substance use and SUDs among adolescents with an MDE. Because of the 2015 changes that affected the SUD estimates, the 2017 estimates of co-occurring MDE and SUD are not comparable with estimates from years prior to 2015.

An estimated 345,000 adolescents aged 12 to 17 in 2017 had an SUD and an MDE in the past year. This number represents 1.4 percent of adolescents in the United States (Figure 51). An estimated 276,000 adolescents in 2017 (1.1 percent of adolescents) had an SUD and an MDE with severe impairment in the past year.

MDE among Adolescents with a Substance Use Disorder

The 345,000 adolescents in 2017 who had a co-occurring MDE and an SUD in the past year represent about one third (35.9 percent) of the 992,000 adolescents who had a past year SUD (Figure 52 and Table A.29B). Among adolescents without a past year SUD, 12.3 percent (2.9 million adolescents) had an MDE in the past year.

Substance Use and Substance Use Disorders among Adolescents with MDE

Estimates of illicit drug use among adolescents that were previously described in this report focused on use in the past month (i.e., current use). Because MDE estimates are for the past year, however, this section focuses mainly on co-occurring MDE and substance use in the past year among adolescents. In 2017, the percentage of adolescents aged 12 to 17 who used illicit drugs in the past year was higher among those with a past year MDE than it was among those without a past year MDE (29.3 vs. 14.3 percent) (Figure 53). Youths in 2017 who had a past year MDE were more likely than those without an MDE to be users of marijuana, misusers of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives), users of inhalants, and users of hallucinogens in the past year.

Figure 51. Past Year Substance Use Disorder (SUD) and Major Depressive Episode (MDE) Status among Youths Aged 12 to 17: Percentages, 2017

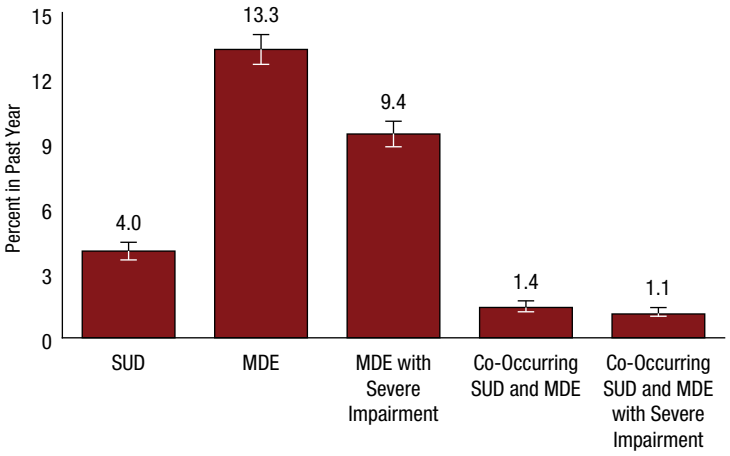
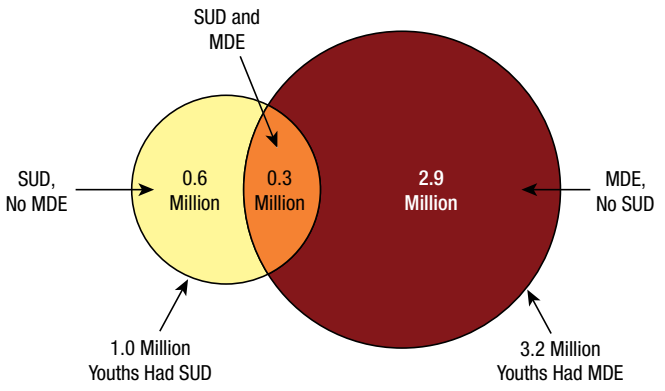


Figure 52. Past Year Substance Use Disorder (SUD) and Major Depressive Episode (MDE) among Youths Aged 12 to 17: Numbers in Millions, 2017



Note: Youth respondents with unknown MDE data were excluded.

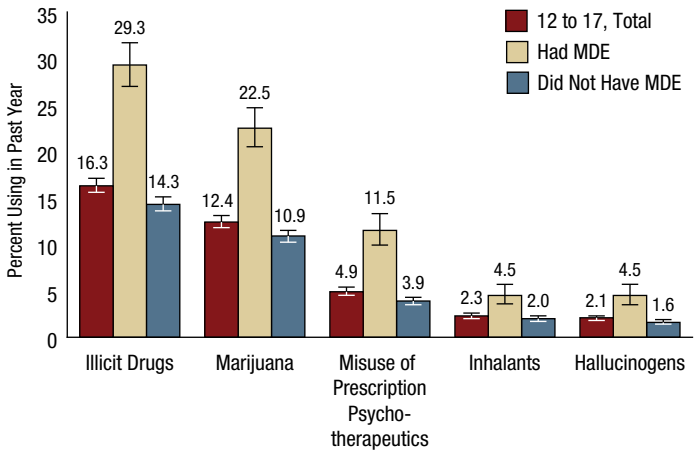
Unlike the illicit drug use estimates described previously, NSDUH estimates of daily cigarette smoking and heavy alcohol use are available only for the past month. Among adolescents aged 12 to 17 in 2017, 0.8 percent of those with a past year MDE were daily cigarette smokers in the past month compared with 0.3 percent of those without a past year MDE (Table A.30B). In addition, 1.2 percent of adolescents aged 12 to 17 with a past year MDE were heavy alcohol drinkers in the past month compared with 0.6 percent of those without a past year MDE.

Among the 3.2 million adolescents aged 12 to 17 in 2017 who had a past year MDE, 10.7 percent of adolescents (345,000 adolescents) had a past year SUD. In contrast, 2.9 percent of adolescents without a past year MDE (615,000 adolescents) had an SUD in the past year (Figure 52 and Table A.29B).

Co-Occurring Mental Health Issues and Substance Use Disorders among Adults

As noted previously, adults who had both a mental disorder and an SUD in the past year are referred to as having co-occurring disorders. Because NSDUH data allow estimates to be made for the presence of a mental disorder (as defined by AMI and SMI) and SUDs for adults, percentages of adults with co-occurring disorders can be estimated. This section presents findings on mental disorders (i.e., AMI and SMI) that co-occurred with SUDs (i.e., alcohol use disorder or illicit drug use disorder) among adults aged 18 or older in the United States. Because of the 2015 changes that affected SUD estimates, the 2017 estimates of co-occurring mental disorders and SUDs among adults are not comparable with estimates prior to 2015.

Figure 53. Past Year Illicit Drug Use among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) Status: Percentages, 2017



As noted previously, 46.6 million adults aged 18 or older in 2017 had AMI in the past year, including 11.2 million who had SMI. In addition, 18.7 million adults had a past year SUD.

Among adults in 2017, 8.5 million had both AMI and an SUD (Figure 54) in the past year, which corresponds to 3.4 percent of adults (Table A.31B). An estimated 3.1 million adults aged 18 or older had co-occurring SMI and an SUD in the past year (Figure 55), which corresponds to 1.3 percent of adults.

Co-Occurring Mental Health Issues and Substance Use Disorders among All Adults

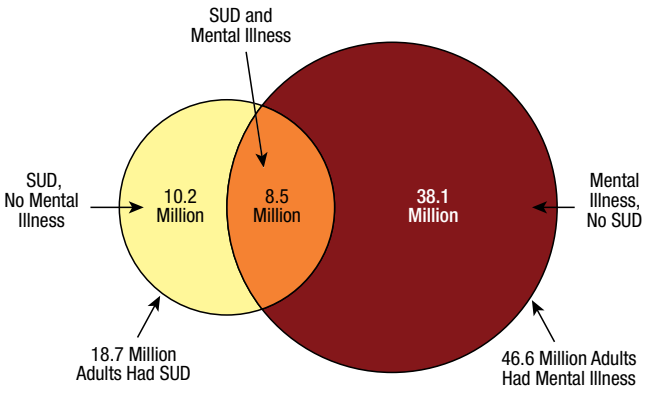
Aged 18 to 25

In 2017, 8.8 million young adults aged 18 to 25 had AMI in the past year, and 5.1 million had a past year SUD. Among young adults, 2.4 million had both AMI and an SUD in the past year. This corresponds to 6.9 percent of young adults (Table A.31B). An estimated 947,000 young adults had co-occurring SMI and an SUD in the past year, which corresponds to 2.8 percent of young adults.

Aged 26 to 49

In 2017, 22.3 million adults aged 26 to 49 had AMI in the past year, and 9.1 million had a past year SUD. Among adults aged 26 to 49, 4.4 million had both AMI and an SUD in the past year. This corresponds to 4.4 percent of adults in this age group (Table A.31B). An estimated 1.6 million adults aged 26 to 49 had co-occurring SMI and an SUD in the past year, which corresponds to 1.6 percent of adults in this age group.

Figure 54. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: Numbers in Millions, 2017



Aged 50 or Older

In 2017, 15.5 million adults aged 50 or older had AMI in the past year, and 4.6 million had a past year SUD. Among adults aged 50 or older, 1.8 million had both AMI and an SUD in the past year. This corresponds to 1.6 percent of adults in this age group (Table A.31B). An estimated 562,000 adults aged 50 or older had co-occurring SMI and an SUD in the past year, which corresponds to 0.5 percent of adults in this age group.

Mental Illness among Adults with a Substance Use Disorder

In 2017, among the 18.7 million adults with a past year SUD, 8.5 million (45.6 percent) had AMI in the past year (Figure 54 and Table A.32B). In contrast, among adults without a past year SUD, 16.7 percent (38.1 million adults) had AMI in the past year.

Among the 18.7 million adults in 2017 who had a past year SUD, 3.1 million (16.5 percent) also had SMI in the past year (Figure 55 and Table A.32B). In contrast, among adults without a past year SUD, 3.5 percent (8.1 million adults) had SMI in the past year.

Aged 18 to 25

In 2017, among the 5.1 million young adults aged 18 to 25 with a past year SUD, 2.4 million (46.8 percent) had AMI in the past year (Table A.32B). In contrast, among young adults without a past year SUD, 22.1 percent (6.5 million adults) had AMI in the past year.

Among the 5.1 million young adults aged 18 to 25 with a past year SUD, 947,000 (18.6 percent) had SMI in the past year. In contrast, among young adults without a past year SUD, 5.5 percent (1.6 million adults) had SMI in the past year.

Aged 26 to 49

Among the 9.1 million adults aged 26 to 49 in 2017 with a past year SUD, 4.4 million (48.1 percent) had AMI in the past year (Table A.32B). Among adults aged 26 to 49 without a past year SUD, 19.6 percent (17.9 million adults) had AMI in the past year.

Among the 9.1 million adults aged 26 to 49 with a past year SUD, 1.6 million (17.5 percent) had SMI in the past year. Among adults aged 26 to 49 without a past year SUD, 4.4 percent (4.0 million adults) had SMI in the past year.

Aged 50 or Older

Among the 4.6 million adults aged 50 or older in 2017 with a past year SUD, 1.8 million (39.1 percent) had AMI in the past year (Table A.32B). Among adults aged 50 or older without a past year SUD, 12.7 percent (13.7 million adults) had AMI in the past year.

Among the 4.6 million adults aged 50 or older with a past year SUD, 562,000 (12.3 percent) had SMI in the past year. Among adults aged 50 or older without a past year SUD, 2.3 percent (2.5 million adults) had SMI in the past year.

Substance Use Disorders among Adults with Mental Illness

In 2017, among the 46.6 million adults who had AMI in the past year, 8.5 million (18.3 percent) had an SUD in the past year (Figures 54 and 56). In contrast, 5.1 percent of adults who did not have past year AMI (10.2 million adults) met the criteria for an SUD (Table A.33B and

Figure 55. Past Year Substance Use Disorder (SUD) and Serious Mental Illness (SMI) among Adults Aged 18 or Older: Numbers in Millions, 2017

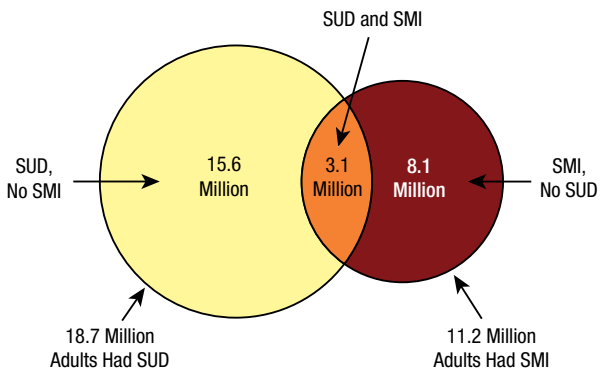


Figure 56. Past Year Substance Use Disorder among Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group: Percentages, 2017

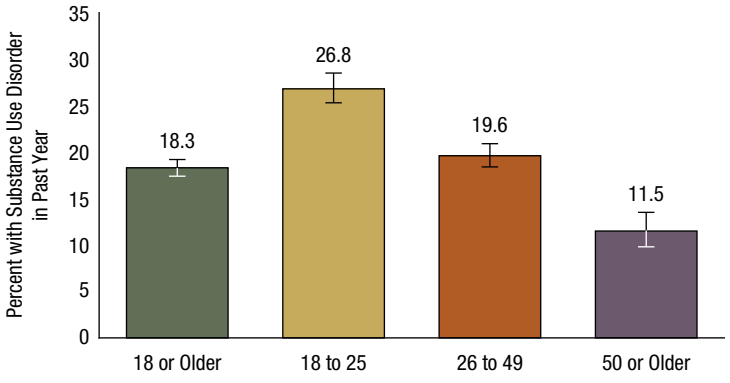


Figure 54). Among the 11.2 million adults who had SMI in the past year, 3.1 million (27.6 percent) had an SUD in the past year (Figure 57).

Aged 18 to 25

In 2017, about 2.4 million young adults aged 18 to 25 with AMI had a past year SUD. That is, 26.8 percent of young adults with AMI had an SUD in the past year (Figure 56). In contrast, 10.6 percent of young adults who did not have past year AMI (2.7 million adults) met the criteria for an SUD (Table A.33B). Among young adults with SMI in the past year, about 947,000 (36.9 percent) had an SUD (Figure 57).

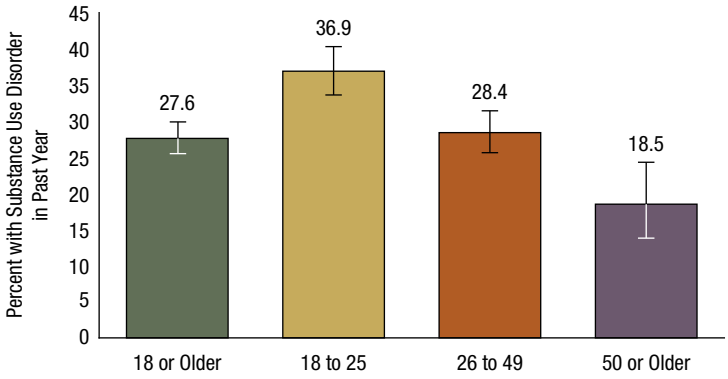
Aged 26 to 49

Among adults aged 26 to 49 in 2017 with AMI, about 4.4 million had an SUD. That is, 19.6 percent of adults aged 26 to 49 with AMI had an SUD in the past year (Figure 56). In contrast, 6.0 percent of adults aged 26 to 49 who did not have past year AMI (4.7 million adults) met the criteria for an SUD (Table A.33B). Among adults aged 26 to 49 with SMI, about 1.6 million (28.4 percent) had an SUD (Figure 57).

Aged 50 or Older

In 2017, about 1.8 million adults aged 50 or older with AMI had an SUD. That is, 11.5 percent of adults aged 50 or older with AMI had an SUD in the past year (Figure 56). In contrast, 2.9 percent of adults aged 50 or older who did not have past year AMI (2.8 million adults) met the criteria for an SUD (Table A.33B). Among adults aged 50 or older with SMI, 562,000 (18.5 percent) had an SUD (Figure 57).

Figure 57. Past Year Substance Use Disorder among Adults Aged 18 or Older with Serious Mental Illness in the Past Year, by Age Group: Percentages, 2017



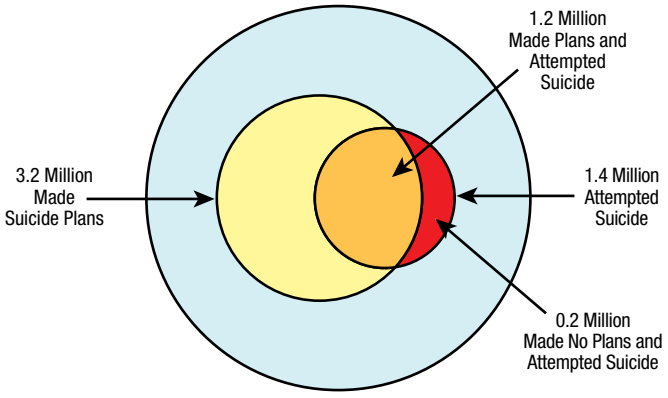
Suicidal Thoughts and Behavior among Adults

Suicide is an important public health problem in the United States and a tragedy for all involved—the individuals and their families, friends, neighbors, colleagues, and communities. In 2016, nearly 45,000 people in the United States died from suicide. In addition, suicide rates increased in most states between 1999 and 2016, including increases by more than 30 percent in 25 states over this period.[53] However, individuals who die from suicide represent a fraction of those who consider or attempt suicide.[54] Out of every 31 adults in 2008 to 2011 in the United States who attempted suicide in the past 12 months, there was 1 death by suicide.[55] Individuals are likely to have thought about suicide before attempting suicide. NSDUH has collected information on past year suicidal thoughts and behavior among adults aged 18 or older in the United States since 2008. Information from NSDUH on adults who have seriously thought about suicide or have made suicide plans or attempts can be useful to policymakers and service providers in gauging the size of the adult population at a high level of risk for suicide and in tracking changes in the size of this population over time.

NSDUH respondents aged 18 or older were asked if at any time during the past 12 months they had thought seriously about trying to kill themselves. Adults who had serious thoughts of suicide in the past 12 months were asked whether they made a plan to kill themselves or tried to kill themselves in that period.

In 2017, 10.6 million adults aged 18 or older (4.3 percent) had thought seriously about trying to kill themselves (Figures 58 and 59). Of the 10.6 million adults who had

Figure 58. Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older: Numbers in Millions, 2017



serious thoughts of suicide, 3.2 million had made suicide plans, and 1.4 million made a nonfatal suicide attempt. Among the 1.4 million adults aged 18 or older who attempted suicide in the past year, 1.2 million made suicide plans, and 0.2 million did not make suicide plans.[56] Stated another way, about 1 in 3 adults who had serious thoughts of suicide made suicide plans, and about 1 in 8 adults who had serious thoughts of suicide made a suicide attempt.[24]

Serious Thoughts of Suicide

The estimated 10.6 million adults aged 18 or older in 2017 who had serious thoughts of suicide in the past year (Figure 58) represent 4.3 percent of adults aged 18 or older (Figure 59). The percentage of adults aged 18 or older in 2017 who had serious thoughts of suicide was higher than the percentages in 2008 to 2014, but it was similar to the percentages in 2015 and 2016.

Aged 18 to 25

An estimated 3.6 million young adults aged 18 to 25 in 2017 had serious thoughts of suicide in the past year, which represents 10.5 percent of young adults (Figure 59). The percentage of young adults who had serious thoughts of suicide was higher in 2017 than in 2008 to 2016.

Aged 26 to 49

In 2017, 4.3 million adults aged 26 to 49 had serious thoughts of suicide in the past year, or 4.3 percent of adults in this age group (Figure 59). The percentage of adults aged 26 to 49 who had serious thoughts of suicide was similar in most years between 2008 and 2017.

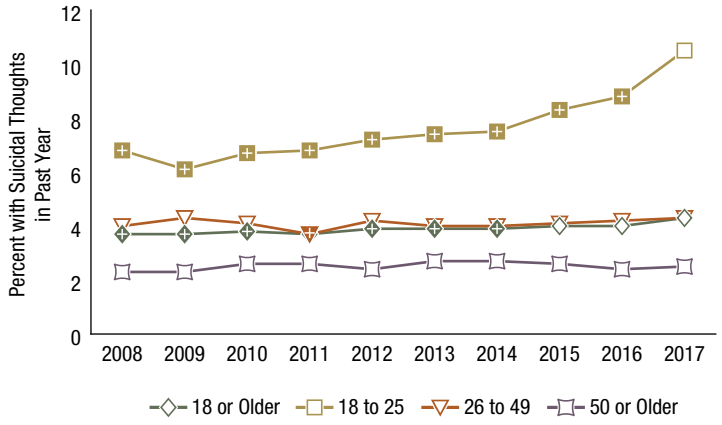
Aged 50 or Older

In 2017, 2.8 million adults aged 50 or older had serious thoughts of suicide in the past year, which represents 2.5 percent of adults in this age group (Figure 59). The percentage of adults aged 50 or older who had serious thoughts of suicide was similar from 2008 to 2017.

Suicide Plans

The estimated 3.2 million adults in 2017 who made suicide plans in the past year (Figure 58) represent 1.3 percent of adults aged 18 or older (Figure 60). The percentage of adults aged 18 or older in 2017 who made suicide plans was higher than in all but 2 years between 2008 and 2016.

Figure 59. Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



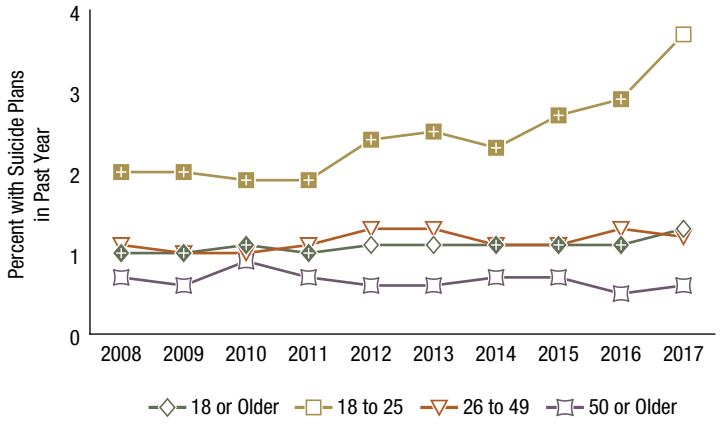
+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 59 Table. Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	3.7+	3.7+	3.8+	3.7+	3.9+	3.9+	3.9+	4.0	4.0	4.3
18 to 25	6.8+	6.1+	6.7+	6.8+	7.2+	7.4+	7.5+	8.3+	8.8+	10.5
26 to 49	4.0	4.3	4.1	3.7+	4.2	4.0	4.0	4.1	4.2	4.3
50 or Older	2.3	2.3	2.6	2.6	2.4	2.7	2.7	2.6	2.4	2.5

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 60. Suicide Plans in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 60 Table. Suicide Plans in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	1.0+	1.0+	1.1+	1.0+	1.1	1.1	1.1+	1.1+	1.1+	1.3
18 to 25	2.0+	2.0+	1.9+	1.9+	2.4+	2.5+	2.3+	2.7+	2.9+	3.7
26 to 49	1.1	1.0	1.0	1.1	1.3	1.3	1.1	1.1	1.3	1.2
50 or Older	0.7	0.6	0.9	0.7	0.6	0.6	0.7	0.7	0.5	0.6

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Aged 18 to 25

In 2017, about 1.3 million young adults aged 18 to 25 made suicide plans in the past year, which corresponds to 3.7 percent of young adults (Figure 60). The percentage of young adults in 2017 who made suicide plans was higher than the percentages in 2008 to 2016.

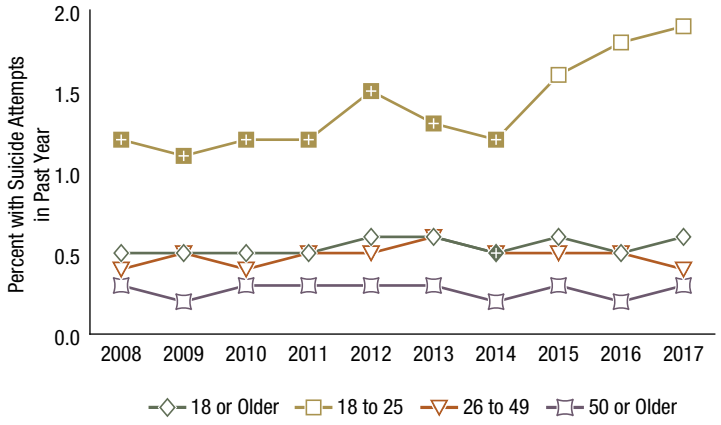
Aged 26 to 49

In 2017, about 1.2 million adults aged 26 to 49 made suicide plans in the past year, which represents 1.2 percent of adults in this age group (Figure 60). The percentage of adults in this age group in 2017 who made suicide plans in the past year was similar to the percentages in 2008 through 2016.

Aged 50 or Older

In 2017, about 700,000 adults aged 50 or older made suicide plans in the past year, which represents 0.6 percent of adults aged 50 or older (Figure 60). The percentage of adults in this age group in 2017 who made suicide plans in the past year was similar to the percentages in 2008 to 2016.

Figure 61. Suicide Attempts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 61 Table. Suicide Attempts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	0.5	0.5	0.5	0.5	0.6	0.6	0.5+	0.6	0.5	0.6
18 to 25	1.2+	1.1+	1.2+	1.2+	1.5+	1.3+	1.2+	1.6	1.8	1.9
26 to 49	0.4	0.5	0.4	0.5	0.5	0.6	0.5	0.5	0.5	0.4
50 or Older	0.3	0.2	0.3	0.3	0.3	0.3	0.2	0.3	0.2	0.3

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Suicide Attempts

The estimated 1.4 million adults aged 18 or older in 2017 who attempted suicide in the past year (with or without first making suicide plans) (Figure 58) represent 0.6 percent of all adults (Figure 61). The percentage of adults aged 18 or older in 2017 who attempted suicide was similar to the percentages in most years between 2008 and 2016.

Aged 18 to 25

In 2017, about 648,000 young adults aged 18 to 25 attempted suicide in the past year. This number represents 1.9 percent of young adults (Figure 61). The percentage of young adults who attempted suicide was higher in 2017 than in 2008 to 2014, but it was similar to the percentages in 2015 and 2016.

Aged 26 to 49

In 2017, about 435,000 adults aged 26 to 49 attempted suicide in the past year, which represents 0.4 percent of adults in this age group (Figure 61). The percentages of adults aged 26 to 49 who attempted suicide in the past year were stable from 2008 to 2017.

Aged 50 or Older

In 2017, about 304,000 adults aged 50 or older attempted suicide in the past year, which represents 0.3 percent of adults in that age group (Figure 61). The percentages of adults aged 50 or older who attempted suicide in the past year were stable from 2008 to 2017.

Substance Use Treatment in the Past Year

Substance use treatment services are intended to help people address problems associated with their substance use. NSDUH provides two measures related to substance use treatment: (a) the need for substance use treatment and (b) the receipt of substance use treatment. NSDUH also collects information on the types of settings where people received treatment, and whether people needed substance use treatment but did not receive it. In addition, NSDUH collects information about people who did not receive treatment but felt that they needed it and why they did not get treatment. The substance use treatment estimates in this section are presented for 2017 but are not considered to be comparable with estimates prior to 2015 because changes in the measurement of substance use may have affected the group of respondents who were asked the substance use treatment questions. Also, estimates of the need for

substance use treatment in 2017 are not comparable with estimates prior to 2015 because of the noncomparability of several SUD estimates in 2017 with those prior to 2015.

Need for Substance Use Treatment

NSDUH includes questions that are used to identify people who needed substance use treatment (i.e., treatment for problems related to the use of alcohol or illicit drugs) in the past year. For this report, people are classified as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility[57] in the past year.[58,59]

In 2017, an estimated 20.7 million people aged 12 or older needed substance use treatment. Stated another way, about 1 in 13 people aged 12 or older (7.6 percent) needed substance use treatment (Figure 62). About 1.0 million adolescents aged 12 to 17 needed treatment for a substance use problem in the past year, representing 4.1 percent of adolescents, or about 1 in 24 adolescents. About 5.2 million young adults aged 18 to 25 needed treatment for a substance use problem in the past year, representing 15.1 percent of young adults. Stated another way, about 1 in 7 young adults needed substance use treatment. About 14.5 million adults aged 26 or older needed substance use treatment in the past year. This number represents 6.8 percent of adults aged 26 or older, or about 1 in 15 adults in this age group.

Receipt of Substance Use Treatment

NSDUH respondents who used alcohol or illicit drugs in their lifetime are asked whether they ever received substance use treatment, and those who received substance use treatment in their lifetime are asked whether they received treatment in the 12 months prior to the survey interview (i.e., the past year). As mentioned earlier, substance use treatment refers to treatment or counseling received for alcohol or illicit drug use or for medical problems associated with the use of alcohol or illicit drugs. NSDUH collects information on the receipt of any substance use treatment and the receipt of substance use treatment at a specialty facility. The categories of any substance use treatment and treatment at a specialty facility are not mutually exclusive categories; substance use treatment at a specialty facility is included in estimates of any substance use treatment. Receipt of any substance use treatment includes treatment that was 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 a self-help group (e.g., such as Alcoholics Anonymous or Narcotics Anonymous). Receipt of substance use treatment at a specialty facility is defined as substance use treatment that a respondent received at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. People could report receiving treatment at more than one location. This section presents estimates of the receipt of any substance use treatment among all people aged 12 or older, receipt of specialty substance use treatment among people aged 12 or older, and receipt of specialty substance use treatment among people aged 12 or older who needed substance use treatment in the past year.

In 2017, approximately 4.0 million people aged 12 or older received any substance use treatment in the past year, or 1.5 percent of people aged 12 or older (Figure 63).

Figure 62. Need for Substance Use Treatment in the Past Year among People Aged 12 or Older, by Age Group: 2017

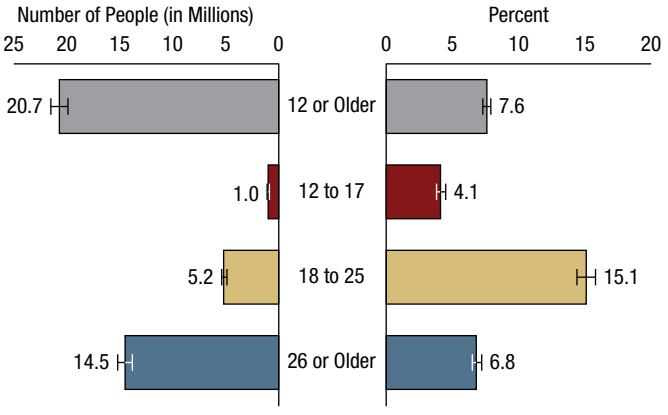
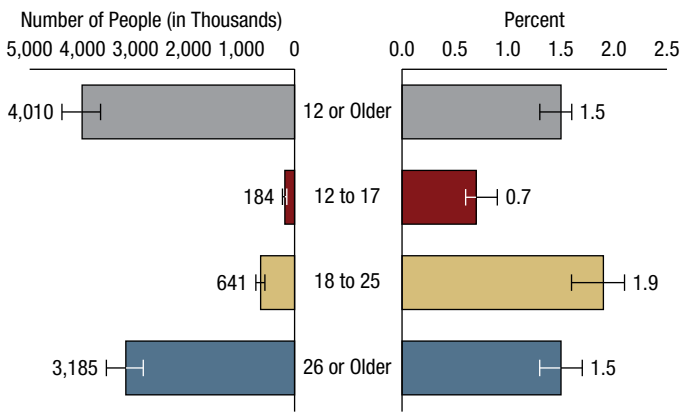


Figure 63. Received Any Substance Use Treatment in the Past Year among People Aged 12 or Older, by Age Group: 2017

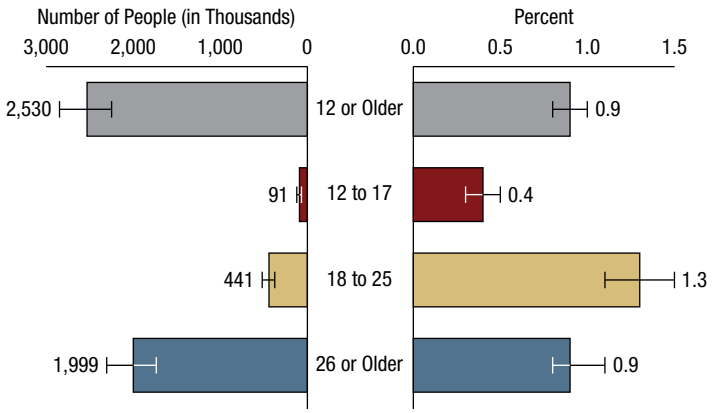


Among adolescents aged 12 to 17, 184,000 received any substance use treatment in the past year, or 0.7 percent of adolescents. An estimated 641,000 young adults aged 18 to 25 received any substance use treatment in the past year; this number represents 1.9 percent of young adults receiving any substance use treatment. About 3.2 million adults aged 26 or older received any substance use treatment in the past year, or 1.5 percent of adults in this age group.

Approximately 2.5 million people aged 12 or older in 2017 received substance use treatment at a specialty facility, or 0.9 percent of the population aged 12 or older (Figure 64). Among adolescents aged 12 to 17, 91,000 (0.4 percent) received substance use treatment at a specialty facility. An estimated 441,000 young adults aged 18 to 25 received substance use treatment at a specialty facility; this number represents 1.3 percent of young adults receiving substance use treatment at a specialty facility. About 2.0 million adults aged 26 or older received substance use treatment at a specialty facility in the past year, or 0.9 percent of adults in this age group.

The estimated 2.5 million people aged 12 or older in 2017 who received substance use treatment at a specialty facility in the past year also represents 12.2 percent of the people who needed treatment (Figure 65). Among people in specific age groups who needed substance use treatment, 8.8 percent of adolescents aged 12 to 17, 8.5 percent of young adults aged 18 to 25, and 13.8 percent of adults aged 26 or older received substance use treatment at a specialty facility in the past year. These percentages represent 91,000 adolescents, 441,000 young adults, and 2.0 million adults aged 26 or older who needed substance use treatment and received treatment at a specialty facility in the past year.

Figure 64. Received Specialty Substance Use Treatment in the Past Year among People Aged 12 or Older, by Age Group: 2017



Perceived Need for Substance Use Treatment

NSDUH respondents are defined as having a perceived need for substance use treatment (i.e., treatment for problems related to their use of alcohol or illicit drugs) if they indicated that they felt they needed substance use treatment in the past year. Respondents may have a perceived need for substance use treatment, regardless of whether they had an SUD in the past year. In this report, estimates for the perceived need for substance use treatment are discussed only for people aged 12 or older who were classified as needing treatment but who did not receive *specialty* treatment for their use of alcohol or illicit drugs. As described previously, people are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility[60] in the past year.[58,59]

In 2017, among the estimated 18.2 million people aged 12 or older who needed substance use treatment but did not receive specialty treatment in the past year, about 1.0 million perceived a need for treatment for their use of illicit drugs or alcohol (Figure 66). The estimated 1.0 million people who perceived a need for substance use treatment correspond to about 5.7 percent of people aged 12 or older who needed treatment but did not receive specialty substance use treatment in the past year. Thus, the large majority (94.3 percent) of people aged 12 or older who needed substance use treatment but did not receive specialty treatment did not think that they needed treatment in the past 12 months for their substance use.[24]

Figure 65. Received Specialty Substance Use Treatment in the Past Year among People Aged 12 or Older Who Needed Substance Use Treatment in the Past Year, by Age Group: 2017

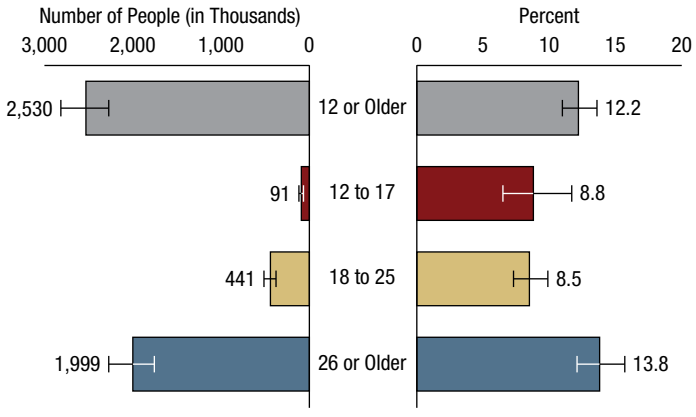
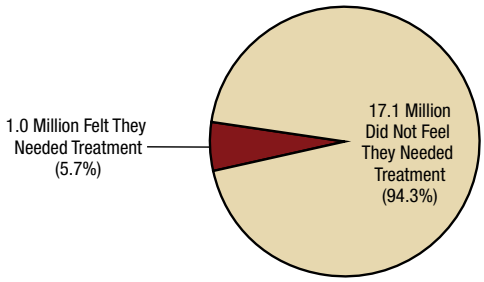


Figure 66. Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2017



18.2 Million People Needed but Did Not Receive Specialty Substance Use Treatment

By Age Group

Most adolescents in 2017 who needed treatment for their use of illicit drugs or alcohol but did not receive specialty treatment did not perceive a need for treatment. Among the estimated 942,000 adolescents in 2017 who needed substance use treatment but did not receive treatment at a specialty facility in the past year, about 18,000 perceived a need for treatment for their illicit drug or alcohol use (Table A.40A). This number of adolescents who perceived a need for substance use treatment represents 1.9 percent of adolescents who needed but did not receive specialty treatment in the past year.

Most young adults aged 18 to 25 in 2017 who needed treatment for their use of illicit drugs or alcohol but did not receive specialty treatment did not perceive a need for treatment. Among the estimated 4.7 million young adults in 2017 who needed substance use treatment but did not receive treatment at a specialty facility in the past year, about 181,000 perceived a need for treatment for their illicit drug or alcohol use (Table A.40A). This number of young adults who perceived a need for substance use treatment represents 3.8 percent of young adults who needed treatment but did not receive specialty treatment in the past year.

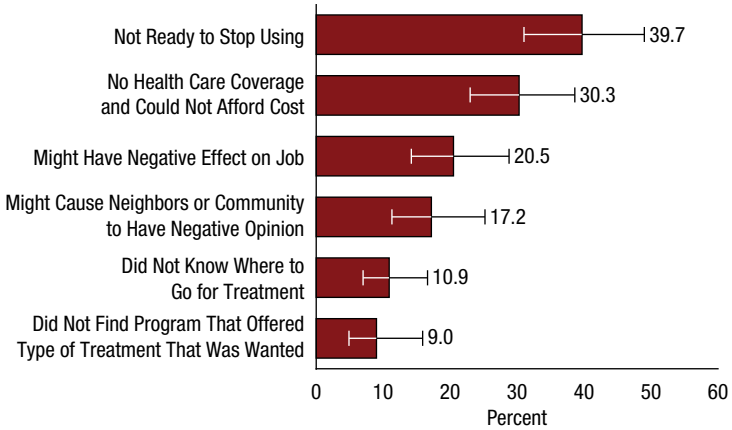
In 2017, the estimated 12.5 million adults aged 26 or older who needed substance use treatment but did not receive specialty treatment in the past year include approximately 834,000 adults in this age group who perceived a need for treatment for their illicit drug or alcohol use (Table A.40A). This number of adults aged 26 or older who perceived a need for substance use treatment represents 6.7 percent of adults in this age group who needed treatment but did not receive specialty treatment.

Reasons for Not Receiving Specialty Substance Use Treatment

NSDUH respondents who did not receive substance use treatment in the past 12 months but felt that they needed treatment were asked to report the reasons for not receiving treatment. As noted in the previous section, 94.3 percent of people aged 12 or older in 2017 who were classified as needing substance use treatment (i.e., either had an SUD or received specialty substance use treatment) but did not receive specialty substance use treatment did not think that they needed treatment. Information on common reasons for not receiving substance use treatment despite perceiving a need for treatment is important for identifying and addressing barriers to treatment receipt.

In 2017, common reasons for not receiving substance use treatment among people aged 12 or older who perceived a need for treatment but did not receive treatment at a specialty facility were not being ready to stop using (39.7 percent) or having no health care coverage and not being able to afford the cost of treatment (30.3 percent) (Figure 67). Stated another way, about 2 in 5 people who perceived a need for treatment but did not receive treatment at a specialty facility were not ready to stop using, and about 1 in 3 had no health care coverage and were not able to afford the cost. About 1 in 5 people who perceived a need for treatment but did not receive treatment at a specialty facility felt that getting treatment would have a negative effect on their job (20.5 percent), and 17.2 percent felt that getting treatment would cause their neighbors or community to have a negative opinion of them.

Figure 67. Reasons for Not Receiving Substance Use Treatment in the Past Year among People Aged 12 or Older Who Felt They Needed Treatment in the Past Year: Percentages, 2017



Note: Respondents could indicate multiple reasons for not receiving substance use treatment; thus, these response categories are not mutually exclusive.

Mental Health Service Use in the Past Year

NSDUH includes questions to estimate the use of mental health services in the United States among the adolescent and adult populations. In addition to estimating the use of mental health services among the overall adolescent and adult populations, these questions allow the estimation of the use of mental health services among adolescents and adults with mental health issues (i.e., MDE, AMI, and SMI).

Treatment for Depression among Adolescents

Adolescents aged 12 to 17 who had met the criteria for having a past year MDE were asked whether they had received treatment for their depression in the past year. Adolescents who reported seeing or talking to a health professional or taking prescribed medication for their depression were defined as having received treatment for their depression in the past year.[61] Estimates of treatment for depression among adolescents are presented for 2004 to 2017 among adolescents with MDE and for 2006 to 2017 among adolescents with MDE with severe impairment.

Of the 3.2 million adolescents in 2017 with a past year MDE, an estimated 1.3 million adolescents received treatment for depression. Stated another way, 41.5 percent of youths who had a past year MDE received treatment for depression (Figure 68). The 2017 percentage was similar to the percentages in most years from 2004 to 2016.

In 2017, about 1.1 million adolescents who had a past year MDE with severe impairment received treatment for depression, or 47.5 percent of youths who had a past year MDE with severe impairment. The percentage of adolescents in 2017 with an MDE with severe impairment who received treatment for depression was similar to the percentages in most years from 2011 to 2016.

Treatment for Depression among Adults

Adults who had met the criteria for having a past year MDE were asked whether they had received treatment for their depression in the past year. Treatment for depression in adults is defined as seeing or talking to a health professional or other professional or using prescription medication for depression in the past year.[61] Estimates of treatment for depression among adults are presented for 2009 to 2017 for adults with an MDE and adults with an MDE with severe impairment.

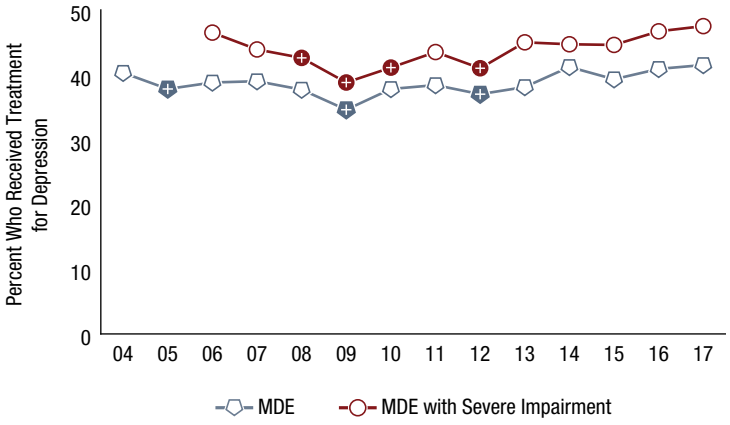
Of the 17.3 million adults aged 18 or older in 2017 who had a past year MDE, 11.5 million received treatment for depression, or 66.8 percent of adults who had a past year MDE (Figure 69). The percentage of adults in 2017 with a past year MDE who received treatment for depression was similar to the percentages in 2009 to 2016.

Among the 11.0 million adults in 2017 who had a past year MDE with severe impairment, 7.9 million received treatment for depression, or 72.1 percent of adults with a past year MDE with severe impairment. The percentage of adults in 2017 with an MDE with severe impairment who received treatment for depression was similar to the percentages in most years from 2009 to 2016.

Aged 18 to 25

Of the 4.4 million young adults aged 18 to 25 with a past year MDE, about 2.2 million received treatment for depression in the past year, or 50.7 percent of young adults with a past year MDE (Table A.43B). The percentage of young adults in 2017 with a past year MDE who received treatment for depression was similar to the percentages in 2009 to 2015, but it was greater than the percentage in 2016.

Figure 68. Received Treatment in the Past Year for Depression among Youths Aged 12 to 17 with a Past Year Major Depressive Episode (MDE) or MDE with Severe Impairment: Percentages, 2004-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

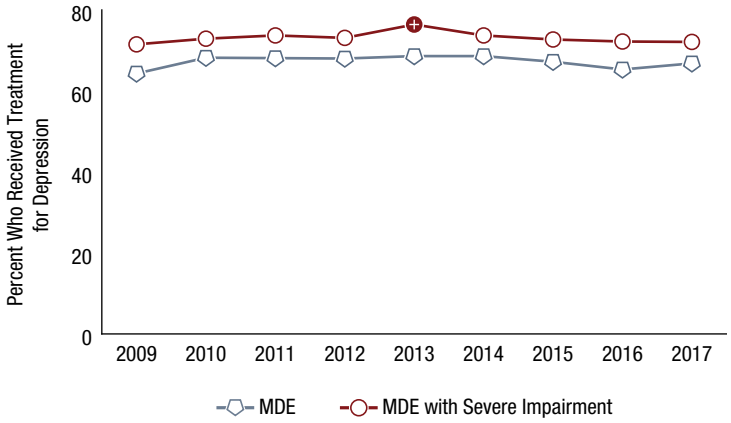
Figure 68 Table. Received Treatment in the Past Year for Depression among Youths Aged 12 to 17 with a Past Year Major Depressive Episode (MDE) or MDE with Severe Impairment: Percentages, 2004-2017

MDE Status	04	05	06	07	08	09	10	11	12	13	14	15	16	17
MDE	40.3	37.8+	38.8	39.0	37.7	34.6+	37.8	38.4	37.0+	38.1	41.2	39.3	40.9	41.5
MDE with Severe Impairment	N/A	N/A	46.5	43.9	42.6+	38.8+	41.1+	43.5	41.0+	45.0	44.7	44.6	46.7	47.5

N/A = not available.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 69. Received Treatment in the Past Year for Depression among Adults Aged 18 or Older with a Past Year Major Depressive Episode (MDE) or MDE with Severe Impairment: Percentages, 2009-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 69 Table. Received Treatment in the Past Year for Depression among Adults Aged 18 or Older with a Past Year Major Depressive Episode (MDE) or MDE with Severe Impairment: Percentages, 2009-2017

MDE Status	2009	2010	2011	2012	2013	2014	2015	2016	2017
MDE	64.3	68.2	68.1	68.0	68.6	68.6	67.2	65.3	66.8
MDE with Severe Impairment	71.5	72.9	73.7	73.1	76.4+	73.7	72.7	72.2	72.1

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

In 2017, 1.6 million of the young adults aged 18 to 25 with a past year MDE with severe impairment received treatment for depression in the past year, or slightly less than three fifths of these young adults (57.1 percent). The percentage of young adults in 2017 with an MDE with severe impairment who received treatment for depression was greater than the percentage in 2016, but it was similar to the percentages in most years from 2009 to 2015.

Aged 26 to 49

In 2017, about 5.1 million of the 7.6 million adults aged 26 to 49 with a past year MDE received treatment for depression in the past year, or about two thirds of the adults in this age group who had a past year MDE (67.3 percent) (Table A.43B). The percentage of adults aged 26 to 49 in 2017 with a past year MDE who received treatment for depression was similar to the percentages in 2009 to 2016.

In 2017, 3.6 million adults aged 26 to 49 with a past year MDE with severe impairment received treatment for depression in the past year, or 71.8 percent of adults in this age group who had a past year MDE with severe impairment. The percentage of adults in this age group in 2017 with an MDE with severe impairment who received treatment for depression was similar to the percentages in 2009 to 2016.

Aged 50 or Older

Of the 5.2 million adults aged 50 or older in 2017 who had a past year MDE, about 4.2 million received treatment for depression in the past year. The percentage of adults aged 50 or older in 2017 with an MDE who received treatment for depression (79.7 percent) was similar to the percentages in 2009 to 2016 (Table A.43B).

In 2017, 2.7 million of the 3.1 million adults aged 50 or older with a past year MDE with severe impairment received treatment for depression in the past year, or 86.4 percent of adults in this age group with a past year MDE with severe impairment. The percentage of adults in this age group in 2017 with an MDE with severe impairment who received treatment for depression was similar to the percentages in 2009 to 2016.

Any Mental Health Service Use among All Adolescents

In addition to asking youths aged 12 to 17 about treatment for depression, NSDUH includes questions for adolescents that ask about any receipt of services for emotional and behavioral problems (i.e., not just depression) that were not caused by substance use. The youth mental health service utilization section of the interview asks respondents aged 12 to 17 whether they received any treatment or counseling within the 12 months prior to the interview for problems with emotions or behavior in the following settings: (a) *specialty mental health settings*;[62] (b) *education settings* (talked with a school social worker, psychologist, or counselor about an emotional or behavioral problem; participated in a program for students with emotional or behavioral problems while in a regular school; or attended a school for students with emotional or behavioral problems); (c) *general medical settings* (care from a pediatrician or family physician for emotional or behavioral problems); (d) *juvenile justice settings* (services for an emotional or behavioral problem in a detention center, prison, or jail); or (e) *child welfare settings* (foster care or therapeutic foster care).

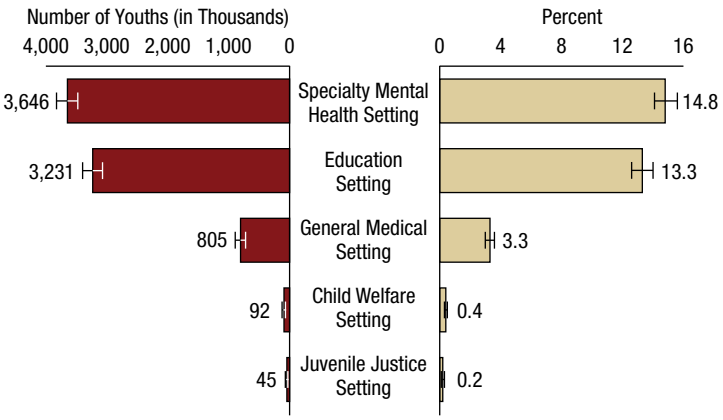
As noted previously, the NSDUH interview does not include questions or methods for estimating the occurrence of mental disorders among adolescents other than whether adolescents had an MDE. Therefore, NSDUH does not include measures for adolescents that are equivalent to AMI or SMI for adults. Consequently, this section focuses on mental health care among all adolescents.

In 2017, the following numbers and percentages of adolescents aged 12 to 17 received mental health services in the past 12 months in specific settings for problems with emotions or behaviors (Figure 70):

- 3.6 million adolescents (14.8 percent) received mental health services in a specialty mental health setting (inpatient or outpatient care),
- 3.2 million adolescents (13.3 percent) received mental health services in an education setting,
- 805,000 adolescents (3.3 percent) received mental health services in a general medical setting,
- 92,000 adolescents (0.4 percent) received mental health services in a child welfare setting, and
- 45,000 adolescents (0.2 percent) received mental health services in a juvenile justice setting.

The percentage of adolescents in 2017 who received mental health services in a specialty mental health setting in the past 12 months (14.8 percent) was higher than the percentages in 2009 to 2015, which ranged from 12.0 to 13.7 percent, but it was similar to the percentage in 2016 (Figure 71). The percentages of youths aged 12 to 17 in 2017 who received mental health services in an education setting (13.3 percent), a child welfare setting (0.4 percent), and a juvenile justice setting (0.2 percent) were similar to the corresponding percentages between 2013 and 2016. In contrast, the percentage of adolescents in 2017 who received mental health services in a general medical setting (3.3 percent) was higher than the percentages in most years from 2009 to 2016.

Figure 70. Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: 2017

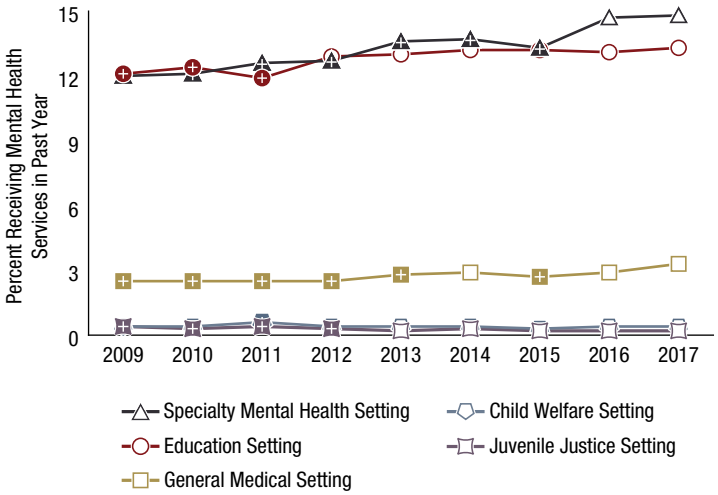


Note: Mental health service for youths aged 12 to 17 is defined as having received treatment/counseling for emotional or behavioral problems not caused by substance use.

Any Mental Health Service Use among All Adults

Adults are asked whether they received treatment or counseling for any problem with emotions, "nerves," or mental health in the past year in any inpatient or outpatient setting or if they used prescription medication in the past year for a mental or emotional condition. All adults are asked these questions about their use of mental health services (i.e., not just those with mental illness). Respondents are asked not to include treatment for their use of alcohol or illicit drugs. Unlike questions about treatment for depression that were discussed previously, general questions for the receipt of treatment or counseling for mental health issues among adults do not ask about treatment for a particular mental disorder. Consequently, references in this section to treatment or counseling for any problem with emotions, nerves, or mental health are described broadly as "mental health service use." This section compares the 2017 estimates of mental health service use with estimates from 2002 to 2016 for the entire adult population.

Figure 71. Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: Percentages, 2009-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service for youths aged 12 to 17 is defined as having received treatment/counseling for emotional or behavioral problems not caused by substance use.

Figure 71 Table. Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: Percentages, 2009-2017

Source	2009	2010	2011	2012	2013	2014	2015	2016	2017
Specialty Mental Health Setting	12.0+	12.1+	12.6+	12.7+	13.6+	13.7+	13.3+	14.7	14.8
Education Setting	12.1+	12.4+	11.9+	12.9	13.0	13.2	13.2	13.1	13.3
General Medical Setting	2.5+	2.5+	2.5+	2.5+	2.8+	2.9	2.7+	2.9	3.3
Child Welfare Setting	0.4	0.4	0.6+	0.4	0.4	0.4	0.3	0.4	0.4
Juvenile Justice Setting	0.4+	0.3+	0.4+	0.3+	0.2	0.3	0.2	0.2	0.2

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

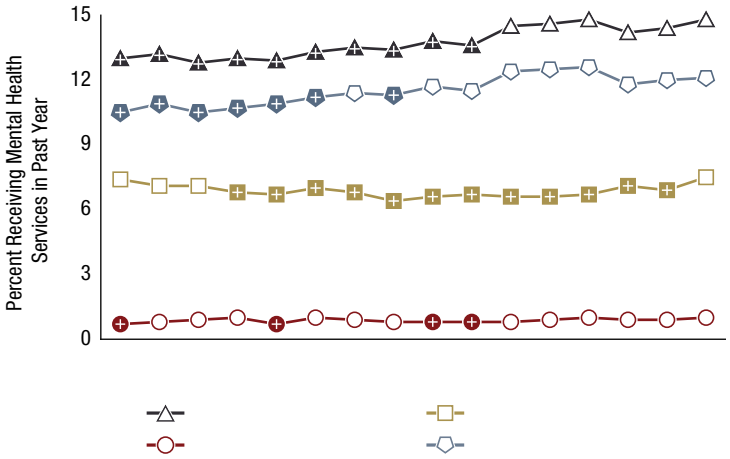
Note: Mental health service for youths aged 12 to 17 is defined as having received treatment/counseling for emotional or behavioral problems not caused by substance use.

In 2017, an estimated 36.4 million adults aged 18 or older received mental health services during the past 12 months. This number represents 14.8 percent of adults, or about 1 in 7 adults (Figure 72). The estimate of 14.8 percent of adults in 2017 who received mental health services in the past 12 months was greater than the estimates in all years between 2002 and 2011, but it was similar to the estimates in 2012 to 2016.

Aged 18 to 25

In 2017, 5.1 million young adults aged 18 to 25 used mental health services in the past year. This number of young adults who received mental health services in the past year represents 14.9 percent of young adults (Table A.45B). The percentage of young adults in 2017 who received mental health services in the past year was higher than the percentages in 2002 to 2016.

Figure 72. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older: Percentages, 2002-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

Figure 72 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older: Percentages, 2002-2017

Service Type	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
Any Mental Health Services	13.0+	13.2+	12.8+	13.0+	12.9+	13.3+	13.5+	13.4+	13.8+	13.6+	14.5	14.6	14.8	14.2	14.4	14.8
Inpatient	0.7+	0.8	0.9	1.0	0.7+	1.0	0.9	0.8	0.8+	0.8+	0.8	0.9	1.0	0.9	0.9	1.0
Outpatient	7.4	7.1	7.1	6.8+	6.7+	7.0+	6.8+	6.4+	6.6+	6.7+	6.6+	6.6+	6.7+	7.1+	6.9+	7.5
Prescription Medication	10.5+	10.9+	10.5+	10.7+	10.9+	11.2+	11.4	11.3+	11.7	11.5	12.4	12.5	12.6	11.8	12.0	12.1

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

Aged 26 to 49

In 2017, 15.7 million adults aged 26 to 49 used mental health services in the past year. This number represents 15.7 percent of adults aged 26 to 49 (Table A.45B). The 2017 estimate of the receipt of mental health services among adults in this age group was higher than estimates from 2002 to 2009, but it was similar to the estimates in all years from 2010 to 2016.

Aged 50 or Older

In 2017, 15.6 million adults aged 50 or older used mental health services in the past year. This number represents 14.0 percent of adults aged 50 or older (Table A.45B). The 2017 estimate of the receipt of mental health services among adults in this age group was higher than the estimates in 2002 to 2006, but it was similar to the estimates in most years from 2007 to 2016.

Any Mental Health Service Use among Adults with Mental Illness

NSDUH data may also be used to assess mental health service use among adults with AMI or SMI. In 2017, among the 46.6 million adults with AMI, 19.8 million (42.6 percent) received mental health services in the past year (Figure 73). About 7.5 million of the 11.2 million adults with past year SMI (66.7 percent) received mental health services in the past year (Figure 74).

The percentage of adults in 2017 with AMI who received mental health care in the past year (42.6 percent) was similar to the percentages in most years from 2008 to 2016 (Figure 73). The percentage of adults in 2017 with SMI who received mental health services in the past year (66.7 percent) also was similar to the estimates in 2008 to 2016 (Figure 74). In any given year, about two thirds of adults with past year SMI received mental health services in the past year. Stated another way, however, about one third of adults with SMI in any given year did *not* receive mental health services.

Aged 18 to 25

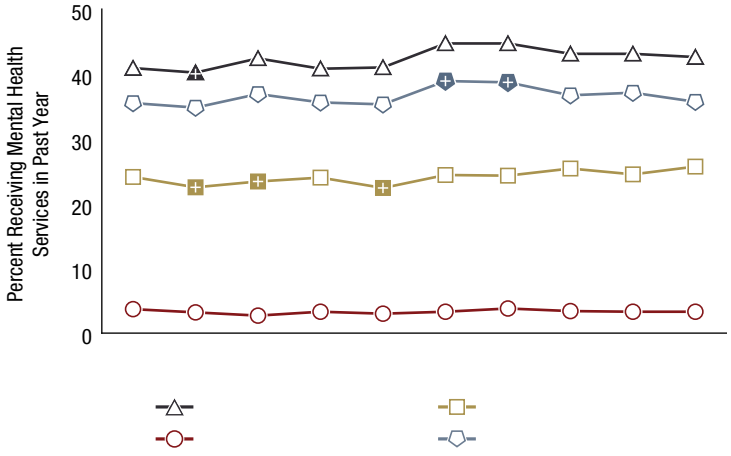
In 2017, 3.4 million young adults aged 18 to 25 with AMI used mental health services in the past year, including 1.5 million young adults with SMI. These numbers of young adults who used mental health services represent 38.4 percent of young adults with AMI in the past year and 57.4 percent of those with SMI (Table A.46B). The percentage of young adults in 2017 with AMI who received

mental health care was higher than the percentages between 2008 and 2016. The percentage of young adults in 2017 with SMI who received mental health services in the past year was similar to the percentages in 2009 to 2014, but it was higher than the percentages in 2008, 2015, and 2016.

Aged 26 to 49

In 2017, 9.6 million adults aged 26 to 49 with AMI used mental health services in the past year, including 3.7 million adults in this age group with SMI. These numbers of adults in this age group who received mental health services in the past year correspond to 43.3 percent of those with AMI and 66.2 percent of those with SMI (Table A.46B). The percentage of adults aged 26 to 49 in 2017 with AMI who received mental health care in the past year was similar to the percentages from 2008 to 2016. The percentage of adults aged 26 to 49 with SMI who received mental health services in the past year also remained steady from 2008 to 2017.

Figure 73. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Any Mental Illness in the Past Year: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

Figure 73 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Any Mental Illness in the Past Year: Percentages, 2008-2017

Service Type	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Any Mental Health Services	40.9	40.2+	42.4	40.8	41.0	44.7	44.7	43.1	43.1	42.6
Inpatient	3.7	3.2	2.7	3.3	3.0	3.3	3.8	3.4	3.3	3.3
Outpatient	24.1	22.5+	23.4+	24.0	22.4+	24.4	24.3	25.4	24.5	25.7
Prescription Medication	35.5	34.8	36.9	35.6	35.3	38.9+	38.7+	36.7	37.1	35.7

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

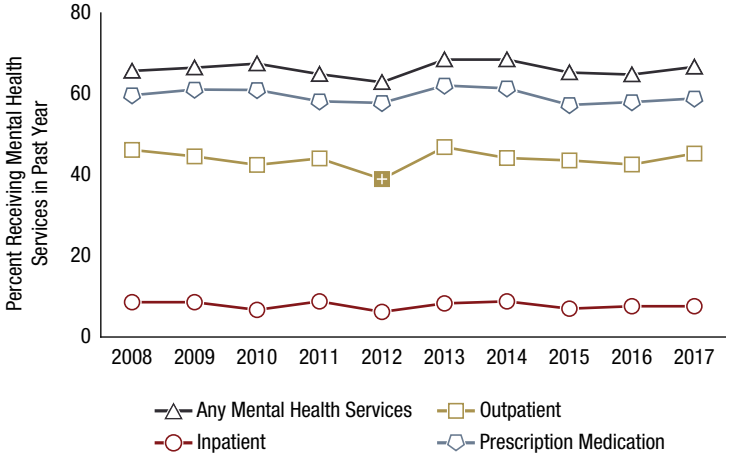
Aged 50 or Older

In 2017, 6.8 million adults aged 50 or older with AMI used mental health services in the past year, including 2.3 million adults in this age group with SMI. These numbers of adults aged 50 or older who used mental health services represent 44.2 percent of those with AMI and three fourths of those with SMI (75.6 percent) (Table A.46B). The percentage of adults aged 50 or older in 2017 with AMI who received mental health care in the past year was similar to the percentages in most years from 2008 to 2016. The percentage of adults aged 50 or older with SMI who received mental health services in the past year also remained steady from 2008 to 2017.

Perceived Unmet Need for Mental Health Services among Adults

This section discusses estimates of the perceived unmet need for mental health services among adults aged 18 or older and

Figure 74. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Serious Mental Illness in the Past Year: Percentages, 2008-2017



+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

Figure 74 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Serious Mental Illness in the Past Year: Percentages, 2008-2017

Service Type	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Any Mental Health Services	65.7	66.5	67.5	64.9	62.9	68.5	68.5	65.3	64.8	66.7
Inpatient	8.6	8.6	6.7	8.8	6.2	8.3	8.8	7.0	7.6	7.6
Outpatient	46.2	44.6	42.5	44.1	39.0+	46.9	44.2	43.6	42.6	45.3
Prescription Medication	59.7	61.1	61.0	58.2	57.8	62.1	61.4	57.3	58.0	58.9

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

reasons for not receiving these services among adults with a perceived unmet need. Estimates of the perceived unmet need for mental health services are presented for adults aged 18 or older overall and among adults with AMI or SMI.

In contrast to how perceived unmet need for substance use treatment is estimated (see the earlier section on the perceived need for substance use treatment), perceived unmet need for mental health services is estimated from a question that asks all adults whether there was any time in the past 12 months when they thought they needed treatment or counseling for mental health issues but did not receive services; all adults are asked this question, regardless of whether they had AMI in the past year or whether they received any mental health services in the past 12 months. Therefore, this measure for the perceived unmet need for mental health services includes adults who may have received some type of mental health care in the past 12 months. Adults who received mental health services in the past 12 months could have felt an unmet need for services before or after they received services.

Perceived Unmet Need for Mental Health Services among All Adults

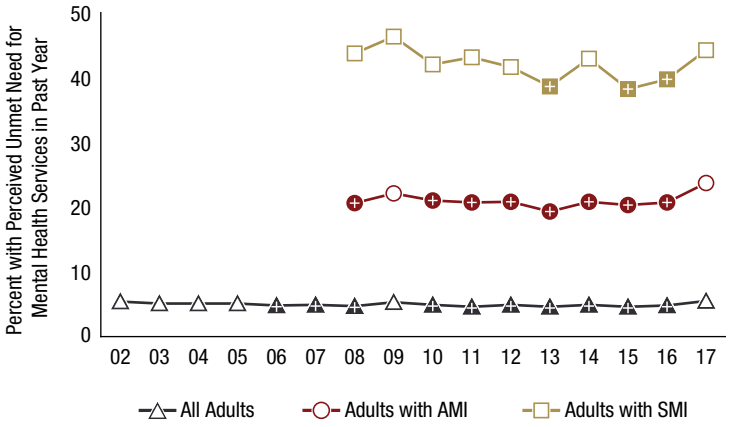
In 2017, an estimated 13.5 million adults aged 18 or older had a perceived unmet need for mental health care at any time in the past year, including 6.5 million adults who did not receive any mental health services in the past year (Table A.47A). The 13.5 million adults who perceived an unmet need for mental health care represent 5.5 percent of all adults (Figure 75). The 6.5 million adults who had a perceived unmet need for mental health services and did not receive any mental health services in the past year represent 48.0 percent of adults with a perceived unmet need for mental health care (Table A.48B).

Among the 13.5 million adults in 2017 who perceived an unmet need for mental health care in the past year, about 3.9 million were young adults aged 18 to 25, 6.5 million were aged 26 to 49, and 3.1 million were aged 50 or older (Table A.47A). These numbers of adults who perceived an unmet need for mental health care at any time in the past year represent 11.4 percent of young adults, 6.5 percent of adults aged 26 to 49, and 2.7 percent of adults aged 50 or older (Table A.47B). In addition, 2.1 million young adults, 3.1 million adults aged 26 to 49, and 1.3 million adults aged 50 or older perceived an unmet need for mental health services but did not receive any services in the past year. These numbers of adults who did not receive any services in the past year represent 54.2 percent of young adults, 47.5 percent of adults aged 26 to 49, and 41.0 percent of those aged 50 or older who had a perceived unmet need for mental health care (Table A.48B).

The percentage of adults in 2017 who perceived an unmet need for mental health care in the past year (5.5 percent) was higher than the percentages in most years from 2006 to 2016, but it was similar to the percentages in 2002 to 2005 (Figure 75). Stated another way, about 1 in 20 adults in the general population each year perceived an unmet need for mental health care. These percentages represent at least 10.5 million adults each year who perceived an unmet need for mental health care (Table A.47A).

Among young adults aged 18 to 25 in 2017, the percentage of those with a perceived unmet need (11.4 percent) was higher than the percentages in all years from 2002 to 2016 (Table A.47B). In 2002 to 2017, from 7.4 to 11.4 percent of young adults had a perceived unmet need for mental health care. Among adults aged 26 to 49, the percentage of adults

Figure 75. Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Mental Illness Status: Percentages, 2002-2017



AMI = any mental illness; SMI = serious mental illness.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Figure 75 Table. Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Mental Illness Status: Percentages, 2002-2017

MI Status	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
All Adults	5.4	5.1	5.1	5.1	4.8+	4.9+	4.7+	5.3	4.9+	4.6+	4.9+	4.6+	4.9+	4.6+	4.8+	5.5
Adults with AMI	N/A	N/A	N/A	N/A	N/A	N/A	20.6+	22.1	21.0+	20.7+	20.8+	19.3+	20.8+	20.3+	20.7+	23.7
Adults with SMI	N/A	N/A	N/A	N/A	N/A	N/A	43.7	46.3	42.0	43.1	41.6	38.6+	42.9	38.2+	39.7+	44.2

AMI = any mental illness; MI = mental illness; N/A = not available; SMI = serious mental illness.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

in 2017 with a perceived unmet need (6.5 percent) was similar to the percentages in most years from 2002 to 2016. The percentage of adults aged 50 or older in 2017 with a perceived unmet need for mental health care (2.7 percent) also was similar to the percentages in most years between 2002 and 2016.

Perceived Unmet Need for Mental Health Services among Adults with AMI

In 2017, approximately 11.1 million adults aged 18 or older with past year AMI perceived an unmet need for mental health care in the past year (Table A.47A), including 4.9 million adults with AMI who did not receive any mental health services in the past year. About 1 in 4 adults with past year AMI (23.7 percent) perceived an unmet need for mental health care in the past year (Figure 75). Among adults with a perceived unmet need and past year AMI, 44.8 percent did not receive any mental health services in the past year (Table A.48B).

Among the 11.1 million adults in 2017 with past year AMI who perceived an unmet need for mental health care in the past year, about 3.1 million were young adults aged 18 to 25, 5.4 million were aged 26 to 49, and 2.5 million were aged 50 or older (Table A.47A). These numbers of adults with AMI who perceived an unmet need for mental health care correspond to 35.3 percent of young adults, 24.5 percent of adults aged 26 to 49, and 16.1 percent of those aged 50 or older (Table A.47B).

In 2017, about half of the 3.1 million young adults with AMI who perceived an unmet need for mental health care did not receive any mental health services in the past year (1.6 million young adults with AMI, or 50.5 percent) (Table A.48B).[63] Among adults aged 26 to 49 with AMI who had a perceived unmet need for mental health care, 44.1 percent (2.4 million adults) did not receive any mental health services in the past year. Among adults aged 50 or older with AMI who had a perceived unmet need for mental health care, 39.2 percent (976,000 adults) did not receive any mental health services in the past year.

The estimate of 23.7 percent of adults aged 18 or older in 2017 with past year AMI who perceived an unmet need for mental health care in that period was higher than the percentages in most years from 2008 to 2016 (Figure 75). Among young adults aged 18 to 25 with past year AMI, the percentage in 2017 who perceived an unmet need for mental health services (35.3 percent) was higher than the percentages in all years from 2008 to 2016 (ranging from 27.8 to 32.4 percent) (Table A.47B). In contrast, among adults aged 26 to 49, the percentages of adults with AMI who perceived an unmet need for mental health services remained steady between 2008 and 2017. For example, the percentage of adults aged 26 to 49 with AMI who perceived an unmet need for mental health services ranged from 21.7 to 24.8 percent. Among adults aged 50 or older with past year AMI, the percentage in 2017 who perceived an unmet need for mental health services was higher than the percentages in most years from 2011 to 2016.

Perceived Unmet Need for Mental Health Services among Adults with SMI

In 2017, about 4.9 million adults with past year SMI perceived an unmet need for mental health care in the past year (Table A.47A), including 1.6 million adults with SMI who did not receive any mental health services in the past year. Nearly 2 out of 5 adults with SMI (44.2 percent) perceived an unmet need for mental health services in the past year (Figure 75). About one third of adults with a perceived unmet need and past year SMI (32.6 percent) did not receive any mental health services in the past year (Table A.48B).

Among adults in 2017 with past year SMI, an estimated 1.4 million young adults aged 18 to 25, 2.5 million adults aged 26 to 49, and 989,000 adults aged 50 or older perceived an unmet need for mental health care in the past year (Table A.47A). About 40.8 percent (582,000) of the 1.4 million young adults with SMI who perceived an unmet need for mental health services, 32.4 percent (814,000) of the 2.5 million adults aged 26 to 49 with SMI who perceived an unmet need for mental health services, and 21.2 percent (210,000) of the 989,000 adults aged 50 or older with SMI who perceived an unmet need for mental health care in the past year did not receive any mental health services (Table A.48B).

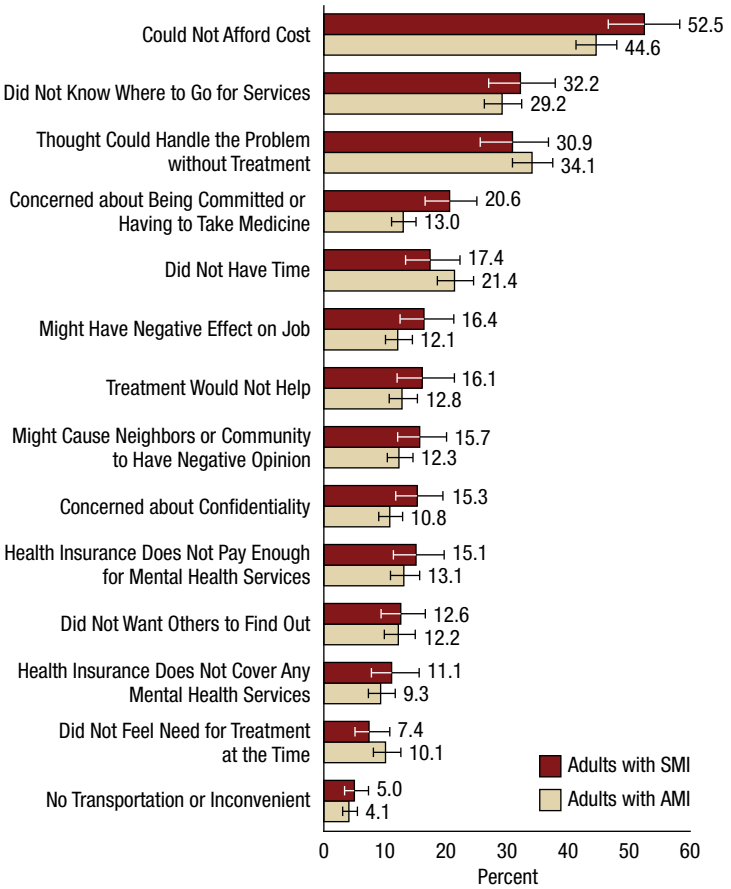
The percentage of adults aged 18 or older in 2017 with SMI who perceived an unmet need for mental health services (44.2 percent) was higher than the percentages in 2015 and 2016, but it was similar to the percentages in most years between 2008 and 2014 (Figure 75). For young adults aged 18 to 25 with SMI, the 2017 estimate of the perceived unmet need for mental health services was greater than the estimate in 2008, but it was similar to the estimates in most years from 2009 to 2016 (Table A.47B). Among adults with SMI who were aged 26 to 49 or aged 50 or older, the 2017

estimates of the perceived unmet need for mental health services also were similar to the estimates in most years from 2008 to 2016. Each year, about 1 in 2 young adults with SMI, about 2 out of 5 adults aged 26 to 49 with SMI, and 3 out of 10 adults aged 50 or older with SMI perceived an unmet need for mental health services.

Reasons for Not Receiving Mental Health Services among Adults with Mental Illness with a Perceived Unmet Need

Among adults in 2017 with AMI in the past year and among those with SMI in the past year who had a perceived unmet need for mental health services but who did not receive services in the past year, the most common reason for not receiving services was that these adults could not afford the cost of care (Figure 76). About 2 out of 5 adults with AMI (44.6 percent) and half of those with SMI (52.5 percent) who perceived an unmet need for mental health services did not receive services because they could not afford the cost of care.

Figure 76. Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with a Perceived Unmet Need for Mental Health Services Who Did Not Receive Mental Health Services, by Mental Illness Status: Percentages, 2017



AMI = any mental illness; SMI = serious mental illness.

Note: Respondents could indicate multiple reasons for not receiving mental health services; thus, these response categories are not mutually exclusive.

Other reasons for not receiving mental health care among adults with mental illness included not knowing where to go for services and believing that they could handle the problem without treatment (Figure 76). In 2017, among adults with AMI who had a perceived unmet need for mental health care and did not receive services in the past year, 34.1 percent believed at the time that they could handle the problem without treatment, and 29.2 percent did not know where to go for services. Among corresponding adults with SMI, 30.9 percent believed at the time they could handle the problem without treatment, and 32.2 percent did not know where to go for services. In addition, 21.4 percent of adults with AMI who had a perceived unmet need for mental health care and did not receive mental health services in the past year did not have the time to go for care. Among adults with SMI who had a perceived unmet need and did not receive mental health services in the past year, 20.6 percent were concerned about being committed to a psychiatric hospital or having to take medication.

Receipt of Services for Co-Occurring Substance Use Disorder and Mental Health Issues

People with co-occurring SUD and mental health issues may receive services to help with either or both of these issues. This section presents estimates of receipt of services among adolescents and adults with co-occurring SUD and mental health issues.

Receipt of Services among Adolescents with Co-Occurring MDE and a Substance Use Disorder

This section presents data from the 2017 NSDUH on the receipt of mental health care or specialty substance use treatment among adolescents aged 12 to 17 who had a co-occurring MDE and an SUD. Because of the 2015 questionnaire changes for substance use and SUD that were described previously, the 2017 NSDUH estimates of the receipt of services among adolescents with a co-occurring MDE and an SUD are not comparable with estimates prior to 2015.

Among the 345,000 adolescents in 2017 who had a co-occurring MDE and an SUD in the past year, 216,000 received either substance use treatment at a specialty facility or mental health services in the past year. This number of adolescents who received mental health care or specialty substance use treatment corresponds to 62.7 percent of adolescents who had a co-occurring MDE and an SUD (Table A.50B). Stated another way, more than a third of adolescents with both an MDE and an SUD in the past year did not receive either type of service. Among adolescents in 2017 with a co-occurring MDE and an SUD, 5.9 percent received both mental health care and specialty substance use treatment, and 56.8 percent received only mental health care. The percentage of adolescents with a co-occurring MDE and an SUD who received only specialty substance use treatment is not shown because of low precision.

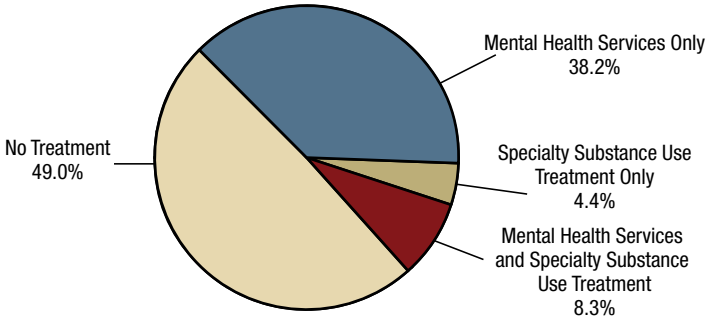
Receipt of Services among Adults with Co-Occurring Mental Illness and a Substance Use Disorder

This section presents data on the receipt of mental health services or specialty substance use treatment among adults with an SUD who have co-occurring AMI or co-occurring SMI. Because of the 2015 questionnaire changes for substance use and SUDs that were described previously, the 2017 NSDUH estimates of the receipt of services among adults with co-occurring mental disorders and SUDs are not comparable with estimates prior to 2015.

Among the 8.5 million adults with co-occurring AMI and an SUD in the past year, 51.0 percent received either substance use treatment at a specialty facility[64] or mental health care in the past year (Figure 77). In other words, about half of the adults with co-occurring AMI and an SUD in the past year did not receive either type of service.[65] An estimated 8.3 percent of adults with these co-occurring disorders received both mental health care and specialty substance use treatment, 38.2 percent received only mental health care, and 4.4 percent received only specialty substance use treatment.

Among the 3.1 million adults who had co-occurring SMI and an SUD in the past year, 64.0 percent received either substance use treatment at a specialty facility or mental health care in the past year (Figure 78). Stated another way, about 1 in 3 adults with co-occurring SMI and an SUD did not receive either type of care in the past year. Among adults with co-occurring SMI and an SUD, 11.8 percent received both mental health care and specialty substance use treatment, 49.6 percent received only mental health care, and 2.6 percent received only specialty substance use treatment.

Figure 77. Receipt of Mental Health Services and Specialty Substance Use Treatment in the Past Year among Adults Aged 18 or Older with Past Year Mental Illness and Substance Use Disorders: Percentages, 2017

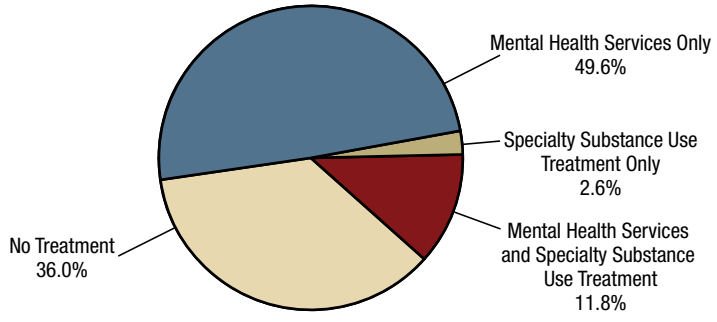


8.5 Million Adults with Co-Occurring Mental Illness and Substance Use Disorders

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Specialty substance use treatment refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Note: The percentages do not add to 100 percent due to rounding.

Figure 78. Receipt of Mental Health Services and Specialty Substance Use Treatment in the Past Year among Adults Aged 18 or Older with Past Year Serious Mental Illness and Substance Use Disorders: Percentages, 2017



3.1 Million Adults with Co-Occurring Serious Mental Illness and Substance Use Disorders

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Specialty substance use treatment refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Aged 18 to 25

Among young adults aged 18 to 25 in 2017 who had co-occurring AMI and an SUD in the past year, 46.7 percent received substance use treatment at a specialty facility or mental health care in the past year (Table A.51B). Among young adults who had co-occurring AMI and an SUD, 36.9 percent received only mental health care, 6.3 percent received both mental health care and specialty substance use treatment, and 3.5 percent received only specialty substance use treatment in the past year. Among young adults in 2017 with co-occurring SMI and an SUD, 59.2 percent received either mental health care or specialty substance treatment, 9.1 percent received both mental health care and specialty substance use treatment, 48.7 percent received only mental health care, and 1.4 percent received only specialty substance use treatment in the past year.

Aged 26 to 49

Among adults aged 26 to 49 in 2017 who had co-occurring AMI and an SUD in the past year, 52.6 percent received mental health care or substance use treatment at a specialty facility in the past year (Table A.51B). Among adults in this age group who had co-occurring AMI and an SUD, 38.1 percent received only mental health care, 9.4 percent received both mental health care and specialty substance use treatment, and 4.9 percent received only specialty substance use treatment in the past year. Among adults aged 26 to 49 with co-occurring SMI and an SUD, 65.4 percent received either mental health care or specialty substance treatment, 14.6 percent received both mental health care and specialty substance use treatment, 47.4 percent received only mental health care, and 3.4 percent received only specialty substance use treatment in the past year.

Aged 50 or Older

Among adults aged 50 or older in 2017 who had co-occurring AMI and an SUD in the past year, 52.6 percent received mental health care or substance use treatment at a specialty facility in the past year (Table A.51B). Among adults in this age group who had co-occurring AMI and an SUD, 40.2 percent received only mental health care, 8.1 percent received both mental health care and specialty substance use treatment, and 4.3 percent received only specialty substance use treatment in the past year. Estimates for the receipt of services among adults aged 50 or older with co-occurring SMI and an SUD were not reported because of low precision.[12]

Endnotes

1. World Health Organization. (2013). *Mental health action plan 2013–2020*. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/

2. Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., McKnight-Eily, L. R., Harrison, L., D'Angelo, D. V., Williams, L., Morrow, B., Gould, D., & Safran, M. A. (2011). Mental illness surveillance among adults in the United States. *Morbidity and Mortality Weekly Report CDC Surveillance Summaries, 60*(Suppl. 3), 1-29. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm

3. Murray, C. J. L., & Lopez, A. D. (2013). Measuring the global burden of disease. *New England Journal of Medicine, 369*, 448-457. https://doi.org/10.1056/nejmra1201534

4. This report occasionally presents estimated numbers of people with a specific characteristic (e.g., estimated numbers of substance users). Some of these estimated numbers are not included in figures or tables in the report but may be found in the detailed tables for the 2017 NSDUH available at https://www.samhsa.gov/data/.

5. In this report, terms such as "Americans," "people in this country," "general population," or similar terms are used broadly to refer to the civilian, noninstitutionalized population that is covered by NSDUH. Although some people in the general population of the United States are outside of the civilian, noninstitutionalized population, information from the 2010 census suggests that the civilian, noninstitutionalized population includes at least 97 percent of the total U.S. population. See the following reference: Lofquist, D., Lugaila, T., O'Connell, M., & Feliz, S. (2012, April). *Households and families: 2010* (C2010BR-14, 2010 Census Briefs). Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf

6. Details about the sample design, weighting, and interviewing results for the 2017 NSDUH are provided in Sections A.1, A.3.4, and B.3.1 of CBHSQ (2018). In particular, Tables A.1 and A.2 in CBHSQ (2018) provide sample design information on the targeted numbers of completed interviews by state and by age group, respectively. See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

7. The screening procedure involves listing all household members in order to determine whether zero, one, or two individuals aged 12 or older should be selected for the interview.

8. Overall response rates are not calculated for adolescents or adults because the screening response rate is not specific to age groups.

9. Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

10. Trend data are presented for 2002 to 2017. The 2002 to 2017 estimates are not comparable with estimates from prior surveys. For more details, see Appendix C in the following report for the 2004 NSDUH: Office of Applied Studies. (2005). *Results from the 2004 National Survey on Drug Use and Health: National findings* (HHS Publication No. SMA 05-4062, NSDUH Series H-28). Retrieved from https://www.samhsa.gov/data/

11. Estimates presented in this report have been weighted to reflect characteristics of the civilian, noninstitutionalized population aged 12 or older in the United States. The calculation of NSDUH weights for analysis includes a step that yields weights that are consistent with population totals obtained from the U.S. Census Bureau based on the most recently available decennial census.

12. For a discussion of the criteria for suppressing (i.e., not publishing) unreliable estimates, see Section B.2.2 in CBHSQ (2018). See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

13. Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health: Summary of the effects of the 2015 NSDUH questionnaire redesign: Implications for data users*. Retrieved from https://www.samhsa.gov/data/

14. Center for Behavioral Health Statistics and Quality. (2015, August). *National Survey on Drug Use and Health: 2014 and 2015 redesign changes*. Retrieved from https://www.samhsa.gov/data/

15. Details about the questionnaire changes for 2015 and their effects on the comparability of estimates are provided in Section C of CBHSQ (2016). See the following reference: Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

16. Some tables in Appendix A present estimates for 2015 to 2017 and statistical comparisons between estimates in 2017 and those in 2015 or 2016 for measures that started new baselines in 2015. However, these statistical comparisons are not discussed in this report because comparisons with estimates in 2017 are not available for 3 prior years.

17. If the number of people in the population with a characteristic of interest has increased (e.g., the number of substance users) simply because the size of the overall population has increased, then the percentages will control for the increases both in the number of people with the characteristic of interest and the total number of people in the population.

18. The term "most years" is used when the 2017 estimate is either similar to or significantly different from the estimates in the majority of prior years. However, estimates may not follow the overall pattern in up to 3 nonsequential years for estimates that are available in 2002 to 2017 and in up to 2 nonsequential years for mental health estimates that are available in 2008 (or 2009) to 2017.

19. Anomalous differences between 2 years of data usually "correct" themselves with 1 or 2 additional years of data.

20. Center for Behavioral Health Statistics and Quality. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 14-4863, NSDUH Series H-48). Retrieved from https://www.samhsa.gov/data/

21. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 grams per deciliter (g/dL). This typically occurs after four drinks for women and five drinks for men in about 2 hours. See the following two references:

    National Institute on Alcohol Abuse and Alcoholism. (2004, Winter). NIAAA council approves definition of binge drinking. *NIAAA Newsletter, 3*, 3. Retrieved from https://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf

National Institute on Alcohol Abuse and Alcoholism. (2016). *Drinking levels defined*. Retrieved from https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

22. In NSDUH, a "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Times when respondents only had a sip or two from a drink are not considered to be alcohol consumption.

23. The threshold for determining binge alcohol use for females was lowered from five or more drinks on an occasion for the 2014 and earlier NSDUHs to four or more drinks on an occasion for the 2015 NSDUH to ensure consistency with federal definitions and other federal data collection programs. The threshold for males in 2015 remained at five or more drinks on an occasion. New baselines began in 2015 for estimates of binge and heavy alcohol use for females and for binge and heavy alcohol use for the overall population (both genders). Estimates from 2002 to 2017 for binge and heavy alcohol use among males are available in the 2017 NSDUH detailed tables at https://www.samhsa.gov/data/.

24. These estimates were calculated from data in the figure being referenced but are not included in the appendix tables or in the 2017 detailed tables.

25. Alcohol Policy Information System, National Institute on Alcohol Abuse and Alcoholism. (2015, December 23). *State profiles of underage drinking laws*. Retrieved from https://alcoholpolicy.niaaa.nih.gov/underage-drinking/state-profiles

26. Although all questions for specific pain relievers in the NSDUH questionnaire ask about opioid pain relievers, respondents could specify that they misused other pain relievers that are not opioids. In 2015 to 2017, however, at least 97 percent of individuals in each year who misused prescription pain relievers in the past year misused a prescription opioid pain reliever. For more information on this topic, see Section C.1.2 in CBHSQ (2018). See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

27. The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past month.

28. Desoxyn® was mentioned only rarely as some other stimulant in 2017. Because Desoxyn® is chemically similar to other prescription amphetamines (e.g., Adderall®), it was grouped with the other amphetamines for 2017.

29. LSD = lysergic acid diethylamide; PCP = phencyclidine; MDMA = methylenedioxy-methamphetamine; DMT = dimethyltryptamine; AMT = alpha-methyltryptamine; Foxy = N, N-diisopropyl-5-methoxytryptamine (5-MeO-DIPT). Definitions for these hallucinogens also are included in Section D of CBHSQ (2018). See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

30. Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, R. M. (2016). Increases in drug and opioid overdose deaths—United States, 2000-2014. *Morbidity and Mortality Weekly Report, 64*(50-51), 1378-1382. https://doi.org/10.1111/ajt.13776

31. To measure initiation for most substances, NSDUH respondents who reported that they ever used a particular substance were asked to report their age when they first used it. To measure initiation of prescription drug misuse (i.e., misuse of pain relievers, tranquilizers, stimulants, and sedatives), NSDUH respondents who reported that they misused a particular prescription drug in the past 12 months were asked to report their age when they first misused it. Respondents who reported first use (or misuse in the case of prescription drugs) of a substance within a year of their current age also were asked to report the year and month when they first used (or misused) it.

32. Estimates relating to the periods prior to the 12-month reference period have not been considered here because of concerns about their validity resulting from recall bias. See the following reference: Gfroerer, J., Hughes, A., Chromy, J., Heller, D., & Packer, L. (2004, July). Estimating trends in substance use based on reports of prior use in a cross-sectional survey. In S. B. Cohen & J. M. Lepkowski (Eds.), *Eighth Conference on Health Survey Research Methods: Conference proceedings [Peachtree City, GA]* (HHS Publication No. PHS 04-1013, pp. 29-34). Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics.

33. For substances other than prescription psychotherapeutic drugs, respondents who had ever used the substance (e.g., marijuana) were asked to report when they first used the substance, and respondents who reported first use within a year of their current age were asked to report the year and month when they first used it. Thus, past year initiates for substances other than prescription psychotherapeutic drugs reported their first use within 12 months of the interview date.

34. Assessing whether respondents in the 2017 NSDUH had initiated misuse of a prescription psychotherapeutic drug in the past 12 months differed from assessing whether respondents had initiated the use of other substances in that period because the psychotherapeutic drug categories (e.g., prescription pain relievers) include many different types of prescription drugs in a given category (e.g., pain relievers containing hydrocodone, such as Vicodin®, Lortab®, Norco®, Zohydro® ER, or generic hydrocodone). Respondents in 2017 were asked questions about initiation of misuse only for the specific prescription drugs that they misused in the past 12 months, including their age when they first misused a drug and (if the first misuse occurred within a year of the current age) the year and month of first misuse for that drug. Respondents who reported that they initiated misuse in the past 12 months for all of the specific prescription drugs in a given category that they misused in that period were asked a follow-up question to establish whether they had *ever* misused prescription drugs in that category more than 12 months before being interviewed. Respondents who answered this follow-up question as "no" were defined as being past year initiates for the misuse of any prescription drug in the overall category. This answer meant that respondents had never misused any prescription drug in that category more than 12 months prior to the interview date.

35. Numbers in Figure 27 refer to people who used a specific substance for the first time in the past year, regardless of whether the initiation of use of other substances occurred prior to the past year.

36. Past year initiates of crack cocaine use were counted as past year initiates for cocaine only if they had not previously used cocaine in any form.

37. For more information, see Section B.2.3 of CBHSQ (2017). See the following reference: Center for Behavioral Health Statistics and Quality. (2017). *2016 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

38. Past year initiates of LSD, PCP, or Ecstasy use are counted as past year initiates for hallucinogens only if respondents had previously not used other hallucinogens.

39. Survey questions for the perceived risk from using different substances vary in terms of the frequency (e.g., weekly or monthly use) and quantity of use (e.g., having five or more drinks of alcohol), making comparisons difficult for perceptions of risk from using different substances.

40. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

41. The DSM-IV criteria for SUDs include separate criteria for dependence or abuse. Individuals who met the criteria for abuse for a given substance (e.g., alcohol) did not meet the criteria for dependence for that substance. For more information, see Section B.4.3 and the definitions for abuse and dependence in Section D of CBHSQ (2018). See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

42. Changes to the questions for the use of hallucinogens and inhalants also affected the comparability of the estimates for hallucinogen use disorder and inhalant use disorder in 2017 with estimates prior to 2015, but estimates for these disorders in 2017 are not discussed in the SUD section of the report. Estimates for methamphetamine use disorder were not produced prior to questions on methamphetamine use disorder being added to the 2015 NSDUH questionnaire.

43. Respondents who reported any use of prescription drugs in a given prescription psychotherapeutic category in the past 12 months (e.g., prescription pain relievers) but did not report misuse of any drugs in that category in the past 12 months were not asked the SUD questions for that category.

44. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5) (5th ed.). Arlington, VA: Author.

45. Adolescents were first asked whether they ever had a period in their lifetime lasting several days or longer when any of the following was true for most of the day: (a) feeling sad, empty, or depressed; (b) feeling very discouraged or hopeless about how things were going in their lives; or (c) losing interest and becoming bored with most things they usually enjoy. Adolescents who reported any of these problems were asked further questions about having an MDE in their lifetime, including whether they had at least five of nine symptoms in the same 2-week period in their lifetime; at least one of the symptoms needed to be having a depressed mood or loss of interest or pleasure in daily activities. Unlike questions for adults, adolescents who reported gaining weight without trying were asked if this occurred because they were growing. Those who had lifetime MDE were asked if they had a period of time in the past 12 months when they felt depressed or lost interest or pleasure in daily activities for 2 weeks or longer, and they reported that they had some of their other lifetime MDE symptoms in the past 12 months. These adolescents were defined as having past year MDE.

46. Adults were first asked whether they ever had a period in their lifetime lasting several days or longer when any of the following was true for most of the day: (a) feeling sad, empty, or depressed; (b) feeling discouraged about how things were going in their lives; or (c) losing interest in most things they usually enjoy. Adults who reported any of these problems were asked further questions about having an MDE in their lifetime, including whether they had at least five of nine symptoms in the same 2-week period in their lifetime; at least one of the symptoms needed to be having a depressed mood or loss of interest or pleasure in daily activities. Those who had lifetime MDE were asked if they had a period of time in the past 12 months when they felt depressed or lost interest or pleasure in daily activities for 2 weeks or longer, and they reported that they had some of their other lifetime MDE symptoms in the past 12 months. These adults were defined as having past year MDE. Data on MDE in the past year for adults are available in NSDUH since 2005. Data on MDE with severe impairment for adults are available since 2009.

47. Questions measuring adolescents' impairment in carrying out life activities because of MDE were added to the survey in 2006.

48. Percentages shown in Figure 42 and in Figure 44 (which is discussed for adults in the next section of the report) may differ from percentages that are calculated from the estimated numbers of people because the estimated numbers are rounded. Also, respondents with unknown information for past year MDE or MDE with severe impairment were excluded.

49. In order to generate estimates of AMI and SMI in the United States, SAMHSA designed and implemented the Mental Health Surveillance Study (MHSS). Over the 5-year period from 2008 to 2012, a subsample of adults was selected from the main study to participate in a follow-up telephone interview that obtained a detailed mental health assessment administered by trained mental health clinicians. The MHSS interview used the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP). A prediction model created from clinical interview data that were collected from 2008 to 2012 was applied to data from the 2008 to 2015 NSDUHs to produce estimates of AMI for the entire NSDUH adult sample in these years. See the following reference: First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP)*. New York, NY: New York State Psychiatric Institute, Biometrics Research.

50. A statistical model that predicts the likelihood of having mental illness was developed based on a subsample of adult NSDUH respondents from 2008 to 2012 who completed a clinical follow-up interview after the main NSDUH interview. The follow-up interviews consisted of detailed mental health assessments administered by trained mental health clinicians. Details about the definitions and estimation methods for mental illness estimates are provided in Section B.4.7 and Section D of CBHSQ (2018). See the following reference: Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

51. In this section, estimated numbers or percentages of adults with SMI and the corresponding estimates for adults who had AMI without SMI may not sum to the overall estimates for adults with AMI because of rounding.

52. Percentages shown in Figure 47 may differ from percentages that are calculated from the estimated numbers of people because the estimated numbers are rounded.

53. Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., Ivey-Stephenson, A. Z, & Crosby, A. E. (2018). *Vital Signs:* Trends in suicide rates — United States, 1999-2016 and circumstances contributing to suicide — 27 states, 2015. *Morbidity and Mortality Weekly Report, 67*(22), 617-624. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6722a1-H.pdf

54. Crosby, A. E., Han, B., Ortega, L. A. G., Parks, S. E., & Gfroerer, J. (2011, October 21). Suicidal thoughts and behaviors among adults aged ≥18 years—United States, 2008-2009. *Morbidity and Mortality Weekly Report Surveillance Summaries, 60*(13), 1-22. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm

55. Han, B., Kott, P. S., Hughes, A., McKeon, R., Blanco, C., & Compton, W. M. (2016). Estimating the rates of deaths by suicide among adults who attempt suicide in the United States. *Journal of Psychiatric Research, 77*, 125-133. https://doi.org/10.1016/j.jpsychires.2016.03.002

56. The estimate for the number of adults aged 18 or older in 2017 who attempted suicide (regardless of whether they made a suicide plan) is presented in the 2017 detailed tables at https://www.samhsa.gov/data/. However, the estimates for the numbers of adults who attempted suicide and made a plan or who attempted suicide without making a plan were made specifically for this report and are not included in the 2017 detailed tables.

57. Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. This NSDUH definition historically has not considered emergency rooms, private doctors' offices, prisons or jails, and self-help groups to be specialty substance use treatment facilities.

58. The NSDUH definition of the need for treatment does not explicitly indicate the need for treatment at a specialty facility. People who had an SUD in the past year can be considered to need some form of assistance for their problems with substance use. However, individuals who met DSM-IV criteria for abuse but not dependence may not necessarily need treatment at a specialty facility. For more information about the DSM-IV criteria for having an SUD, see Section B.4.3 and the definitions for abuse and dependence in Section D of CBHSQ (2018). See the following references:

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. Retrieved from https://www.samhsa.gov/data/

59. Because there were 19.7 million people aged 12 or older in 2017 with an SUD in the past year, about 95 percent of the people in 2017 who needed treatment for a substance use problem were defined as such because they had an SUD in the past year, regardless of whether they received substance use treatment at a specialty facility.

60. Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. This NSDUH definition historically has not considered emergency rooms, private doctors' offices, prisons or jails, and self-help groups to be specialty substance use treatment facilities.

61. Health professionals include general practitioners or family doctors; other medical doctors (e.g., cardiologist, gynecologist, urologist); psychologists; psychiatrists or psychotherapists; social workers; counselors; other mental health professionals (e.g., mental health nurse or other therapist where type is not specified); and nurses, occupational therapists, or other health professionals.

62. The specialty mental health setting includes services in outpatient or inpatient settings. Outpatient services include those from (a) a private therapist, psychologist, psychiatrist, social worker, or counselor; (b) a mental health clinic or center; (c) a partial day hospital or day treatment program; or (d) an in-home therapist, counselor, or family preservation worker. Inpatient or residential specialty mental health services in which adolescents stayed overnight or longer include services in a hospital or a residential treatment center.

63. Percentages that readers calculate from estimated numbers of adults with a perceived unmet need for mental health services may not agree with reported percentages because the estimated numbers are rounded to the nearest 0.1 million adults.

64. A specialty facility refers to a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center.

65. Percentages for the receipt of specific types of services do not sum to the total percentage who received any type of service due to rounding.

Appendix A: Supplemental Tables of Estimates for Key Substance Use and Mental Health Indicators in the United States

Table A.1B Tobacco Product and Alcohol Use in the Past Month among Individuals Aged 12 or Older: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO PRODUCTS	30.4*	(0.35)	29.8*	(0.34)	29.2*	(0.33)	29.4*	(0.35)	29.6*	(0.35)	28.7*	(0.34)	28.4*	(0.35)	27.7*	(0.33)	27.5*	(0.34)	26.5*	(0.33)	26.7*	(0.34)
Cigarettes	26.0*	(0.34)	25.4*	(0.33)	24.9*	(0.32)	24.9*	(0.32)	25.0*	(0.33)	24.3*	(0.33)	24.0*	(0.32)	23.3*	(0.32)	23.0*	(0.31)	22.1*	(0.32)	22.1*	(0.32)
Daily Cigarette Smoking[1]	63.4*	(0.66)	62.9*	(0.67)	62.3*	(0.63)	63.0*	(0.62)	62.3*	(0.59)	61.3*	(0.65)	61.5*	(0.70)	61.0*	(0.68)	59.5*	(0.71)	60.7*	(0.71)	60.7*	(0.71)
Smoked 1+ Packs of Cigarettes per Day[2]	53.1*	(0.91)	53.5*	(0.82)	54.0*	(0.87)	51.4*	(0.86)	50.6*	(0.85)	50.9*	(0.88)	49.2*	(0.94)	45.9*	(0.98)	45.1*	(0.94)	43.8*	(0.90)	42.0	(0.94)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	5.4*	(0.15)	5.4*	(0.14)	5.7*	(0.13)	5.6*	(0.15)	5.6*	(0.14)	5.4*	(0.14)	5.3*	(0.15)	5.3*	(0.14)	5.2*	(0.14)	5.0*	(0.14)	5.2*	(0.15)
Pipe Tobacco	0.8	(0.07)	0.7*	(0.06)	0.8	(0.06)	0.9	(0.06)	0.9	(0.07)	0.8	(0.07)	0.8	(0.06)	0.8	(0.06)	0.8	(0.06)	0.8	(0.06)	1.0	(0.07)
ALCOHOL	51.0	(0.42)	50.1*	(0.39)	50.3*	(0.40)	51.8	(0.40)	51.0	(0.39)	51.2	(0.41)	51.6	(0.39)	51.9	(0.38)	51.8	(0.39)	51.8	(0.39)	52.1	(0.39)
Binge Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Heavy Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.1B Tobacco Product and Alcohol Use in the Past Month among Individuals Aged 12 or Older: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO PRODUCTS	25.5*	(0.32)	25.2*	(0.28)	23.9*	(0.26)	23.5*	(0.27)	22.4	(0.26)
Cigarettes	21.3*	(0.30)	20.8*	(0.26)	19.4*	(0.25)	19.1*	(0.25)	17.9	(0.25)
Daily Cigarette Smoking[1]	59.6*	(0.73)	58.8	(0.59)	58.1	(0.64)	57.9	(0.66)	57.1	(0.69)
Smoked 1+ Packs of Cigarettes per Day[2]	41.3	(1.00)	40.3	(0.83)	41.1	(0.87)	41.1	(0.89)	41.2	(0.92)
Smokeless Tobacco		nc		nc	3.4	(0.11)	3.3	(0.10)	3.2	(0.09)
Cigars	4.7	(0.14)	4.5	(0.11)	4.7	(0.12)	4.6	(0.11)	4.6	(0.11)
Pipe Tobacco	0.9	(0.06)	0.8	(0.05)	0.8	(0.05)	0.8	(0.05)	0.9	(0.05)
ALCOHOL	52.2	(0.41)	52.7*	(0.33)	51.7	(0.32)	50.7*	(0.31)	51.7	(0.33)
Binge Alcohol Use		nc		nc	24.9	(0.27)	24.2	(0.26)	24.5	(0.27)
Heavy Alcohol Use		nc		nc	6.5	(0.14)	6.0	(0.14)	6.1	(0.13)

nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Percentages for daily cigarette smoking are among past month cigarette smokers.

[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for the number of cigarettes smoked per day were excluded from the analysis.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.2B Tobacco Product and Alcohol Use in the Past Month among Youths Aged 12 to 17: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO PRODUCTS	15.2*	(0.33)	14.4*	(0.32)	14.4*	(0.32)	13.1*	(0.31)	12.9*	(0.29)	12.4*	(0.30)	11.5*	(0.28)	11.8*	(0.29)	10.7*	(0.28)	10.0*	(0.27)	8.6*	(0.25)
Cigarettes	13.0*	(0.30)	12.2*	(0.29)	11.9*	(0.30)	10.8*	(0.28)	10.4*	(0.26)	9.9*	(0.27)	9.2*	(0.25)	9.0*	(0.26)	8.4*	(0.26)	7.8*	(0.24)	6.6*	(0.22)
Daily Cigarette Smoking[1]	31.8*	(1.03)	29.7*	(1.06)	27.6*	(1.13)	25.8*	(1.12)	26.5*	(1.19)	26.4*	(1.16)	22.3*	(1.11)	23.0*	(1.17)	22.5*	(1.29)	22.7*	(1.28)	22.0*	(1.33)
Smoked 1+ Packs of Cigarettes per Day[2]	21.8	(1.61)	22.0	(1.68)	19.4	(1.80)	20.1	(1.87)	17.9	(1.94)	18.7	(2.14)	18.4	(2.08)	17.9	(2.12)	16.7	(2.24)	14.8	(1.97)	10.8	(1.88)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	4.5*	(0.19)	4.5*	(0.17)	4.8*	(0.18)	4.2*	(0.18)	4.1*	(0.16)	4.3*	(0.18)	3.8*	(0.16)	4.0*	(0.16)	3.2*	(0.15)	3.4*	(0.16)	2.6*	(0.13)
Pipe Tobacco	0.6	(0.06)	0.6	(0.07)	0.7*	(0.08)	0.6	(0.07)	0.7*	(0.07)	0.7*	(0.08)	0.7*	(0.07)	0.9*	(0.09)	0.6	(0.07)	0.7*	(0.07)	0.7*	(0.07)
ALCOHOL	17.6*	(0.32)	17.7*	(0.33)	17.6*	(0.32)	16.5*	(0.32)	16.7*	(0.32)	16.0*	(0.34)	14.7*	(0.32)	14.8*	(0.32)	13.6*	(0.33)	13.3*	(0.31)	12.9*	(0.31)
Binge Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Heavy Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.2B Tobacco Product and Alcohol Use in the Past Month among Youths Aged 12 to 17: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO PRODUCTS	7.8*	(0.24)	7.0*	(0.25)	6.0*	(0.23)	5.3	(0.21)	4.9	(0.21)
Cigarettes	5.6*	(0.20)	4.9*	(0.21)	4.2*	(0.20)	3.4	(0.18)	3.2	(0.17)
Daily Cigarette Smoking[1]	19.4*	(1.35)	24.1*	(1.89)	20.0*	(1.84)	15.0	(1.64)	12.2	(1.64)
Smoked 1+ Packs of Cigarettes per Day[2]	11.9	(2.47)	11.9	(2.52)	7.8	(2.51)	**	(**)	**	(**)
Smokeless Tobacco		nc		nc	1.5	(0.10)	1.4	(0.11)	1.3	(0.10)
Cigars	2.3*	(0.13)	2.1	(0.13)	2.1	(0.14)	1.8	(0.12)	1.9	(0.13)
Pipe Tobacco	0.6	(0.07)	0.7*	(0.08)	0.3	(0.06)	0.5	(0.06)	0.4	(0.07)
ALCOHOL	11.6*	(0.29)	11.5*	(0.33)	9.6	(0.29)	9.2	(0.30)	9.9	(0.30)
Binge Alcohol Use		nc		nc	5.8	(0.23)	4.9	(0.22)	5.3	(0.22)
Heavy Alcohol Use		nc		nc	0.9	(0.10)	0.8	(0.09)	0.7	(0.08)

**Low precision; no estimate reported; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Percentages for daily cigarette smoking are among past month cigarette smokers.

[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for the number of cigarettes smoked per day were excluded from the analysis.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.3B Tobacco Product and Alcohol Use in the Past Month among Young Adults Aged 18 to 25: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO PRODUCTS	45.3*	(0.48)	44.8*	(0.48)	44.6*	(0.50)	44.3*	(0.48)	44.0*	(0.49)	41.9*	(0.50)	41.4*	(0.47)	41.6*	(0.50)	40.9*	(0.49)	39.5*	(0.49)	38.1*	(0.47)
Cigarettes	40.8*	(0.48)	40.2*	(0.47)	39.5*	(0.49)	39.0*	(0.47)	38.5*	(0.48)	36.2*	(0.49)	35.7*	(0.45)	35.8*	(0.48)	34.3*	(0.47)	33.5*	(0.47)	31.8*	(0.47)
Daily Cigarette Smoking[1]	51.8*	(0.72)	52.7*	(0.69)	51.6*	(0.72)	50.1*	(0.73)	48.8*	(0.77)	49.2*	(0.76)	47.8*	(0.81)	45.3*	(0.80)	45.8*	(0.80)	45.3*	(0.86)	45.1*	(0.88)
Smoked 1+ Packs of Cigarettes per Day[2]	39.1*	(0.93)	37.1*	(0.88)	34.9*	(0.86)	36.9*	(0.93)	34.4*	(0.93)	32.9*	(0.92)	31.6*	(0.91)	29.5*	(0.92)	27.3	(0.94)	26.1	(0.97)	25.1	(0.90)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	11.0*	(0.27)	11.4*	(0.26)	12.7*	(0.30)	12.0*	(0.28)	12.1*	(0.29)	11.9*	(0.28)	11.4*	(0.29)	11.5*	(0.29)	11.3*	(0.30)	10.9*	(0.29)	10.7*	(0.27)
Pipe Tobacco	1.1*	(0.08)	0.9*	(0.08)	1.2*	(0.09)	1.5	(0.11)	1.3	(0.10)	1.2*	(0.10)	1.4	(0.10)	1.8	(0.12)	1.8	(0.12)	1.9	(0.14)	1.8	(0.11)
ALCOHOL	60.5*	(0.53)	61.4*	(0.50)	60.5*	(0.51)	60.9*	(0.51)	62.0*	(0.51)	61.3*	(0.52)	61.1*	(0.49)	61.8*	(0.52)	61.4*	(0.50)	60.7*	(0.54)	60.2*	(0.49)
Binge Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Heavy Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.3B Tobacco Product and Alcohol Use in the Past Month among Young Adults Aged 18 to 25: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO PRODUCTS	37.0*	(0.49)	35.0*	(0.54)	33.0*	(0.48)	30.0	(0.48)	29.1	(0.48)
Cigarettes	30.6*	(0.46)	28.4*	(0.53)	26.7*	(0.46)	23.5	(0.47)	22.3	(0.44)
Daily Cigarette Smoking[1]	43.1*	(0.83)	43.0*	(0.91)	42.0*	(1.02)	39.9	(1.03)	38.4	(1.02)
Smoked 1+ Packs of Cigarettes per Day[2]	22.3	(0.90)	22.5	(1.16)	22.5	(1.11)	26.2	(1.42)	25.0	(1.45)
Smokeless Tobacco		nc		nc	5.4*	(0.22)	5.2	(0.22)	4.8	(0.21)
Cigars	10.0*	(0.29)	9.7	(0.30)	8.9	(0.27)	8.8	(0.27)	9.1	(0.29)
Pipe Tobacco	2.2*	(0.14)	1.9	(0.13)	1.8	(0.13)	1.7	(0.12)	1.6	(0.14)
ALCOHOL	59.6*	(0.53)	59.6*	(0.56)	58.3*	(0.53)	57.1	(0.55)	56.3	(0.60)
Binge Alcohol Use		nc		nc	39.0*	(0.51)	38.4	(0.54)	36.9	(0.57)
Heavy Alcohol Use		nc		nc	10.9*	(0.33)	10.1	(0.32)	9.6	(0.34)

nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Percentages for daily cigarette smoking are among past month cigarette smokers.

[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for the number of cigarettes smoked per day were excluded from the analysis.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.4B Tobacco Product and Alcohol Use in the Past Month among Adults Aged 26 or Older: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO PRODUCTS	29.9*	(0.44)	29.3*	(0.41)	28.5*	(0.41)	29.0*	(0.43)	29.4*	(0.43)	28.6*	(0.42)	28.4*	(0.44)	27.3*	(0.40)	27.2*	(0.42)	26.3*	(0.41)	27.0*	(0.42)
Cigarettes	25.2*	(0.42)	24.7*	(0.41)	24.1*	(0.39)	24.3*	(0.39)	24.7*	(0.40)	24.1*	(0.40)	23.8*	(0.41)	23.0*	(0.39)	22.8*	(0.38)	21.9*	(0.39)	22.4*	(0.40)
Daily Cigarette Smoking[1]	68.8*	(0.87)	68.0*	(0.86)	67.8*	(0.80)	68.9*	(0.79)	67.9*	(0.74)	66.3*	(0.83)	67.0*	(0.86)	67.2*	(0.84)	64.8*	(0.86)	66.5*	(0.88)	66.0*	(0.85)
Smoked 1+ Packs of Cigarettes per Day[2]	57.1*	(1.12)	58.0*	(0.99)	59.2*	(1.05)	55.1*	(1.02)	54.5*	(1.00)	55.1*	(1.06)	53.0*	(1.10)	49.4*	(1.16)	48.8*	(1.09)	47.4*	(1.05)	45.2	(1.09)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	4.6	(0.18)	4.5	(0.18)	4.6	(0.17)	4.7*	(0.18)	4.6	(0.18)	4.4	(0.16)	4.4	(0.18)	4.4	(0.18)	4.4	(0.17)	4.2	(0.18)	4.5	(0.19)
Pipe Tobacco	0.8	(0.09)	0.6	(0.07)	0.7	(0.08)	0.8	(0.08)	0.9	(0.09)	0.8	(0.09)	0.6	(0.07)	0.7	(0.07)	0.7	(0.07)	0.7	(0.07)	0.9	(0.09)
ALCOHOL	53.9*	(0.53)	52.5*	(0.49)	53.0*	(0.51)	55.1	(0.51)	53.7*	(0.49)	54.1*	(0.52)	54.7	(0.50)	54.9	(0.48)	54.9	(0.48)	55.1	(0.49)	55.6	(0.48)
Binge Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Heavy Alcohol Use		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.4B Tobacco Product and Alcohol Use in the Past Month among Adults Aged 26 or Older: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO PRODUCTS	25.7*	(0.40)	25.8*	(0.33)	24.5*	(0.32)	24.6*	(0.33)	23.4	(0.31)
Cigarettes	21.6*	(0.38)	21.5*	(0.32)	20.0*	(0.31)	20.2*	(0.31)	18.9	(0.30)
Daily Cigarette Smoking[1]	64.9*	(0.88)	63.3	(0.72)	62.7	(0.76)	62.2	(0.75)	61.5	(0.79)
Smoked 1+ Packs of Cigarettes per Day[2]	44.7	(1.15)	43.3	(0.93)	44.1	(0.98)	43.1	(1.00)	43.2	(1.02)
Smokeless Tobacco		nc		nc	3.2	(0.13)	3.1	(0.12)	3.1	(0.11)
Cigars	4.1	(0.17)	3.9	(0.12)	4.3	(0.14)	4.2	(0.13)	4.2	(0.13)
Pipe Tobacco	0.7	(0.07)	0.7	(0.06)	0.8	(0.06)	0.7	(0.06)	0.8	(0.06)
ALCOHOL	55.9	(0.50)	56.5	(0.39)	55.6	(0.38)	54.6*	(0.38)	55.8	(0.40)
Binge Alcohol Use		nc		nc	24.8	(0.32)	24.2	(0.32)	24.7	(0.32)
Heavy Alcohol Use		nc		nc	6.4	(0.17)	6.0	(0.17)	6.2	(0.16)

nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Percentages for daily cigarette smoking are among past month cigarette smokers.

[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for the number of cigarettes smoked per day were excluded from the analysis.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.5B Type of Tobacco Product Use among Past Month Tobacco Users Aged 12 or Older, by Age Group: 2017

Tobacco Product Use	Total		12 to 17		18 to 25		26 or Older	
Only Cigarettes	65.2	(0.55)	35.4	(2.11)	53.2	(0.95)	68.3	(0.63)
Cigarettes and Some Other Type of Tobacco Product	14.6	(0.37)	29.3	(2.08)	23.5	(0.80)	12.4	(0.42)
Only Noncigarette Tobacco Products	20.3	(0.48)	35.3	(1.97)	23.2	(0.79)	19.3	(0.56)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.6B Alcohol Use in the Past Month among Individuals Aged 12 to 20: 2002-2017

Alcohol Use	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ALCOHOL	28.8*	(0.39)	29.0*	(0.41)	28.7*	(0.39)	28.2*	(0.41)	28.4*	(0.42)	28.0*	(0.46)	26.5*	(0.40)	27.2*	(0.43)	26.2*	(0.41)	25.1*	(0.47)	24.3*	(0.48)
Binge Alcohol Use	nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc	
Heavy Alcohol Use	nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc	

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.6B Alcohol Use in the Past Month among Individuals Aged 12 to 20: 2002-2017 (continued)

Alcohol Use	2013		2014		2015		2016		2017	
ALCOHOL	22.7*	(0.40)	22.8*	(0.46)	20.3	(0.42)	19.3	(0.45)	19.7	(0.47)
Binge Alcohol Use	nc		nc		13.4*	(0.36)	12.1	(0.35)	11.9	(0.37)
Heavy Alcohol Use	nc		nc		3.3*	(0.20)	2.8	(0.17)	2.5	(0.18)

nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.7B Types of Illicit Drug Use in the Past Month among Individuals Aged 12 or Older: 2002-2017

Drug	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	6.2*	(0.14)	6.2*	(0.14)	6.1*	(0.15)	6.0*	(0.15)	6.0*	(0.15)	5.8*	(0.14)	6.1*	(0.15)	6.7*	(0.16)	6.9*	(0.16)	7.0*	(0.16)	7.3*	(0.17)
Cocaine	0.9	(0.05)	1.0*	(0.06)	0.8	(0.05)	1.0*	(0.06)	1.0*	(0.06)	0.8	(0.06)	0.7	(0.05)	0.7*	(0.05)	0.6*	(0.04)	0.5*	(0.04)	0.6*	(0.05)
Crack	0.2	(0.03)	0.3	(0.04)	0.2	(0.03)	0.3*	(0.04)	0.3*	(0.04)	0.2	(0.03)	0.1	(0.02)	0.2	(0.03)	0.1	(0.02)	0.1*	(0.02)	0.2	(0.04)
Heroin	0.1*	(0.02)	0.1*	(0.01)	0.1*	(0.02)	0.1*	(0.01)	0.1	(0.03)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.01)	0.1*	(0.02)	0.1*	(0.02)	0.1	(0.02)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	0.0*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.0*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.1*	(0.01)	0.1*	(0.01)
PCP	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)	0.0	(0.00)	0.0	(0.01)	0.0	(0.00)	0.0	(0.01)	0.0	(0.01)	0.0	(0.00)	0.0	(0.00)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.7B Types of Illicit Drug Use in the Past Month among Individuals Aged 12 or Older: 2002-2017 (continued)

Drug	2013		2014		2015		2016		2017	
ILLICIT DRUGS		nc		nc	10.1*	(0.17)	10.6*	(0.18)	11.2	(0.19)
Marijuana	7.5*	(0.17)	8.4*	(0.16)	8.3*	(0.15)	8.9*	(0.16)	9.6	(0.18)
Cocaine	0.6*	(0.05)	0.6*	(0.04)	0.7	(0.05)	0.7	(0.04)	0.8	(0.05)
Crack	0.1	(0.02)	0.1	(0.02)	0.1	(0.02)	0.2	(0.02)	0.2	(0.03)
Heroin	0.1*	(0.02)	0.2	(0.02)	0.1*	(0.02)	0.2	(0.02)	0.2	(0.02)
Hallucinogens		nc		nc	0.5	(0.03)	0.5	(0.03)	0.5	(0.03)
LSD	0.1*	(0.01)	0.1*	(0.02)	0.1*	(0.01)	0.1*	(0.02)	0.2	(0.02)
PCP	0.0	(0.01)	**	(**)	0.0	(0.00)	0.0	(0.00)	0.0	(0.01)
Ecstasy		nc		nc	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)
Inhalants		nc		nc	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)
Methamphetamine		nc		nc	0.3	(0.03)	0.2	(0.03)	0.3	(0.03)
Misuse of Psychotherapeutics		nc		nc	2.4	(0.08)	2.3	(0.08)	2.2	(0.08)
Pain Relievers		nc		nc	1.4*	(0.06)	1.2	(0.06)	1.2	(0.06)
Tranquilizers		nc		nc	0.7	(0.04)	0.7	(0.04)	0.6	(0.04)
Stimulants		nc		nc	0.6	(0.04)	0.6	(0.04)	0.7	(0.04)
Sedatives		nc		nc	0.2	(0.02)	0.2	(0.03)	0.1	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	1.5*	(0.06)	1.4	(0.06)	1.3	(0.06)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.8B Types of Illicit Drug Use in the Past Month among Youths Aged 12 to 17: 2002-2017

Drug	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	8.2*	(0.24)	7.9*	(0.24)	7.6*	(0.23)	6.8	(0.22)	6.7	(0.21)	6.7	(0.22)	6.7	(0.22)	7.4*	(0.24)	7.4*	(0.25)	7.9*	(0.24)	7.2*	(0.22)
Cocaine	0.6*	(0.07)	0.6*	(0.06)	0.5*	(0.06)	0.6*	(0.06)	0.4*	(0.05)	0.4*	(0.05)	0.4*	(0.05)	0.3*	(0.05)	0.2*	(0.05)	0.3*	(0.05)	0.1	(0.03)
Crack	0.1	(0.03)	0.1	(0.03)	0.1	(0.02)	0.1	(0.03)	0.0	(0.02)	0.1	(0.02)	0.0	(0.01)	0.0	(0.02)	0.0	(0.01)	0.0	(0.01)	**	(**)
Heroin	0.0	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.0	(0.01)	0.1	(0.03)	0.1*	(0.02)	0.0	(0.01)	0.1	(0.03)	**	(**)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	0.2	(0.05)	0.2	(0.04)	0.2	(0.03)	0.1	(0.03)	0.1	(0.03)	0.1	(0.03)	0.2	(0.04)	0.1	(0.03)	0.2	(0.04)	0.1	(0.03)	0.1*	(0.02)
PCP	0.1*	(0.02)	0.1*	(0.02)	0.0	(0.02)	0.1	(0.02)	0.0	(0.02)	0.0	(0.02)	0.1	(0.02)	0.1	(0.02)	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.8B Types of Illicit Drug Use in the Past Month among Youths Aged 12 to 17: 2002-2017 (continued)

Drug	2013		2014		2015		2016		2017	
ILLICIT DRUGS		nc		nc	8.8*	(0.27)	7.9	(0.26)	7.9	(0.26)
Marijuana	7.1	(0.23)	7.4*	(0.27)	7.0	(0.24)	6.5	(0.24)	6.5	(0.24)
Cocaine	0.2	(0.04)	0.2	(0.04)	0.2	(0.05)	0.1	(0.03)	0.1	(0.03)
Crack	0.0	(0.01)	0.0	(0.02)	0.0	(0.01)	0.0	(0.01)	**	(**)
Heroin	0.1*	(0.02)	0.1*	(0.02)	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)
Hallucinogens		nc		nc	0.5	(0.07)	0.5	(0.06)	0.6	(0.08)
LSD	0.2	(0.04)	0.3	(0.06)	0.2	(0.05)	0.2	(0.04)	0.2	(0.04)
PCP	0.0	(0.01)	0.0	(0.01)	0.0	(0.02)	0.0	(0.01)	0.0	(0.02)
Ecstasy		nc		nc	0.1	(0.04)	0.1	(0.03)	0.2	(0.04)
Inhalants		nc		nc	0.7	(0.08)	0.6	(0.07)	0.6	(0.07)
Methamphetamine		nc		nc	0.1	(0.02)	0.0	(0.01)	0.1	(0.02)
Misuse of Psychotherapeutics		nc		nc	2.0*	(0.15)	1.6	(0.12)	1.5	(0.11)
Pain Relievers		nc		nc	1.1	(0.11)	1.0	(0.09)	0.9	(0.09)
Tranquilizers		nc		nc	0.7	(0.09)	0.5	(0.07)	0.5	(0.06)
Stimulants		nc		nc	0.5	(0.07)	0.4	(0.06)	0.5	(0.07)
Sedatives		nc		nc	0.1	(0.03)	0.1	(0.03)	0.1	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	1.1	(0.11)	1.0	(0.09)	0.9	(0.09)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.9B Types of Illicit Drug Use in the Past Month among Young Adults Aged 18 to 25: 2002-2017

Drug	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	17.3*	(0.36)	17.0*	(0.37)	16.1*	(0.37)	16.6*	(0.37)	16.3*	(0.35)	16.5*	(0.37)	16.6*	(0.37)	18.2*	(0.38)	18.5*	(0.38)	19.0*	(0.39)	18.7*	(0.39)
Cocaine	2.0	(0.12)	2.2	(0.13)	2.1	(0.13)	2.6*	(0.15)	2.2	(0.13)	1.7	(0.12)	1.6*	(0.12)	1.4*	(0.11)	1.5*	(0.11)	1.4*	(0.12)	1.1*	(0.09)
Crack	0.2*	(0.03)	0.2*	(0.04)	0.3*	(0.04)	0.3*	(0.05)	0.2*	(0.04)	0.2*	(0.03)	0.2*	(0.03)	0.1	(0.03)	0.2*	(0.05)	0.1	(0.02)	0.1	(0.03)
Heroin	0.1*	(0.03)	0.1*	(0.02)	0.1*	(0.03)	0.2	(0.03)	0.2	(0.04)	0.1*	(0.03)	0.2	(0.04)	0.2	(0.04)	0.3	(0.05)	0.3	(0.06)	0.4	(0.06)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	0.1*	(0.03)	0.2*	(0.04)	0.3*	(0.04)	0.2*	(0.04)	0.2*	(0.04)	0.2*	(0.04)	0.3*	(0.05)	0.3*	(0.05)	0.3*	(0.05)	0.3*	(0.04)	0.3*	(0.05)
PCP	0.0	(0.02)	0.1	(0.03)	0.1	(0.02)	0.0	(0.02)	0.0	(0.02)	0.0	(0.02)	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)	0.0	(0.02)	0.0	(0.01)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.9B Types of Illicit Drug Use in the Past Month among Young Adults Aged 18 to 25: 2002-2017 (continued)

Drug	2013		2014		2015		2016		2017	
ILLICIT DRUGS		nc		nc	22.3*	(0.42)	23.2	(0.43)	24.2	(0.47)
Marijuana	19.1*	(0.39)	19.6*	(0.45)	19.8*	(0.40)	20.8*	(0.42)	22.1	(0.46)
Cocaine	1.1*	(0.10)	1.4*	(0.11)	1.7	(0.14)	1.6	(0.13)	1.9	(0.14)
Crack	0.1	(0.03)	0.1	(0.03)	0.1	(0.04)	0.0	(0.02)	0.1	(0.02)
Heroin	0.3	(0.05)	0.2	(0.05)	0.3	(0.05)	0.3	(0.05)	0.3	(0.06)
Hallucinogens		nc		nc	1.8	(0.14)	1.9	(0.14)	1.7	(0.14)
LSD	0.3*	(0.05)	0.3*	(0.05)	0.6	(0.08)	0.6	(0.07)	0.8	(0.10)
PCP	0.0	(0.01)	0.0	(0.01)	0.0	(0.00)	**	(**)	**	(**)
Ecstasy		nc		nc	0.9	(0.10)	0.9	(0.10)	0.7	(0.09)
Inhalants		nc		nc	0.4	(0.06)	0.4	(0.07)	0.5	(0.06)
Methamphetamine		nc		nc	0.4	(0.07)	0.2*	(0.04)	0.4	(0.08)
Misuse of Psychotherapeutics		nc		nc	5.1	(0.21)	4.6	(0.21)	4.5	(0.22)
Pain Relievers		nc		nc	2.4*	(0.13)	1.8	(0.13)	1.8	(0.13)
Tranquilizers		nc		nc	1.7	(0.13)	1.5	(0.12)	1.6	(0.13)
Stimulants		nc		nc	2.2	(0.15)	2.2	(0.17)	2.1	(0.16)
Sedatives		nc		nc	0.2	(0.05)	0.1	(0.03)	0.2	(0.04)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	2.5*	(0.14)	2.0	(0.14)	2.0	(0.16)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.10B Types of Illicit Drug Use in the Past Month among Adults Aged 26 or Older: 2002-2017

Drug	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	4.0*	(0.16)	4.0*	(0.16)	4.1*	(0.17)	4.1*	(0.17)	4.2*	(0.17)	3.9*	(0.16)	4.2*	(0.18)	4.6*	(0.18)	4.8*	(0.19)	4.8*	(0.19)	5.3*	(0.20)
Cocaine	0.7	(0.07)	0.8	(0.08)	0.7	(0.06)	0.8	(0.07)	0.8	(0.08)	0.7	(0.08)	0.7	(0.06)	0.6	(0.07)	0.5*	(0.05)	0.4*	(0.05)	0.6	(0.07)
Crack	0.3	(0.04)	0.3	(0.05)	0.2	(0.03)	0.3	(0.05)	0.3	(0.05)	0.3	(0.04)	0.2	(0.03)	0.2	(0.04)	0.2	(0.03)	0.1*	(0.02)	0.2	(0.05)
Heroin	0.1*	(0.02)	0.0*	(0.01)	0.1*	(0.02)	0.0*	(0.01)	0.1	(0.04)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	0.0*	(0.01)	0.0*	(0.00)	0.0*	(0.01)	0.0*	(0.00)	0.0*	(0.01)	0.0*	(0.02)	**	(**)	0.0*	(0.01)	**	(**)	0.0*	(0.01)	0.0*	(0.01)
PCP	0.0	(0.01)	**	(**)	0.0	(0.01)	0.0	(0.01)	**	(**)	0.0	(0.01)	**	(**)	0.0	(0.01)	0.0	(0.01)	**	(**)	0.0	(0.01)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.10B Types of Illicit Drug Use in the Past Month among Adults Aged 26 or Older: 2002-2017 (continued)

Drug	2013		2014		2015		2016		2017	
ILLICIT DRUGS		nc		nc	8.2*	(0.19)	8.9*	(0.21)	9.5	(0.22)
Marijuana	5.6*	(0.20)	6.6*	(0.18)	6.5*	(0.17)	7.2*	(0.19)	7.9	(0.20)
Cocaine	0.5	(0.06)	0.5*	(0.05)	0.6	(0.06)	0.6	(0.05)	0.7	(0.06)
Crack	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)
Heroin	0.1*	(0.02)	0.2	(0.03)	0.1*	(0.02)	0.2	(0.03)	0.2	(0.03)
Hallucinogens		nc		nc	0.2*	(0.03)	0.3	(0.04)	0.3	(0.03)
LSD	0.0*	(0.02)	0.1	(0.02)	0.0*	(0.01)	0.1	(0.01)	0.1	(0.02)
PCP	0.0	(0.01)	**	(**)	0.0	(0.00)	0.0	(0.00)	0.0	(0.01)
Ecstasy		nc		nc	0.1	(0.02)	0.1	(0.02)	0.1	(0.02)
Inhalants		nc		nc	0.1	(0.02)	0.2	(0.03)	0.1	(0.02)
Methamphetamine		nc		nc	0.4	(0.04)	0.3	(0.03)	0.3	(0.03)
Misuse of Psychotherapeutics		nc		nc	2.0	(0.09)	2.0	(0.09)	1.9	(0.09)
Pain Relievers		nc		nc	1.3	(0.07)	1.2	(0.07)	1.1	(0.07)
Tranquilizers		nc		nc	0.5	(0.05)	0.6	(0.05)	0.5	(0.04)
Stimulants		nc		nc	0.4	(0.04)	0.4	(0.04)	0.5	(0.04)
Sedatives		nc		nc	0.2	(0.03)	0.2	(0.03)	0.1	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	1.3	(0.08)	1.3	(0.08)	1.2	(0.08)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.11B Opioid Misuse in the Past Year among Individuals Aged 12 or Older, by Age Group: 2002-2017

Opioid Misuse Status/ Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
OPIOID MISUSE (HEROIN USE OR PAIN RELIEVER MISUSE)	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
12-17	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
18-25	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
26 or Older	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
HEROIN USE	0.2* (0.02)	0.1* (0.02)	0.2* (0.02)	0.2* (0.02)	0.2* (0.03)	0.2* (0.02)	0.2* (0.02)	0.2* (0.03)	0.2 (0.03)	0.2* (0.03)	0.3 (0.03)
12-17	0.2* (0.04)	0.1* (0.03)	0.2* (0.04)	0.1* (0.03)	0.1* (0.03)	0.1 (0.02)	0.2* (0.04)	0.1* (0.03)	0.1 (0.03)	0.2* (0.05)	0.1 (0.04)
18-25	0.4* (0.05)	0.3* (0.04)	0.4* (0.05)	0.5 (0.06)	0.4 (0.06)	0.4 (0.06)	0.5 (0.06)	0.5 (0.06)	0.6 (0.07)	0.7 (0.07)	0.8 (0.08)
26 or Older	0.1* (0.03)	0.1* (0.02)	0.1* (0.03)	0.1* (0.02)	0.2* (0.04)	0.1* (0.03)	0.1* (0.03)	0.2* (0.04)	0.2* (0.04)	0.2* (0.03)	0.2* (0.04)
PAIN RELIEVER MISUSE	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
12-17	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
18-25	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc
26 or Older	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.11B Opioid Misuse in the Past Year among Individuals Aged 12 or Older, by Age Group: 2002-2017 (continued)

Opioid Misuse Status/ Age Group	2013	2014	2015	2016	2017
OPIOID MISUSE (HEROIN USE OR PAIN RELIEVER MISUSE)	nc	nc	4.7* (0.12)	4.4 (0.11)	4.2 (0.10)
12-17	nc	nc	3.9* (0.19)	3.6* (0.17)	3.1 (0.16)
18-25	nc	nc	8.7* (0.27)	7.3 (0.27)	7.3 (0.26)
26 or Older	nc	nc	4.2 (0.14)	4.0 (0.13)	3.8 (0.12)
HEROIN USE	0.3 (0.03)	0.3 (0.03)	0.3 (0.03)	0.4 (0.03)	0.3 (0.03)
12-17	0.1* (0.03)	0.1 (0.03)	0.1 (0.03)	0.1 (0.02)	0.1 (0.02)
18-25	0.7 (0.08)	0.8 (0.09)	0.6 (0.08)	0.7 (0.08)	0.6 (0.08)
26 or Older	0.2* (0.03)	0.3 (0.03)	0.3 (0.04)	0.3 (0.04)	0.3 (0.03)
PAIN RELIEVER MISUSE	nc	nc	4.7* (0.11)	4.3 (0.11)	4.1 (0.10)
12-17	nc	nc	3.9* (0.19)	3.5 (0.17)	3.1 (0.16)
18-25	nc	nc	8.5* (0.26)	7.1 (0.27)	7.2 (0.26)
26 or Older	nc	nc	4.1* (0.14)	3.9 (0.13)	3.7 (0.12)

nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level. Rounding may make the estimates appear identical.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.12B Misuse of Pain Reliever Subtypes in the Past Year among Individuals Aged 12 or Older: 2017

Pain Reliever Subtype	Number[1]		Percentage[2]	
MISUSE OF ANY PAIN RELIEVER[3]	11,077	(274)	4.1	(0.10)
Hydrocodone Products	6,262	(208)	2.3	(0.08)
Oxycodone Products	3,735	(153)	1.4	(0.06)
Tramadol Products	1,753	(125)	0.6	(0.05)
Codeine Products	2,832	(151)	1.0	(0.06)
Morphine Products	501	(54)	0.2	(0.02)
Fentanyl Products	245	(39)	0.1	(0.01)
Buprenorphine Products	766	(73)	0.3	(0.03)
Oxymorphone Products	332	(47)	0.1	(0.02)
Demerol®	116	(35)	0.0	(0.01)
Hydromorphone Products	244	(36)	0.1	(0.01)
Methadone	261	(46)	0.1	(0.02)
Any Other Prescription Pain Reliever[4]	966	(80)	0.4	(0.03)

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

[1] Estimates shown are numbers in thousands with standard errors included in parentheses.

[2] Estimates shown are percentages with standard errors included in parentheses.

[3] Includes *hydrocodone products* (Vicodin®, Lortab®, Norco®, Zohydro® ER, generic hydrocodone, or other similar products); *oxycodone products* (OxyContin®, Percocet®, Percodan®, Roxicodone®, generic oxycodone, or other similar products); *tramadol products* (Ultram®, Ultram® ER, Ultracet®, generic tramadol, generic extended-release tramadol, or other similar products); *codeine products* (Tylenol® with codeine 3 or 4, generic codeine pills, or other similar products); *morphine products* (Avinza®, Kadian®, MS Contin®, generic morphine, generic extended-release morphine, or other similar products); *fentanyl products* (Duragesic®, Fentora®, generic fentanyl, or other similar products); *buprenorphine products* (Suboxone®, generic buprenorphine, generic buprenorphine plus naloxone, or other similar products); *oxymorphone products* (Opana®, Opana® ER, generic oxymorphone, generic extended-release oxymorphone, or other similar products); *meperidine products* (Demerol® or other similar products); *hydromorphone products* (Dilaudid® or generic hydromorphone, Exalgo® or generic extended-release hydromorphone, or other similar products); *methadone products* (methadone or other similar products); or any other prescription pain reliever. Over-the-counter drugs are not included.

[4] Includes misuse of pain relievers containing other active ingredients. Reports of misuse of "any other prescription pain reliever" that correspond only to the specific pain reliever categories shown in the table are excluded from estimates for Any Other Prescription Pain Reliever and are included instead in the relevant pain reliever category.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.13B Main Reasons for Pain Reliever Misuse for the Last Episode of Misuse among Individuals Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2017

Main Reason for Misuse	Past Year Misusers of Pain Relievers	
Relieve Physical Pain	62.6	(1.19)
Relax or Relieve Tension	8.4	(0.69)
Help with Sleep	5.4	(0.66)
Help with Feelings or Emotions	3.6	(0.42)
Experiment or See What It's Like	2.8	(0.40)
Feel Good or Get High	13.2	(0.81)
Increase or Decrease Effect of Other Drug	0.7	(0.17)
Because I Am Hooked or Have to Have It	2.2	(0.36)
Some Other Reason	1.0	(0.22)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown information for their main reason for misuse were excluded from the analysis, including respondents who reported some other reason but had unknown data in their write-in responses.

NOTE: Responses to the Some Other Reason category for one drug type may fall into a response category that is asked only for another drug type (e.g., "to relieve physical pain" for tranquilizer misuse).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.14B Source Where Pain Relievers Were Obtained for Most Recent Misuse among Individuals Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2017

Source for Most Recent Misuse	Past Year Misusers of Pain Relievers	
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE PROVIDER	36.6	(1.32)
Prescription from One Doctor	34.6	(1.29)
Prescriptions from More Than One Doctor	1.5	(0.39)
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.5	(0.15)
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR RELATIVE	53.1	(1.35)
From Friend or Relative for Free	38.5	(1.35)
Bought from Friend or Relative	10.6	(0.78)
Took from Friend or Relative without Asking	4.0	(0.43)
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	5.7	(0.52)
SOME OTHER WAY[1]	4.6	(0.70)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents were asked to choose one of eight sources as their best answer. Respondents with unknown data on Source for Most Recent Misuse and respondents with unknown or invalid responses to the corresponding other-specify questions were excluded from the analysis.

[1] Some Other Way includes write-in responses not already listed in this table or responses with insufficient information that could allow them to be placed in another category.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.15A Past Year Initiation of Specific Substance Use among Individuals Aged 12 or Older: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO																						
Cigarettes	1,940	(75)	1,983	(72)	2,122*	(72)	2,282*	(86)	2,456*	(79)	2,231*	(71)	2,453*	(90)	2,545*	(89)	2,403*	(81)	2,394*	(86)	2,336*	(89)
Daily Cigarette Use	1,016*	(64)	1,064*	(58)	1,101*	(55)	965*	(58)	1,049*	(54)	983*	(52)	945*	(57)	1,136*	(66)	962*	(57)	878*	(55)	778*	(53)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	2,858*	(103)	2,736*	(99)	3,058*	(112)	3,349*	(113)	3,061*	(104)	3,078*	(107)	2,918*	(105)	3,146*	(121)	2,950*	(120)	2,800*	(143)	2,664*	(108)
ALCOHOL	3,942*	(101)	4,082*	(104)	4,396*	(127)	4,274*	(108)	4,378*	(107)	4,551*	(111)	4,466*	(116)	4,561*	(112)	4,675	(131)	4,699	(124)	4,589	(130)
ILLICIT DRUGS																						
Marijuana	2,196*	(70)	1,973*	(70)	2,142*	(81)	2,114*	(121)	2,061*	(79)	2,089*	(77)	2,224*	(89)	2,379*	(79)	2,439*	(93)	2,617*	(97)	2,398*	(96)
Cocaine	1,032	(61)	986	(56)	998	(65)	872	(50)	977	(60)	906	(57)	724*	(52)	623*	(47)	642*	(57)	670*	(48)	639*	(48)
Crack	337*	(44)	269*	(36)	215*	(29)	230*	(30)	243*	(31)	353*	(72)	209*	(34)	95	(15)	83	(20)	76	(14)	84	(16)
Heroin	117	(20)	92	(20)	118	(28)	108	(20)	90	(15)	106	(21)	116	(23)	187*	(30)	142*	(24)	178*	(26)	156*	(23)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	338*	(30)	200*	(20)	235*	(25)	243*	(29)	265*	(32)	271*	(23)	400*	(31)	341*	(28)	381*	(39)	358*	(30)	421*	(41)
PCP	123*	(15)	105*	(14)	106*	(20)	77*	(13)	70*	(13)	58*	(11)	53*	(10)	45	(9)	46	(11)	48	(10)	90*	(21)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics																						
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.15A Past Year Initiation of Specific Substance Use among Individuals Aged 12 or Older: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO										
Cigarettes	2,071	(81)	2,164*	(90)	1,956	(77)	1,782	(77)	1,898	(80)
Daily Cigarette Use	813*	(52)	756*	(51)	622	(45)	620	(54)	608	(47)
Smokeless Tobacco		nc		nc	1,335*	(75)	1,157	(86)	1,013	(61)
Cigars	2,770*	(144)	2,597	(104)	2,569	(110)	2,359	(103)	2,338	(107)
ALCOHOL	4,559*	(113)	4,655	(127)	4,761	(126)	4,639	(126)	4,914	(136)
ILLICIT DRUGS										
Marijuana	2,427*	(86)	2,568*	(95)	2,600*	(95)	2,582*	(99)	3,033	(117)
Cocaine	601*	(47)	766*	(57)	968	(68)	1,085	(73)	1,037	(69)
Crack	58	(13)	109	(24)	37*	(9)	88	(19)	83	(21)
Heroin	169*	(36)	212*	(35)	135	(24)	170*	(29)	81	(17)
Hallucinogens		nc		nc	1,160	(69)	1,178	(70)	1,194	(68)
LSD	482*	(40)	586*	(48)	664	(45)	844	(62)	794	(51)
PCP	32	(7)	41	(10)	42	(11)	43	(20)	23	(8)
Ecstasy		nc		nc	839	(62)	757	(55)	787	(56)
Inhalants		nc		nc	600	(44)	526	(43)	575	(42)
Methamphetamine		nc		nc	225	(37)	192	(32)	195	(31)
Misuse of Psychotherapeutics										
Pain Relievers		nc		nc	2,126	(115)	2,139	(119)	2,010	(119)
Tranquilizers		nc		nc	1,437	(94)	1,374	(77)	1,446	(102)
Stimulants		nc		nc	1,260	(80)	1,374	(89)	1,192	(76)
Sedatives		nc		nc	425*	(63)	294	(42)	271	(42)

LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.16A Past Year Initiation of Specific Substance Use among Youths Aged 12 to 17: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO																						
Cigarettes	1,187*	(44)	1,226*	(47)	1,294*	(50)	1,303*	(50)	1,333*	(48)	1,198*	(48)	1,288*	(50)	1,273*	(50)	1,205*	(47)	1,165*	(46)	1,032*	(43)
Daily Cigarette Use	403*	(27)	439*	(27)	417*	(32)	334*	(24)	386*	(27)	333*	(23)	277*	(23)	313*	(24)	286*	(24)	268*	(22)	197*	(22)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	1,113*	(40)	1,163*	(46)	1,246*	(48)	1,270*	(47)	1,217*	(42)	1,145*	(44)	1,120*	(43)	1,085*	(43)	940*	(40)	969*	(41)	849*	(38)
ALCOHOL	2,588*	(64)	2,593*	(65)	2,743*	(73)	2,749*	(69)	2,706*	(68)	2,698*	(69)	2,568*	(64)	2,662*	(69)	2,476	(62)	2,622*	(69)	2,448	(72)
ILLICIT DRUGS																						
Marijuana	1,373*	(50)	1,219	(45)	1,252	(45)	1,139	(44)	1,194	(48)	1,168	(45)	1,248	(49)	1,343	(49)	1,274	(51)	1,375*	(53)	1,255	(49)
Cocaine	310*	(24)	282*	(22)	274*	(23)	286*	(23)	260*	(22)	254*	(22)	196*	(20)	145*	(17)	156*	(18)	146*	(16)	120	(16)
Crack	86*	(13)	76*	(11)	42*	(9)	32*	(7)	41*	(8)	52*	(10)	17	(5)	18	(5)	14	(4)	19	(5)	18	(8)
Heroin	39*	(10)	25*	(7)	31*	(8)	18	(5)	24	(7)	16	(5)	29	(10)	19	(5)	23	(7)	38*	(10)	21	(7)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	180	(18)	96*	(13)	99*	(13)	105*	(14)	76*	(11)	97*	(13)	147	(16)	106*	(12)	100*	(15)	123*	(16)	125*	(15)
PCP	77*	(11)	59*	(10)	43*	(9)	55*	(11)	43*	(10)	38*	(8)	37*	(7)	26	(7)	22	(6)	29	(7)	45*	(11)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics																						
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.16A Past Year Initiation of Specific Substance Use among Youths Aged 12 to 17: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO										
Cigarettes	932*	(41)	838*	(44)	823*	(43)	723*	(42)	604	(37)
Daily Cigarette Use	209*	(19)	165*	(19)	119	(15)	105	(14)	86	(13)
Smokeless Tobacco		nc		nc	460	(29)	353	(28)	397	(29)
Cigars	730*	(36)	797*	(41)	671	(37)	575	(34)	599	(35)
ALCOHOL	2,417	(67)	2,335	(67)	2,358	(75)	2,293	(71)	2,332	(66)
ILLICIT DRUGS										
Marijuana	1,200	(46)	1,203	(52)	1,169	(50)	1,197	(50)	1,204	(52)
Cocaine	94	(13)	117	(20)	112	(16)	107	(16)	98	(14)
Crack	10	(4)	11	(5)	**	(**)	6	(3)	9	(4)
Heroin	21	(6)	13	(7)	11	(4)	8	(3)	9	(4)
Hallucinogens		nc		nc	340	(31)	319	(26)	344	(28)
LSD	122*	(14)	165	(22)	206	(24)	160	(18)	188	(20)
PCP	19	(6)	17	(6)	34	(11)	12	(4)	13	(5)
Ecstasy		nc		nc	168	(22)	143	(19)	146	(20)
Inhalants		nc		nc	349	(27)	262	(23)	289	(25)
Methamphetamine		nc		nc	24	(8)	16	(5)	27	(7)
Misuse of Psychotherapeutics										
Pain Relievers		nc		nc	415*	(32)	423*	(30)	316	(29)
Tranquilizers		nc		nc	210	(23)	228	(22)	223	(23)
Stimulants		nc		nc	276	(27)	244	(28)	217	(25)
Sedatives		nc		nc	46	(11)	55	(11)	34	(9)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.17A Past Year Initiation of Specific Substance Use among Young Adults Aged 18 to 25: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO																						
Cigarettes	641*	(40)	659*	(45)	765*	(46)	848*	(46)	1,041	(52)	989*	(48)	1,076	(58)	1,147	(60)	1,120	(54)	1,156	(59)	1,204	(65)
Daily Cigarette Use	447	(31)	474	(35)	566*	(36)	493*	(33)	554*	(36)	566*	(38)	549*	(35)	618*	(39)	599*	(44)	525*	(37)	488	(39)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	1,031	(46)	1,055	(48)	1,199	(54)	1,332*	(58)	1,275	(54)	1,379*	(58)	1,277	(54)	1,417*	(61)	1,388*	(66)	1,238	(58)	1,291*	(61)
ALCOHOL	1,230*	(51)	1,430*	(64)	1,484*	(62)	1,421*	(61)	1,612*	(68)	1,741*	(70)	1,706*	(68)	1,775*	(66)	2,008*	(79)	1,971*	(80)	1,945*	(77)
ILLICIT DRUGS																						
Marijuana	733*	(37)	666*	(37)	714*	(45)	723*	(45)	742*	(46)	787*	(45)	817*	(49)	988*	(55)	918*	(51)	1,060*	(61)	966*	(57)
Cocaine	594*	(42)	576*	(36)	592*	(41)	498*	(35)	570*	(40)	541*	(38)	426*	(33)	397*	(32)	372*	(32)	467*	(38)	443*	(37)
Crack	100*	(15)	109*	(15)	120*	(17)	142*	(21)	132*	(18)	88*	(15)	91*	(15)	62*	(11)	39	(8)	40	(9)	49*	(11)
Heroin	66	(13)	42	(9)	46	(10)	57	(13)	56	(12)	70	(14)	58	(11)	83*	(13)	83	(15)	100*	(17)	95*	(16)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	142*	(18)	98*	(14)	112*	(16)	114*	(16)	162*	(22)	171*	(18)	235*	(23)	228*	(25)	261*	(33)	222*	(23)	264*	(33)
PCP	46*	(11)	41*	(9)	49*	(14)	22	(6)	27	(8)	19	(7)	16	(6)	17	(6)	24	(9)	18	(8)	28	(8)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics																						
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.17A Past Year Initiation of Specific Substance Use among Young Adults Aged 18 to 25: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO										
Cigarettes	1,031	(57)	1,181	(72)	1,050	(58)	978*	(61)	1,151	(61)
Daily Cigarette Use	505*	(36)	479	(40)	403	(34)	363	(37)	393	(36)
Smokeless Tobacco		nc		nc	517*	(43)	452	(39)	398	(34)
Cigars	1,334*	(61)	1,311*	(67)	1,281	(67)	1,226	(68)	1,118	(64)
ALCOHOL	2,056*	(76)	2,225	(86)	2,203	(78)	2,191*	(86)	2,440	(95)
ILLICIT DRUGS										
Marijuana	1,017*	(54)	1,094*	(62)	1,048*	(57)	1,013*	(58)	1,304	(73)
Cocaine	432*	(37)	501*	(40)	663	(52)	766	(57)	729	(52)
Crack	25	(6)	54*	(14)	37	(9)	48	(14)	21	(7)
Heroin	66	(13)	75	(15)	57	(12)	82	(19)	46	(13)
Hallucinogens		nc		nc	670	(54)	725	(53)	683	(47)
LSD	312*	(31)	371*	(37)	387	(35)	567	(48)	487	(39)
PCP	13	(5)	24	(8)	8	(4)	9	(6)	9	(5)
Ecstasy		nc		nc	531	(45)	460	(42)	507	(44)
Inhalants		nc		nc	188	(25)	184	(26)	212	(25)
Methamphetamine		nc		nc	91	(21)	79	(15)	95	(18)
Misuse of Psychotherapeutics										
Pain Relievers		nc		nc	596*	(43)	585	(50)	465	(40)
Tranquilizers		nc		nc	489	(40)	617*	(45)	473	(40)
Stimulants		nc		nc	600	(48)	617	(49)	581	(47)
Sedatives		nc		nc	86	(16)	75	(18)	51	(12)

LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.18A Past Year Initiation of Specific Substance Use among Adults Aged 26 or Older: 2002-2017

Substance	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOBACCO																						
Cigarettes	111	(36)	98	(31)	63*	(20)	131	(40)	83	(30)	45*	(15)	89	(31)	124	(35)	78	(24)	73	(25)	101	(28)
Daily Cigarette Use	166	(48)	150	(39)	118	(29)	137	(42)	109	(33)	84	(23)	119	(37)	204	(49)	77	(23)	85	(32)	92	(27)
Smokeless Tobacco		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Cigars	714	(82)	518	(74)	614	(79)	747	(86)	570	(77)	555	(73)	521	(77)	644	(90)	622	(87)	593	(119)	524	(72)
ALCOHOL	124	(40)	60	(21)	169	(74)	105	(31)	60	(22)	112	(32)	193	(50)	124	(34)	191	(76)	106	(32)	196	(56)
ILLICIT DRUGS																						
Marijuana	90*	(25)	88*	(30)	176*	(47)	252*	(97)	126*	(33)	134*	(37)	159*	(45)	49*	(15)	247*	(60)	182*	(49)	177*	(53)
Cocaine	127	(33)	128	(36)	133	(39)	87*	(23)	147	(38)	112*	(32)	102*	(34)	81*	(28)	114	(41)	56*	(22)	76*	(26)
Crack	151*	(38)	83	(31)	53	(21)	55	(19)	70	(24)	212*	(69)	101	(30)	15	(10)	30	(18)	17	(9)	17	(8)
Heroin	12	(11)	25	(16)	40	(25)	33	(15)	9	(6)	20	(14)	28	(17)	85*	(27)	37	(17)	40	(17)	40	(15)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
LSD	16*	(13)	**	(**)	24*	(15)	24*	(19)	28*	(19)	**	(**)	18*	(12)	**	(**)	20*	(15)	13*	(8)	33*	(16)
PCP	**	(**)	**	(**)	14	(10)	**	(**)	**	(**)	**	(**)	**	(**)	**	(**)	**	(**)	**	(**)	17	(16)
Ecstasy		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Misuse of Psychotherapeutics																						
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.18A Past Year Initiation of Specific Substance Use among Adults Aged 26 or Older: 2002-2017 (continued)

Substance	2013		2014		2015		2016		2017	
TOBACCO										
Cigarettes	108	(32)	144	(29)	84	(20)	81	(20)	142	(29)
Daily Cigarette Use	99	(31)	113	(25)	100	(24)	152	(35)	130	(26)
Smokeless Tobacco		nc		nc	358*	(53)	352	(72)	218	(41)
Cigars	706	(126)	489	(62)	617	(75)	558	(72)	622	(75)
ALCOHOL	85	(26)	95	(37)	200	(48)	156	(44)	143	(38)
ILLICIT DRUGS										
Marijuana	210*	(44)	271*	(45)	383	(55)	372	(53)	525	(68)
Cocaine	75*	(29)	148	(35)	193	(39)	213	(39)	210	(37)
Crack	23	(11)	44	(18)	**	(**)	34	(13)	52	(19)
Heroin	82	(32)	124*	(31)	68	(20)	80*	(21)	26	(11)
Hallucinogens		nc		nc	150	(29)	134	(30)	167	(35)
LSD	48	(25)	50*	(19)	71	(20)	117	(32)	120	(28)
PCP	**	(**)	**	(**)	**	(**)	22	(19)	**	(**)
Ecstasy		nc		nc	141	(31)	154	(27)	134	(31)
Inhalants		nc		nc	62	(20)	80	(25)	75	(27)
Methamphetamine		nc		nc	110	(29)	97	(28)	73	(24)
Misuse of Psychotherapeutics										
Pain Relievers		nc		nc	1,114	(101)	1,130	(102)	1,229	(111)
Tranquilizers		nc		nc	738	(82)	530*	(59)	749	(89)
Stimulants		nc		nc	384	(57)	513	(65)	394	(54)
Sedatives		nc		nc	293	(61)	164	(37)	186	(39)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; nc = not comparable due to methodological changes; PCP = phencyclidine.

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.19A Average Number of Initiates per Day among Individuals Aged 12 or Older, by Age Group: 2017

Substance	Aged 12 or Older		Aged 12 to 17		Aged 18 to 25		Aged 26 or Older	
TOBACCO								
Cigarettes	5,199	(220)	1,656	(101)	3,154	(168)	389	(79)
Daily Cigarette Use	1,666	(130)	235	(35)	1,076	(98)	355	(72)
Smokeless Tobacco	2,775	(168)	1,089	(80)	1,090	(94)	596	(113)
Cigars	6,406	(294)	1,640	(95)	3,062	(175)	1,703	(205)
ALCOHOL	13,464	(372)	6,388	(180)	6,684	(261)	392	(105)
ILLICIT DRUGS								
Marijuana	8,309	(321)	3,298	(142)	3,572	(199)	1,440	(186)
Cocaine	2,841	(189)	268	(37)	1,997	(142)	576	(102)
Crack	227	(56)	25	(12)	59	(20)	143	(51)
Heroin	223	(47)	25	(10)	126	(36)	71	(30)
Hallucinogens	3,270	(186)	942	(78)	1,872	(129)	457	(96)
LSD	2,175	(141)	515	(54)	1,333	(108)	328	(78)
PCP	63	(21)	34	(15)	**	(**)	**	(**)
Ecstasy	2,156	(154)	400	(54)	1,390	(121)	367	(84)
Inhalants	1,576	(115)	792	(68)	580	(70)	205	(74)
Methamphetamine	534	(85)	73	(18)	262	(51)	200	(66)
Misuse of Psychotherapeutics								
Pain Relievers	5,506	(326)	866	(78)	1,273	(109)	3,367	(305)
Tranquilizers	3,961	(279)	612	(62)	1,296	(110)	2,053	(244)
Stimulants	3,265	(209)	595	(68)	1,592	(129)	1,078	(149)
Sedatives	741	(116)	92	(26)	139	(32)	510	(108)

**Low precision; no estimate reported; LSD = lysergic acid diethylamide; PCP = phencyclidine.

NOTE: Estimates shown are unrounded averages with standard errors included in parentheses.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.20B Perceived Great Risk of Harm Associated with Substance Use and Perceived Availability of Substances among Individuals Aged 12 or Older, by Age Group: 2017

Risk/Availability	Aged 12 or Older		Aged 12 to 17		Aged 18 to 25		Aged 26 or Older	
PERCEPTIONS OF GREAT RISK[1]								
Marijuana								
Smoke Once a Month	26.1	(0.31)	24.4	(0.43)	12.3	(0.36)	28.5	(0.38)
Smoke Once or Twice a Week	31.9	(0.32)	37.7	(0.53)	15.4	(0.40)	34.0	(0.39)
Cocaine								
Use Once a Month	71.3	(0.29)	55.6	(0.49)	63.0	(0.53)	74.5	(0.35)
Use Once or Twice a Week	86.8	(0.21)	80.1	(0.42)	83.3	(0.37)	88.2	(0.25)
Heroin								
Try Once or Twice	86.4	(0.20)	66.3	(0.47)	82.6	(0.39)	89.3	(0.24)
Use Once or Twice a Week	94.5	(0.13)	84.0	(0.39)	93.9	(0.25)	95.8	(0.16)
LSD								
Try Once or Twice	68.2	(0.31)	49.6	(0.54)	51.8	(0.54)	72.9	(0.36)
Use Once or Twice a Week	82.7	(0.23)	70.4	(0.48)	71.7	(0.47)	85.9	(0.26)
Alcohol								
Have Four or Five Drinks Nearly Every Day	68.9	(0.28)	65.2	(0.47)	63.2	(0.50)	70.2	(0.35)
Have Five or More Drinks Once or Twice a Week	44.6	(0.31)	43.6	(0.50)	37.9	(0.52)	45.8	(0.38)
Cigarettes								
Smoke One or More Packs per Day	71.6	(0.27)	67.2	(0.49)	66.6	(0.50)	73.0	(0.33)
PERCEIVED AVAILABILITY[2]								
Fairly or Very Easy to Obtain								
Marijuana	61.0	(0.35)	46.1	(0.48)	74.6	(0.52)	60.5	(0.42)
Cocaine	22.4	(0.27)	12.8	(0.33)	26.8	(0.49)	22.8	(0.33)
Crack	18.7	(0.25)	11.3	(0.32)	15.8	(0.36)	20.1	(0.32)
Heroin	17.1	(0.24)	8.4	(0.28)	15.4	(0.38)	18.4	(0.30)
LSD	13.9	(0.22)	12.4	(0.34)	20.2	(0.44)	13.1	(0.27)
Approached in the Past Month by Someone Selling Drugs	5.7	(0.12)	10.9	(0.31)	14.2	(0.37)	3.7	(0.13)

LSD = lysergic acid diethylamide.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

[1] Respondents with unknown Perception of Great Risk data were excluded.

[2] Respondents with unknown Perceived Availability data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.21B Substance Use Disorder for Specific Substances in the Past Year among Individuals Aged 12 or Older: 2002-2017

Past Year Use Disorder	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ALCOHOL	7.7*	(0.18)	7.5*	(0.16)	7.8*	(0.17)	7.7*	(0.16)	7.7*	(0.17)	7.5*	(0.17)	7.4*	(0.16)	7.5*	(0.17)	7.1*	(0.16)	6.5*	(0.15)	6.8*	(0.16)
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	1.8*	(0.07)	1.8*	(0.06)	1.9*	(0.07)	1.7*	(0.06)	1.7*	(0.06)	1.6	(0.06)	1.7*	(0.06)	1.7*	(0.06)	1.8*	(0.07)	1.6	(0.06)	1.7	(0.07)
Cocaine	0.6*	(0.05)	0.6*	(0.05)	0.7*	(0.05)	0.6*	(0.04)	0.7*	(0.05)	0.6*	(0.05)	0.6*	(0.04)	0.4	(0.04)	0.4	(0.04)	0.3	(0.03)	0.4	(0.05)
Heroin	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.01)	0.1*	(0.03)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.03)	0.1*	(0.02)	0.2*	(0.02)	0.2	(0.03)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		--		--		--		--		--		--		--		--		--		--		--
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.21B Substance Use Disorder for Specific Substances in the Past Year among Individuals Aged 12 or Older: 2002-2017 (continued)

Past Year Use Disorder	2013		2014		2015		2016		2017	
ALCOHOL	6.6*	(0.16)	6.4*	(0.14)	5.9*	(0.13)	5.6	(0.13)	5.3	(0.12)
ILLICIT DRUGS		nc		nc	2.9	(0.08)	2.7	(0.08)	2.8	(0.08)
Marijuana	1.6	(0.07)	1.6	(0.06)	1.5	(0.05)	1.5	(0.06)	1.5	(0.06)
Cocaine	0.3	(0.03)	0.3	(0.03)	0.3	(0.03)	0.3	(0.03)	0.4	(0.03)
Heroin	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)
Hallucinogens		nc		nc	0.1	(0.01)	0.1	(0.02)	0.1	(0.01)
Inhalants		nc		nc	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)
Methamphetamine		--		--	0.3	(0.03)	0.3*	(0.02)	0.4	(0.03)
Misuse of Psychotherapeutics		nc		nc	1.0	(0.05)	0.9	(0.05)	0.9	(0.05)
Pain Relievers		nc		nc	0.8*	(0.04)	0.7	(0.04)	0.6	(0.04)
Tranquilizers		nc		nc	0.3	(0.02)	0.2	(0.02)	0.3	(0.02)
Stimulants		nc		nc	0.2	(0.02)	0.2	(0.02)	0.2	(0.02)
Sedatives		nc		nc	0.1	(0.01)	0.1	(0.02)	0.1	(0.01)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	0.9	(0.05)	0.8	(0.05)	0.8	(0.05)
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc	1.0*	(0.05)	0.9	(0.04)	0.9	(0.04)
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc	7.8*	(0.15)	7.5	(0.15)	7.2	(0.14)

-- = not available; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level. Rounding may make the estimates appear identical.

[1] The term "alcohol or illicit drugs" in this table corresponds to the term "substance use disorder" in the main body of the report.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.22B Substance Use Disorder for Specific Substances in the Past Year among Youths Aged 12 to 17: 2002-2017

Past Year Use Disorder	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ALCOHOL	5.9*	(0.20)	5.9*	(0.20)	6.0*	(0.20)	5.5*	(0.20)	5.4*	(0.19)	5.4*	(0.19)	4.9*	(0.20)	4.6*	(0.20)	4.6*	(0.20)	3.8*	(0.18)	3.4*	(0.16)
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	4.3*	(0.18)	3.8*	(0.15)	3.9*	(0.16)	3.6*	(0.16)	3.4*	(0.16)	3.1*	(0.14)	3.4*	(0.16)	3.4*	(0.16)	3.6*	(0.16)	3.5*	(0.16)	3.2*	(0.16)
Cocaine	0.4*	(0.07)	0.3*	(0.05)	0.4*	(0.05)	0.4*	(0.05)	0.4*	(0.05)	0.4*	(0.05)	0.3*	(0.05)	0.2*	(0.04)	0.1	(0.03)	0.2*	(0.04)	0.2	(0.04)
Heroin	0.1	(0.02)	0.0	(0.01)	0.1*	(0.03)	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)	0.1*	(0.02)	0.1*	(0.02)	0.0	(0.01)	0.1*	(0.04)	0.1	(0.03)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		--		--		--		--		--		--		--		--		--		--		--
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.22B Substance Use Disorder for Specific Substances in the Past Year among Youths Aged 12 to 17: 2002-2017 (continued)

Past Year Use Disorder	2013		2014		2015		2016		2017	
ALCOHOL	2.8*	(0.14)	2.7*	(0.17)	2.5*	(0.15)	2.0	(0.13)	1.8	(0.12)
ILLICIT DRUGS		nc		nc	3.4*	(0.17)	3.2	(0.18)	3.0	(0.15)
Marijuana	2.9*	(0.15)	2.7*	(0.16)	2.6	(0.15)	2.3	(0.15)	2.2	(0.13)
Cocaine	0.1	(0.02)	0.1	(0.03)	0.1	(0.04)	0.1	(0.03)	0.1	(0.02)
Heroin	0.0	(0.02)	0.1	(0.03)	0.0	(0.01)	0.0	(0.00)	0.0	(0.01)
Hallucinogens		nc		nc	0.3	(0.06)	0.3	(0.05)	0.2	(0.04)
Inhalants		nc		nc	0.2*	(0.04)	0.2*	(0.04)	0.1	(0.03)
Methamphetamine		--		--	0.1	(0.03)	0.0	(0.02)	0.1	(0.03)
Misuse of Psychotherapeutics		nc		nc	0.9	(0.09)	0.9	(0.10)	0.8	(0.08)
Pain Relievers		nc		nc	0.5	(0.07)	0.6*	(0.08)	0.4	(0.06)
Tranquilizers		nc		nc	0.3	(0.06)	0.3	(0.06)	0.3	(0.06)
Stimulants		nc		nc	0.2	(0.04)	0.2	(0.04)	0.2	(0.05)
Sedatives		nc		nc	0.1	(0.03)	0.1*	(0.04)	0.0	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	0.5	(0.07)	0.6*	(0.08)	0.4	(0.06)
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc	1.0	(0.10)	0.9	(0.09)	0.8	(0.07)
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc	5.0*	(0.20)	4.3	(0.20)	4.0	(0.18)

-- = not available; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] The term "alcohol or illicit drugs" in this table corresponds to the term "substance use disorder" in the main body of the report.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.23B Substance Use Disorder for Specific Substances in the Past Year among Young Adults Aged 18 to 25: 2002-2017

Past Year Use Disorder	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ALCOHOL	17.7*	(0.36)	17.2*	(0.34)	17.4*	(0.37)	17.5*	(0.37)	17.6*	(0.37)	16.9*	(0.35)	17.4*	(0.35)	16.1*	(0.35)	15.7*	(0.37)	14.4*	(0.34)	14.3*	(0.33)
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	6.0*	(0.20)	5.9*	(0.20)	6.0*	(0.23)	5.9*	(0.22)	5.7	(0.21)	5.6	(0.21)	5.6	(0.22)	5.6	(0.22)	5.7	(0.22)	5.7	(0.21)	5.5	(0.23)
Cocaine	1.2*	(0.09)	1.2*	(0.09)	1.4*	(0.10)	1.5*	(0.10)	1.3*	(0.10)	1.4*	(0.10)	1.2*	(0.10)	0.9	(0.08)	0.7	(0.08)	0.6	(0.07)	0.6	(0.08)
Heroin	0.2*	(0.04)	0.1*	(0.03)	0.2*	(0.04)	0.3*	(0.04)	0.2*	(0.04)	0.2*	(0.04)	0.3*	(0.05)	0.3	(0.05)	0.3	(0.05)	0.4	(0.06)	0.5	(0.06)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		--		--		--		--		--		--		--		--		--		--		--
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.23B Substance Use Disorder for Specific Substances in the Past Year among Young Adults Aged 18 to 25: 2002-2017 (continued)

Past Year Use Disorder	2013		2014		2015		2016		2017	
ALCOHOL	13.0*	(0.35)	12.3*	(0.34)	10.9*	(0.32)	10.7	(0.32)	10.0	(0.31)
ILLICIT DRUGS		nc		nc	7.2	(0.26)	7.0	(0.27)	7.3	(0.27)
Marijuana	5.4	(0.22)	4.9	(0.22)	5.1	(0.21)	5.0	(0.24)	5.2	(0.24)
Cocaine	0.7	(0.08)	0.5	(0.07)	0.7	(0.08)	0.6	(0.08)	0.7	(0.08)
Heroin	0.5	(0.07)	0.5	(0.07)	0.4	(0.06)	0.4	(0.06)	0.5	(0.07)
Hallucinogens		nc		nc	0.3	(0.05)	0.5	(0.07)	0.4	(0.06)
Inhalants		nc		nc	0.0	(0.02)	0.0	(0.01)	0.1	(0.03)
Methamphetamine		--		--	0.4	(0.07)	0.4	(0.06)	0.5	(0.08)
Misuse of Psychotherapeutics		nc		nc	2.0	(0.14)	1.6	(0.12)	1.9	(0.13)
Pain Relievers		nc		nc	1.2	(0.11)	0.8	(0.09)	1.0	(0.09)
Tranquilizers		nc		nc	0.7	(0.08)	0.5*	(0.07)	0.8	(0.09)
Stimulants		nc		nc	0.5	(0.06)	0.5	(0.07)	0.5	(0.06)
Sedatives		nc		nc	0.1	(0.02)	0.1	(0.03)	0.1	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	1.5	(0.12)	1.1	(0.10)	1.3	(0.11)
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc	2.9	(0.16)	2.5	(0.16)	2.6	(0.16)
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc	15.3	(0.37)	15.1	(0.37)	14.8	(0.36)

-- = not available; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] The term "alcohol or illicit drugs" in this table corresponds to the term "substance use disorder" in the main body of the report.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.24B Substance Use Disorder for Specific Substances in the Past Year among Adults Aged 26 or Older: 2002-2017

Past Year Use Disorder	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ALCOHOL	6.2*	(0.22)	6.0*	(0.20)	6.3*	(0.21)	6.2*	(0.19)	6.2*	(0.20)	6.2*	(0.20)	6.0*	(0.19)	6.3*	(0.20)	5.9*	(0.20)	5.4*	(0.18)	5.9*	(0.19)
ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Marijuana	0.8	(0.07)	0.7	(0.06)	0.8	(0.07)	0.7	(0.06)	0.8	(0.07)	0.7	(0.07)	0.8	(0.06)	0.8	(0.07)	0.9	(0.08)	0.7	(0.06)	0.8	(0.07)
Cocaine	0.6*	(0.06)	0.6*	(0.06)	0.6*	(0.06)	0.5*	(0.05)	0.6*	(0.07)	0.6*	(0.06)	0.5*	(0.05)	0.4	(0.05)	0.4	(0.05)	0.3	(0.04)	0.4	(0.06)
Heroin	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.03)	0.1*	(0.02)	0.1*	(0.03)	0.1*	(0.02)	0.1*	(0.02)	0.1*	(0.03)	0.1*	(0.03)	0.1*	(0.03)	0.1*	(0.03)
Hallucinogens		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Inhalants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Methamphetamine		--		--		--		--		--		--		--		--		--		--		--
Misuse of Psychotherapeutics		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Pain Relievers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Tranquilizers		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Stimulants		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Sedatives		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc		nc

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.24B Substance Use Disorder for Specific Substances in the Past Year among Adults Aged 26 or Older: 2002-2017 (continued)

Past Year Use Disorder	2013		2014		2015		2016		2017	
ALCOHOL	6.0*	(0.19)	5.9*	(0.16)	5.4*	(0.15)	5.2	(0.15)	5.0	(0.14)
ILLICIT DRUGS		nc		nc	2.1	(0.09)	2.0	(0.09)	2.0	(0.09)
Marijuana	0.8	(0.08)	0.9	(0.06)	0.8	(0.05)	0.8	(0.06)	0.8	(0.06)
Cocaine	0.3	(0.04)	0.3	(0.04)	0.3	(0.04)	0.3	(0.04)	0.3	(0.04)
Heroin	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)	0.2	(0.03)
Hallucinogens		nc		nc	0.0	(0.01)	0.1	(0.01)	0.1	(0.01)
Inhalants		nc		nc	0.0	(0.01)	0.0	(0.01)	0.0	(0.01)
Methamphetamine		--		--	0.3	(0.04)	0.3	(0.03)	0.4	(0.04)
Misuse of Psychotherapeutics		nc		nc	0.9	(0.06)	0.8	(0.06)	0.8	(0.06)
Pain Relievers		nc		nc	0.7	(0.05)	0.6	(0.05)	0.6	(0.05)
Tranquilizers		nc		nc	0.2	(0.03)	0.2	(0.02)	0.2	(0.02)
Stimulants		nc		nc	0.1	(0.02)	0.1	(0.02)	0.2	(0.02)
Sedatives		nc		nc	0.1	(0.01)	0.1	(0.02)	0.1	(0.02)
Opioids (Heroin Use or Pain Reliever Misuse)		nc		nc	0.8	(0.06)	0.8	(0.06)	0.7	(0.05)
BOTH ALCOHOL AND ILLICIT DRUGS		nc		nc	0.7	(0.05)	0.6	(0.05)	0.6	(0.05)
ALCOHOL OR ILLICIT DRUGS[1]		nc		nc	6.9	(0.17)	6.6	(0.17)	6.4	(0.16)

-- = not available; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] The term "alcohol or illicit drugs" in this table corresponds to the term "substance use disorder" in the main body of the report.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.25B Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: 2004-2017

MDE	2004		2005		2006		2007		2008		2009		2010		2011		2012		2013		2014	
MDE	9.0*	(0.25)	8.8*	(0.25)	7.9*	(0.24)	8.2*	(0.25)	8.3*	(0.25)	8.1*	(0.24)	8.0*	(0.24)	8.2*	(0.24)	9.1*	(0.26)	10.7*	(0.30)	11.4*	(0.32)
MDE with Severe Impairment[1]		--		--	5.5*	(0.20)	5.5*	(0.20)	6.0*	(0.22)	5.8*	(0.20)	5.7*	(0.20)	5.7*	(0.19)	6.3*	(0.22)	7.7*	(0.26)	8.2*	(0.27)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.25B Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: 2004-2017 (continued)

MDE	2015		2016		2017	
MDE	12.5	(0.33)	12.8	(0.32)	13.3	(0.35)
MDE with Severe Impairment[1]	8.8	(0.28)	9.0	(0.27)	9.4	(0.31)

-- = not available.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year MDE data were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Impairment is based on the Sheehan Disability Scale (SDS) role domains, which measure the impact of a disorder on a youth's life. Impairment is defined as the highest severity level of role impairment across four domains: (1) chores at home, (2) school or work, (3) close relationships with family, and (4) social life. Ratings ≥ 7 on a 0 to 10 scale were considered Severe Impairment. Respondents with unknown impairment data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2017.

Table A.26B Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: 2005-2017

MDE/Age Group	2005		2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
MDE	6.6*	(0.19)	6.5*	(0.18)	6.7	(0.18)	6.5*	(0.18)	6.6*	(0.18)	6.8	(0.19)	6.6*	(0.18)	6.9	(0.19)	6.7	(0.19)	6.6*	(0.15)	6.7	(0.15)
18-25	8.8*	(0.26)	8.1*	(0.23)	8.0*	(0.24)	8.4*	(0.25)	8.0*	(0.24)	8.3*	(0.25)	8.3*	(0.25)	8.9*	(0.27)	8.7*	(0.26)	9.3*	(0.29)	10.3*	(0.28)
26-49	7.6	(0.27)	7.7	(0.29)	7.6	(0.26)	7.4	(0.27)	7.6	(0.26)	7.5	(0.27)	7.7	(0.28)	7.6	(0.27)	7.6	(0.29)	7.2	(0.21)	7.5	(0.21)
50 or Older	4.5	(0.32)	4.5	(0.29)	5.2	(0.34)	4.8	(0.35)	4.9	(0.32)	5.6*	(0.35)	4.8	(0.30)	5.5	(0.34)	5.1	(0.31)	5.2	(0.24)	4.8	(0.26)
MDE with Severe Impairment[1]	--		--		--		--		4.0*	(0.14)	4.2	(0.15)	4.2	(0.15)	4.5	(0.15)	4.3	(0.15)	4.3	(0.12)	4.3	(0.12)
18-25	--		--		--		--		5.2*	(0.20)	5.2*	(0.21)	5.2*	(0.20)	5.8*	(0.21)	5.7*	(0.22)	6.0*	(0.24)	6.5*	(0.23)
26-49	--		--		--		--		4.8	(0.21)	4.7	(0.21)	5.2	(0.23)	5.1	(0.23)	4.9	(0.24)	4.6	(0.17)	4.9	(0.17)
50 or Older	--		--		--		--		2.6	(0.23)	3.5*	(0.28)	2.9	(0.24)	3.4	(0.28)	3.2	(0.25)	3.5*	(0.21)	3.0	(0.21)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.26B Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: 2005-2017 (continued)

MDE/Age Group	2016		2017	
MDE	6.7	(0.15)	7.1	(0.16)
18-25	10.9*	(0.31)	13.1	(0.34)
26-49	7.4	(0.21)	7.7	(0.23)
50 or Older	4.8	(0.25)	4.7	(0.24)
MDE with Severe Impairment[1]	4.3	(0.12)	4.5	(0.12)
18-25	7.0*	(0.27)	8.5	(0.29)
26-49	4.7	(0.16)	5.0	(0.18)
50 or Older	3.0	(0.22)	2.8	(0.18)

-- = not available.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year MDE data were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Impairment is based on the Sheehan Disability Scale (SDS) role domains, which measure the impact of a disorder on an adult's life. Impairment is defined as the highest severity level of role impairment across four domains: (1) home management, (2) work, (3) close relationships with others, and (4) social life. Ratings ≥ 7 on a 0 to 10 scale were considered Severe Impairment. Respondents with unknown impairment data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005-2017.

Table A.27B Level of Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: 2008-2017

Mental Illness/Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
AMI	17.7*	(0.30)	18.1	(0.31)	18.1*	(0.30)	17.8*	(0.30)	18.6	(0.31)	18.5	(0.31)	18.1*	(0.23)	17.9*	(0.25)	18.3	(0.24)	18.9	(0.27)
18-25	18.5*	(0.34)	18.0*	(0.32)	18.1*	(0.35)	18.5*	(0.37)	19.6*	(0.35)	19.4*	(0.36)	20.1*	(0.39)	21.7*	(0.38)	22.1*	(0.43)	25.8	(0.49)
26-49	20.7*	(0.42)	21.6	(0.43)	20.9*	(0.42)	20.3*	(0.43)	21.2	(0.44)	21.5	(0.45)	20.4*	(0.34)	20.9*	(0.34)	21.1*	(0.33)	22.2	(0.36)
50 or Older	14.1	(0.59)	14.5	(0.54)	15.1	(0.55)	15.0	(0.53)	15.8*	(0.55)	15.3*	(0.52)	15.4*	(0.40)	14.0	(0.42)	14.5	(0.40)	13.8	(0.42)
SMI	3.7*	(0.14)	3.7*	(0.14)	4.1*	(0.16)	3.9*	(0.14)	4.1*	(0.14)	4.2	(0.16)	4.1*	(0.12)	4.0*	(0.12)	4.2	(0.12)	4.5	(0.12)
18-25	3.8*	(0.16)	3.3*	(0.15)	3.9*	(0.17)	3.8*	(0.17)	4.1*	(0.17)	4.2*	(0.18)	4.8*	(0.21)	5.0*	(0.21)	5.9*	(0.24)	7.5	(0.26)
26-49	4.8*	(0.21)	4.9*	(0.22)	5.2	(0.23)	5.0	(0.22)	5.2	(0.23)	5.3	(0.25)	4.9*	(0.18)	5.0*	(0.18)	5.3	(0.18)	5.6	(0.19)
50 or Older	2.5	(0.24)	2.5	(0.23)	3.0	(0.27)	2.8	(0.22)	3.0	(0.25)	3.2	(0.26)	3.1	(0.19)	2.8	(0.20)	2.7	(0.20)	2.7	(0.19)
AMI Excluding SMI	14.0	(0.27)	14.4	(0.27)	14.0	(0.27)	13.9	(0.26)	14.5	(0.28)	14.2	(0.27)	14.0	(0.21)	13.9	(0.22)	14.0	(0.21)	14.3	(0.24)
18-25	14.8*	(0.31)	14.6*	(0.29)	14.1*	(0.31)	14.8*	(0.33)	15.5*	(0.33)	15.2*	(0.33)	15.3*	(0.35)	16.7*	(0.36)	16.2*	(0.36)	18.3	(0.43)
26-49	16.0	(0.38)	16.7	(0.38)	15.7	(0.37)	15.3*	(0.37)	16.0	(0.38)	16.2	(0.40)	15.5*	(0.29)	15.9	(0.30)	15.8*	(0.29)	16.6	(0.32)
50 or Older	11.6	(0.54)	12.0	(0.50)	12.2	(0.49)	12.3	(0.48)	12.8*	(0.50)	12.1	(0.48)	12.3*	(0.37)	11.1	(0.37)	11.8	(0.37)	11.1	(0.38)

AMI = any mental illness; SMI = serious mental illness.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.28B Co-Occurring Substance Use Disorder (SUD) and Major Depressive Episode (MDE) and Co-Occurring SUD and MDE with Severe Impairment in the Past Year among Youths Aged 12 to 17: 2017

SUD and MDE	12 to 17	
SUD and MDE	1.4	(0.11)
SUD and MDE with Severe Impairment[1]	1.1	(0.10)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year MDE data were excluded.

[1] Impairment is based on the Sheehan Disability Scale (SDS) role domains, which measure the impact of a disorder on a youth's life. Impairment is defined as the highest severity level of role impairment across four domains: (1) chores at home, (2) school or work, (3) close relationships with family, and (4) social life. Ratings ≥ 7 on a 0 to 10 scale were considered Severe Impairment. Respondents with unknown impairment data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.29B Substance Use Disorder (SUD) and Past Year Major Depressive Episode (MDE) among Youths Aged 12 to 17, by SUD and MDE Status: 2017

SUD or MDE	SUD		No SUD		MDE		No MDE	
SUD	100.0	(0.00)		da	10.7	(0.80)	2.9	(0.17)
MDE	35.9	(2.27)	12.3	(0.34)	100.0	(0.00)		da

da = does not apply.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year MDE data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.30B Substance Use in the Past Year and Past Month among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE): 2017

Period/Substance	Total[1]		MDE		No MDE	
PAST YEAR USE						
Illicit Drugs	16.3	(0.37)	29.3	(1.19)	14.3	(0.37)
Marijuana	12.4	(0.33)	22.5	(1.09)	10.9	(0.34)
Cocaine	0.5	(0.06)	1.1	(0.24)	0.4	(0.06)
Crack	0.1	(0.03)	0.1	(0.05)	0.1	(0.03)
Heroin	0.1	(0.02)	0.2	(0.09)	0.0	(0.02)
Hallucinogens	2.1	(0.14)	4.5	(0.55)	1.6	(0.14)
LSD	1.0	(0.09)	2.2	(0.41)	0.8	(0.09)
PCP	0.1	(0.03)	0.4	(0.17)	0.0	(0.02)
Ecstasy	0.7	(0.08)	1.5	(0.31)	0.6	(0.08)
Inhalants	2.3	(0.14)	4.5	(0.53)	2.0	(0.14)
Methamphetamine	0.2	(0.04)	0.4	(0.15)	0.1	(0.04)
Misuse of Psychotherapeutics	4.9	(0.21)	11.5	(0.88)	3.9	(0.21)
Pain Relievers	3.1	(0.16)	6.5	(0.64)	2.5	(0.16)
Tranquilizers	1.8	(0.13)	5.1	(0.60)	1.3	(0.12)
Stimulants	1.8	(0.14)	4.9	(0.64)	1.3	(0.12)
Sedatives	0.3	(0.05)	0.7	(0.17)	0.2	(0.06)
Opioids (Heroin Use or Pain Reliever Misuse)	3.1	(0.16)	6.6	(0.64)	2.5	(0.16)
PAST MONTH USE						
Daily Cigarette Use	0.4	(0.05)	0.8	(0.23)	0.3	(0.05)
Heavy Alcohol Use	0.7	(0.08)	1.2	(0.27)	0.6	(0.08)

LSD = lysergic acid diethylamide; PCP = phencyclidine.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

NOTE: Misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

[1] Estimates in the Total column represent all youths aged 12 to 17, including those with unknown past year MDE information.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.31B Co-Occurring Past Year Substance Use Disorder and Level of Mental Illness Status in the Past Year among Adults Aged 18 or Older, by Age Group: 2017

SUD and Level of Mental Illness Status	18 or Older		18 to 25		26 to 49		50 or Older	
SUD and AMI	3.4	(0.10)	6.9	(0.25)	4.4	(0.16)	1.6	(0.14)
SUD and SMI	1.3	(0.06)	2.8	(0.17)	1.6	(0.10)	0.5	(0.08)
SUD and AMI Excluding SMI	2.2	(0.08)	4.2	(0.19)	2.8	(0.13)	1.1	(0.12)

AMI = any mental illness; SMI = serious mental illness, SUD = substance use disorder.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.32B Level of Mental Illness in the Past Year among Adults Aged 18 or Older, by Past Year Substance Use Disorder Status and Age Group: 2017

Level of Mental Illness/SUD Status	18 or Older		18 to 25		26 to 49		50 or Older	
AMI								
SUD	45.6	(1.02)	46.8	(1.37)	48.1	(1.32)	39.1	(2.72)
No SUD	16.7	(0.26)	22.1	(0.48)	19.6	(0.36)	12.7	(0.41)
SMI								
SUD	16.5	(0.76)	18.6	(1.04)	17.5	(1.03)	12.3	(1.96)
No SUD	3.5	(0.11)	5.5	(0.24)	4.4	(0.17)	2.3	(0.17)
AMI EXCLUDING SMI								
SUD	29.0	(0.88)	28.1	(1.16)	30.7	(1.18)	26.8	(2.45)
No SUD	13.1	(0.24)	16.6	(0.46)	15.2	(0.32)	10.4	(0.38)

AMI = any mental illness; SMI = serious mental illness, SUD = substance use disorder.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.33B Substance Use Disorder in the Past Year among Adults Aged 18 or Older, by Past Year Level of Mental Illness and Age Group: 2017

Level of Mental Illness	18 or Older		18 to 25		26 to 49		50 or Older	
AMI	18.3	(0.46)	26.8	(0.82)	19.6	(0.65)	11.5	(0.94)
SMI	27.6	(1.11)	36.9	(1.71)	28.4	(1.47)	18.5	(2.68)
AMI Excluding SMI	15.3	(0.50)	22.7	(0.98)	16.7	(0.70)	9.8	(0.98)
No Mental Illness	5.1	(0.14)	10.6	(0.38)	6.0	(0.23)	2.9	(0.20)

AMI = any mental illness; SMI = serious mental illness.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.34B Had Serious Thoughts of Suicide in the Past Year among Adults Aged 18 or Older, by Age Group: 2008-2017

Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
18 or Older	3.7*	(0.13)	3.7*	(0.13)	3.8*	(0.14)	3.7*	(0.13)	3.9*	(0.13)	3.9*	(0.14)	3.9*	(0.12)	4.0	(0.12)	4.0	(0.11)	4.3	(0.12)
18-25	6.8*	(0.23)	6.1*	(0.20)	6.7*	(0.22)	6.8*	(0.25)	7.2*	(0.23)	7.4*	(0.24)	7.5*	(0.25)	8.3*	(0.26)	8.8*	(0.28)	10.5	(0.32)
26-49	4.0	(0.19)	4.3	(0.20)	4.1	(0.20)	3.7*	(0.17)	4.2	(0.21)	4.0	(0.21)	4.0	(0.17)	4.1	(0.17)	4.2	(0.16)	4.3	(0.16)
50 or Older	2.3	(0.23)	2.3	(0.23)	2.6	(0.22)	2.6	(0.23)	2.4	(0.21)	2.7	(0.26)	2.7	(0.18)	2.6	(0.19)	2.4	(0.17)	2.5	(0.19)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown suicide information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.35B Made Any Suicide Plans in the Past Year among Adults Aged 18 or Older, by Age Group: 2008-2017

Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
18 or Older	1.0*	(0.07)	1.0*	(0.07)	1.1*	(0.07)	1.0*	(0.07)	1.1	(0.07)	1.1	(0.07)	1.1*	(0.06)	1.1*	(0.06)	1.1*	(0.05)	1.3	(0.06)
18-25	2.0*	(0.12)	2.0*	(0.12)	1.9*	(0.12)	1.9*	(0.13)	2.4*	(0.14)	2.5*	(0.14)	2.3*	(0.14)	2.7*	(0.16)	2.9*	(0.16)	3.7	(0.20)
26-49	1.1	(0.10)	1.0	(0.10)	1.0	(0.09)	1.1	(0.10)	1.3	(0.12)	1.3	(0.12)	1.1	(0.09)	1.1	(0.08)	1.3	(0.09)	1.2	(0.09)
50 or Older	0.7	(0.12)	0.6	(0.12)	0.9	(0.14)	0.7	(0.11)	0.6	(0.10)	0.6	(0.09)	0.7	(0.09)	0.7	(0.09)	0.5	(0.07)	0.6	(0.08)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown suicide information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.36B Attempted Suicide in the Past Year among Adults Aged 18 or Older, by Age Group: 2008-2017

Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
18 or Older	0.5	(0.05)	0.5	(0.04)	0.5	(0.05)	0.5	(0.05)	0.6	(0.04)	0.6	(0.05)	0.5*	(0.03)	0.6	(0.04)	0.5	(0.04)	0.6	(0.04)
18-25	1.2*	(0.10)	1.1*	(0.09)	1.2*	(0.09)	1.2*	(0.10)	1.5*	(0.12)	1.3*	(0.10)	1.2*	(0.10)	1.6	(0.13)	1.8	(0.13)	1.9	(0.14)
26-49	0.4	(0.07)	0.5	(0.06)	0.4	(0.06)	0.5	(0.07)	0.5	(0.08)	0.6	(0.09)	0.5	(0.06)	0.5	(0.06)	0.5	(0.05)	0.4	(0.05)
50 or Older	0.3	(0.08)	0.2	(0.06)	0.3	(0.08)	0.3	(0.08)	0.3	(0.06)	0.3	(0.07)	0.2	(0.04)	0.3	(0.07)	0.2	(0.06)	0.3	(0.06)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown suicide information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.37B Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older: 2017

Suicidal Behavior	Aged 18 or Older, Number[1]		Percentage among Adults Aged 18 or Older[2]	
Had Serious Thoughts of Suicide	10,642	(289)	4.3	(0.12)
Made Suicide Plans	3,195	(148)	1.3	(0.06)
Attempted Suicide	1,388	(97)	0.6	(0.04)
Made Suicide Plans	1,222	(94)	0.5	(0.04)
Did Not Make Suicide Plans	166	(29)	0.1	(0.01)

[1] Estimates shown are numbers in thousands with standard errors included in parentheses.

[2] Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown suicide information were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.38B Need for Substance Use Treatment and Receipt of Substance Use Treatment at a Specialty Facility in the Past Year among Individuals Aged 12 or Older, by Age Group: 2017

Needed/Received Substance Use Treatment	Aged 12 or Older, Number[1]		Percentage among Individuals Aged 12 or Older[2]		Aged 12-17, Number[1]		Percentage among Youths Aged 12-17[2]		Aged 18-25, Number[1]		Percentage among Adults Aged 18-25[2]		Aged 26 or Older, Number[1]		Percentage among Adults Aged 26 or Older[2]	
Needed Substance Use Treatment[3]	20,707	(396)	7.6	(0.15)	1,033	(47)	4.1	(0.19)	5,170	(123)	15.1	(0.36)	14,504	(366)	6.8	(0.17)
Received Substance Use Treatment at a Specialty Facility among Individuals Who Needed Substance Use Treatment	2,530	(152)	12.2	(0.67)	91	(14)	8.8	(1.29)	441	(38)	8.5	(0.67)	1,999	(144)	13.8	(0.91)

[1] Estimates shown are numbers in thousands with standard errors included in parentheses.

[2] Estimates shown are percentages with standard errors included in parentheses.

[3] Respondents were classified as needing substance use treatment if they met the criteria for a substance use disorder as defined in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.39A Received Substance Use Treatment at Any Treatment Location or at a Specialty Facility in the Past Year among Individuals Aged 12 or Older, by Age Group: 2017

Treatment Facility Type	Aged 12 or Older, Number[1]		Percentage among Individuals Aged 12 or Older[2]		Aged 12-17, Number[1]		Percentage among Youths Aged 12-17[2]		Aged 18-25, Number[1]		Percentage among Adults Aged 18-25[2]		Aged 26 or Older, Number[1]		Percentage among Adults Aged 26 or Older[2]	
Any Treatment Location	4,010	(185)	1.5	(0.07)	184	(21)	0.7	(0.08)	641	(44)	1.9	(0.13)	3,185	(177)	1.5	(0.08)
Specialty Facility	2,530	(152)	0.9	(0.06)	91	(14)	0.4	(0.06)	441	(36)	1.3	(0.11)	1,999	(144)	0.9	(0.07)

[1] Estimates shown are numbers in thousands with standard errors included in parentheses.

[2] Estimates shown are percentages with standard errors included in parentheses.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.40A Perceived Need for Substance Use Treatment and Whether Made an Effort to Get Treatment in the Past Year among Individuals Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment, by Age Group: 2017

Age Group	Felt Need for Treatment		Felt Need and Made Effort to Get Treatment		Felt Need and Made No Effort to Get Treatment		Did Not Feel Need for Treatment	
12 or Older	1,033	(93)	495	(77)	538	(54)	17,143	(371)
12-17	18	(6)	8	(3)	11	(5)	924	(46)
18-25	181	(25)	69	(16)	112	(20)	4,549	(140)
26 or Older	834	(90)	418	(76)	416	(51)	11,670	(339)

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Respondents were classified as needing substance use treatment if they met the criteria for a substance use disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) or received treatment for illicit drug use or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.41B Detailed Reasons for Not Receiving Substance Use Treatment in the Past Year among Individuals Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment at a Specialty Facility and Who Felt a Need for Treatment in the Past Year: 2017

Reason for Not Receiving Substance Use Treatment[1]	Total	
No Health Care Coverage and Could Not Afford Cost	30.3	(4.00)
Had Health Care Coverage But Did Not Cover Treatment or Did Not Cover Full Cost	10.5	(2.70)
No Transportation/Programs Too Far Away/Hours Inconvenient	6.7	(1.75)
Did Not Find a Program that Offered the Type of Treatment Wanted	9.0	(2.70)
Not Ready to Stop Using	39.7	(4.63)
No Openings in a Program	5.0	(1.77)
Did Not Know Where to Go for Treatment	10.9	(2.41)
Might Cause Neighbors/Community to Have Negative Opinion	17.2	(3.51)
Might Have Negative Effect on Job	20.5	(3.73)
Did Not Feel Need for Treatment at the Time	12.3	(3.07)
Could Handle the Problem without Treatment	12.6	(2.86)
Treatment Would Not Help	3.9	(1.75)
Did Not Have Time	7.9	(2.20)
Did Not Want Others to Find Out	7.1	(2.12)
Some Other Reason	3.0	(1.16)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents were classified as needing substance use treatment if they met the criteria for substance use disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) or received treatment for substance use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).

[1] Respondents could indicate multiple reasons for not receiving treatment; thus, these response categories are not mutually exclusive.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.42B Receipt of Treatment for Depression in the Past Year among Youths Aged 12 to 17 with Major Depressive Episode (MDE) or MDE with Severe Impairment in the Past Year: 2004-2017

MDE	2004		2005		2006		2007		2008		2009		2010		2011		2012		2013		2014	
MDE	40.3	(1.38)	37.8*	(1.42)	38.8	(1.60)	39.0	(1.52)	37.7	(1.48)	34.6*	(1.52)	37.8	(1.51)	38.4	(1.47)	37.0*	(1.34)	38.1	(1.35)	41.2	(1.42)
MDE with Severe Impairment[1]	--		--		46.5	(1.95)	43.9	(1.90)	42.6*	(1.73)	38.8*	(1.83)	41.1*	(1.80)	43.5	(1.79)	41.0*	(1.66)	45.0	(1.61)	44.7	(1.67)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.42B Receipt of Treatment for Depression in the Past Year among Youths Aged 12 to 17 with Major Depressive Episode (MDE) or MDE with Severe Impairment in the Past Year: 2004-2017 (continued)

MDE	2015		2016		2017	
MDE	39.3	(1.40)	40.9	(1.30)	41.5	(1.29)
MDE with Severe Impairment[1]	44.6	(1.63)	46.7	(1.58)	47.5	(1.57)

-- = not available.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year depression treatment data and/or unknown past year MDE data were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Impairment is based on the Sheehan Disability Scale (SDS) role domains, which measure the impact of a disorder on a youth's life. Impairment is defined as the highest severity level of role impairment across four domains: (1) chores at home, (2) school or work, (3) close relationships with family, and (4) social life. Ratings ≥ 7 on a 0 to 10 scale were considered Severe Impairment. Respondents with unknown impairment data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2017.

Table A.43B Receipt of Treatment for Depression in the Past Year among Adults Aged 18 or Older with Major Depressive Episode (MDE) or MDE with Severe Impairment in the Past Year: 2009-2017

MDE/Age Group	2009		2010		2011		2012		2013		2014		2015		2016		2017	
MDE	64.3	(1.31)	68.2	(1.25)	68.1	(1.24)	68.0	(1.24)	68.6	(1.22)	68.6	(1.03)	67.2	(1.08)	65.3	(1.09)	66.8	(1.01)
18-25	47.0	(1.57)	48.7	(1.57)	47.8	(1.64)	49.8	(1.52)	50.8	(1.50)	49.5	(1.64)	46.8	(1.58)	44.1*	(1.45)	50.7	(1.40)
26-49	64.8	(1.72)	68.1	(1.69)	68.1	(1.74)	68.8	(1.75)	66.7	(1.80)	67.9	(1.36)	67.4	(1.36)	67.4	(1.35)	67.3	(1.36)
50 or Older	73.8	(2.83)	78.4	(2.55)	80.0	(2.50)	76.8	(2.52)	81.3	(2.64)	80.8	(2.04)	80.9	(2.32)	77.3	(2.23)	79.7	(2.15)
MDE with Severe Impairment[1]	71.5	(1.49)	72.9	(1.47)	73.7	(1.44)	73.1	(1.47)	76.4*	(1.36)	73.7	(1.19)	72.7	(1.22)	72.2	(1.23)	72.1	(1.13)
18-25	51.2*	(1.95)	53.9	(1.94)	54.2	(2.08)	55.5	(1.89)	56.8	(1.80)	55.3	(2.02)	52.0	(1.98)	51.3*	(1.75)	57.1	(1.82)
26-49	72.4	(1.97)	74.2	(1.89)	74.1	(1.96)	73.7	(2.14)	74.4	(2.12)	72.3	(1.68)	72.0	(1.63)	74.3	(1.52)	71.8	(1.62)
50 or Older	84.4	(3.20)	81.4	(3.01)	85.0	(3.00)	82.4	(2.91)	90.8	(2.48)	85.9	(2.17)	87.9	(2.26)	84.1	(2.57)	86.4	(2.18)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown past year depression treatment data and/or unknown past year MDE data were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Impairment is based on the Sheehan Disability Scale (SDS) role domains, which measure the impact of a disorder on an adult's life. Impairment is defined as the highest severity level of role impairment across four domains: (1) home management, (2) work, (3) close relationships with others, and (4) social life. Ratings ≥ 7 on a 0 to 10 scale were considered Severe Impairment. Respondents with unknown impairment data were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2017.

Table A.44B Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: 2002-2017

Source of Mental Health Service	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
Specialty Mental Health Service	11.8*	(0.28)	12.4*	(0.28)	13.4*	(0.31)	13.4*	(0.30)	13.0*	(0.29)	12.4*	(0.31)	12.7*	(0.29)	12.0*	(0.30)	12.1*	(0.30)	12.6*	(0.31)	12.7*	(0.28)
Outpatient	10.8*	(0.27)	11.3*	(0.27)	12.1*	(0.30)	12.1*	(0.29)	11.7*	(0.29)	11.2*	(0.29)	11.5*	(0.29)	10.9*	(0.29)	10.9*	(0.28)	11.5*	(0.30)	11.5*	(0.27)
Inpatient or Residential (Overnight or Longer Stay)	2.1*	(0.12)	2.2*	(0.13)	2.5	(0.14)	2.5	(0.14)	2.4*	(0.14)	2.3*	(0.13)	2.2*	(0.13)	2.1*	(0.13)	2.2*	(0.13)	2.1*	(0.13)	2.2*	(0.13)
Education[1]		nc		nc		nc		nc		nc		nc		nc	12.1*	(0.30)	12.4*	(0.29)	11.9*	(0.28)	12.9	(0.29)
General Medicine																						
Pediatrician or Other Family Doctor	2.7*	(0.13)	2.9	(0.15)	3.4	(0.15)	3.2	(0.17)	2.8*	(0.14)	2.8*	(0.14)	2.9	(0.14)	2.5*	(0.14)	2.5*	(0.14)	2.5*	(0.14)	2.5*	(0.13)
Juvenile Justice																						
Juvenile Detention Center, Prison, or Jail[2]		--		--		--		--		--		--		--	0.4*	(0.06)	0.3*	(0.05)	0.4*	(0.06)	0.3*	(0.05)
Child Welfare																						
Foster Care or Therapeutic Foster Care	0.6*	(0.06)	0.7*	(0.08)	0.6*	(0.07)	0.6*	(0.07)	0.5	(0.07)	0.5	(0.05)	0.5	(0.06)	0.4	(0.05)	0.4	(0.06)	0.6*	(0.07)	0.4	(0.05)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.44B Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: 2002-2017 (continued)

Source of Mental Health Service	2013		2014		2015		2016		2017	
Specialty Mental Health Service	13.6*	(0.32)	13.7*	(0.34)	13.3*	(0.32)	14.7	(0.33)	14.8	(0.36)
Outpatient	12.5*	(0.31)	12.7	(0.33)	12.0*	(0.31)	13.2	(0.32)	13.6	(0.35)
Inpatient or Residential (Overnight or Longer Stay)	2.3*	(0.14)	2.5	(0.15)	2.6	(0.15)	3.0	(0.16)	2.9	(0.16)
Education[1]	13.0	(0.32)	13.2	(0.33)	13.2	(0.34)	13.1	(0.33)	13.3	(0.34)
General Medicine										
Pediatrician or Other Family Doctor	2.8*	(0.15)	2.9	(0.15)	2.7*	(0.16)	2.9	(0.15)	3.3	(0.17)
Juvenile Justice										
Juvenile Detention Center, Prison, or Jail[2]	0.2	(0.04)	0.3	(0.05)	0.2	(0.04)	0.2	(0.05)	0.2	(0.04)
Child Welfare										
Foster Care or Therapeutic Foster Care	0.4	(0.05)	0.4	(0.06)	0.3	(0.05)	0.4	(0.07)	0.4	(0.06)

-- = not available; nc = not comparable due to methodological changes.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown receipt of mental health service information were excluded.

NOTE: Respondents could indicate multiple service sources; thus, these response categories are not mutually exclusive.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Respondents who did not report their school enrollment status, who reported not being enrolled in school in the past 12 months, or who reported being home-schooled were not asked about receipt of mental health services from this source; however, respondents who reported not being enrolled in school in the past 12 months were classified as not having received mental health services from this source.

[2] These services were often provided by psychiatrists, psychologists, social workers, or counselors who work for the court system.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.45B Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older, by Age Group: 2002-2017

Mental Health Services[1]/Age Group	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
ANY MENTAL HEALTH SERVICE	13.0*	(0.27)	13.2*	(0.26)	12.8*	(0.26)	13.0*	(0.26)	12.9*	(0.26)	13.3*	(0.27)	13.5*	(0.29)	13.4*	(0.27)	13.8*	(0.27)	13.6*	(0.26)	14.5	(0.28)
18-25	10.5*	(0.25)	11.1*	(0.28)	10.8*	(0.26)	11.2*	(0.27)	10.8*	(0.28)	10.4*	(0.28)	11.0*	(0.28)	11.2*	(0.27)	11.0*	(0.27)	11.4*	(0.30)	12.0*	(0.29)
26-49	14.5*	(0.36)	14.5*	(0.35)	14.4*	(0.34)	13.9*	(0.34)	14.0*	(0.37)	14.3*	(0.35)	14.1*	(0.34)	14.6*	(0.36)	14.9	(0.37)	14.9	(0.36)	15.2	(0.38)
50 or Older	12.0*	(0.54)	12.3*	(0.53)	11.7*	(0.51)	12.5*	(0.53)	12.4*	(0.48)	13.2	(0.53)	13.7	(0.57)	12.9	(0.52)	13.6	(0.52)	13.2	(0.47)	14.8	(0.51)
INPATIENT	0.7*	(0.06)	0.8	(0.07)	0.9	(0.07)	1.0	(0.08)	0.7*	(0.06)	1.0	(0.08)	0.9	(0.10)	0.8	(0.07)	0.8*	(0.07)	0.8*	(0.06)	0.8	(0.06)
18-25	0.9*	(0.08)	1.0*	(0.09)	1.2	(0.10)	1.1*	(0.09)	1.1*	(0.08)	1.1*	(0.09)	1.1*	(0.10)	1.1*	(0.10)	1.0*	(0.09)	1.1*	(0.09)	1.1*	(0.10)
26-49	0.8	(0.09)	0.9	(0.10)	0.8	(0.09)	0.9	(0.10)	0.8	(0.09)	1.1	(0.11)	0.8	(0.09)	1.0	(0.11)	0.8	(0.09)	0.8	(0.09)	0.7*	(0.08)
50 or Older	0.5*	(0.10)	0.7	(0.14)	0.9	(0.14)	1.0	(0.17)	0.5	(0.10)	0.7	(0.15)	0.9	(0.22)	0.6	(0.11)	0.7	(0.13)	0.7	(0.11)	0.8	(0.12)
OUTPATIENT[2]	7.4	(0.21)	7.1	(0.19)	7.1	(0.19)	6.8*	(0.20)	6.7*	(0.20)	7.0*	(0.19)	6.8*	(0.20)	6.4*	(0.19)	6.6*	(0.20)	6.7*	(0.19)	6.6*	(0.19)
18-25	6.7*	(0.21)	6.6*	(0.21)	6.2*	(0.21)	6.4*	(0.22)	5.9*	(0.23)	5.6*	(0.21)	5.9*	(0.21)	6.1*	(0.20)	5.7*	(0.21)	6.2*	(0.22)	6.5*	(0.22)
26-49	8.9	(0.29)	8.7	(0.28)	8.6	(0.27)	7.8*	(0.27)	7.6*	(0.27)	8.0	(0.28)	7.9	(0.26)	7.5*	(0.27)	7.8	(0.28)	7.8	(0.28)	7.6*	(0.26)
50 or Older	5.7	(0.39)	5.3*	(0.35)	5.6	(0.36)	5.9	(0.39)	6.0	(0.37)	6.3	(0.37)	6.0	(0.39)	5.3*	(0.34)	5.7	(0.35)	5.7	(0.34)	5.7	(0.33)
PRESCRIPTION MEDICATION	10.5*	(0.25)	10.9*	(0.25)	10.5*	(0.23)	10.7*	(0.24)	10.9*	(0.24)	11.2*	(0.25)	11.4	(0.27)	11.3*	(0.25)	11.7	(0.24)	11.5	(0.25)	12.4	(0.26)
18-25	7.5*	(0.22)	8.3*	(0.25)	8.1*	(0.23)	8.3*	(0.23)	8.0*	(0.24)	8.0*	(0.24)	8.1*	(0.24)	8.5*	(0.23)	8.4*	(0.24)	8.8*	(0.25)	9.0*	(0.25)
26-49	11.4*	(0.32)	11.9*	(0.32)	11.7*	(0.31)	11.4*	(0.31)	11.7*	(0.34)	11.8*	(0.32)	11.7*	(0.32)	12.3	(0.33)	12.5	(0.33)	12.3	(0.33)	13.0	(0.36)
50 or Older	10.5*	(0.51)	10.9	(0.51)	10.1*	(0.48)	10.8	(0.49)	11.0	(0.45)	11.7	(0.50)	12.2	(0.53)	11.3	(0.49)	12.0	(0.49)	11.8	(0.45)	12.9	(0.49)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.45B Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older, by Age Group: 2002-2017 (continued)

Mental Health Services[1]/Age Group	2013		2014		2015		2016		2017	
ANY MENTAL HEALTH SERVICE	14.6	(0.28)	14.8	(0.23)	14.2	(0.23)	14.4	(0.23)	14.8	(0.25)
18-25	12.2*	(0.32)	11.9*	(0.34)	11.7*	(0.31)	12.9*	(0.34)	14.9	(0.39)
26-49	15.5	(0.40)	15.3	(0.28)	15.3	(0.29)	15.4	(0.29)	15.7	(0.30)
50 or Older	14.6	(0.52)	15.4*	(0.42)	13.9	(0.40)	14.0	(0.42)	14.0	(0.42)
INPATIENT	0.9	(0.07)	1.0	(0.06)	0.9	(0.06)	0.9	(0.06)	1.0	(0.06)
18-25	1.3	(0.11)	1.2	(0.11)	1.4	(0.12)	1.5	(0.11)	1.5	(0.12)
26-49	1.0	(0.10)	1.0	(0.08)	0.9	(0.07)	1.0	(0.08)	0.9	(0.07)
50 or Older	0.7	(0.11)	1.0	(0.12)	0.8	(0.11)	0.7	(0.10)	0.8	(0.10)
OUTPATIENT[2]	6.6*	(0.21)	6.7*	(0.16)	7.1*	(0.17)	6.9*	(0.16)	7.5	(0.18)
18-25	6.3*	(0.22)	6.4*	(0.25)	6.6*	(0.24)	7.3*	(0.26)	9.0	(0.29)
26-49	7.4*	(0.29)	7.5*	(0.20)	7.9	(0.22)	8.1	(0.22)	8.5	(0.22)
50 or Older	6.0	(0.37)	6.1	(0.29)	6.4	(0.29)	5.8	(0.27)	6.3	(0.30)
PRESCRIPTION MEDICATION	12.5	(0.27)	12.6	(0.21)	11.8	(0.21)	12.0	(0.21)	12.1	(0.22)
18-25	9.4*	(0.27)	8.8*	(0.30)	8.6*	(0.27)	9.7*	(0.30)	11.1	(0.33)
26-49	13.1	(0.37)	12.8	(0.26)	12.6	(0.26)	12.6	(0.26)	12.7	(0.27)
50 or Older	12.9	(0.49)	13.5*	(0.39)	12.0	(0.38)	12.3	(0.39)	11.8	(0.39)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown mental health service information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Respondents could indicate multiple service sources; thus, these response categories are not mutually exclusive.

[2] Because of revisions in 2017 to the outpatient mental health service estimates, these 2010 to 2016 estimates may differ slightly from estimates published prior to the 2017 NSDUH.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.46B Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older, by Past Year Level of Mental Illness and Age Group: 2008-2017

Level of Mental Illness/ Mental Health Services[1]/ Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
AMI																				
Mental Health Services	40.9	(0.93)	40.2*	(0.86)	42.4	(0.89)	40.8	(0.82)	41.0	(0.82)	44.7	(0.91)	44.7	(0.72)	43.1	(0.72)	43.1	(0.75)	42.6	(0.71)
18-25	30.3*	(0.94)	32.0*	(0.97)	32.6*	(0.93)	32.9*	(0.98)	34.5*	(0.96)	34.7*	(0.98)	33.6*	(1.05)	32.0*	(0.91)	35.1*	(0.94)	38.4	(0.98)
26-49	41.4	(1.09)	40.8	(1.10)	43.3	(1.07)	41.1	(1.09)	42.0	(1.10)	43.5	(1.15)	44.2	(0.83)	43.3	(0.89)	43.1	(0.87)	43.3	(0.88)
50 or Older	45.2	(2.26)	42.8	(1.92)	45.1	(1.93)	43.6	(1.75)	42.4	(1.67)	50.5*	(1.95)	49.9*	(1.48)	48.3	(1.54)	46.8	(1.57)	44.2	(1.63)
Inpatient	3.7	(0.51)	3.2	(0.29)	2.7	(0.25)	3.3	(0.31)	3.0	(0.28)	3.3	(0.29)	3.8	(0.26)	3.4	(0.26)	3.3	(0.24)	3.3	(0.24)
18-25	3.5	(0.39)	4.1	(0.45)	3.3	(0.35)	3.9	(0.40)	3.8	(0.39)	4.2	(0.40)	3.7	(0.37)	4.3	(0.42)	4.6	(0.41)	4.2	(0.42)
26-49	2.9	(0.38)	3.7	(0.43)	2.8	(0.38)	2.9	(0.38)	2.3*	(0.30)	3.3	(0.37)	3.7	(0.34)	3.1	(0.31)	3.4	(0.32)	3.3	(0.28)
50 or Older	5.2	(1.42)	2.1	(0.50)	2.1	(0.44)	3.5	(0.63)	3.6	(0.65)	2.9	(0.60)	3.9	(0.56)	3.5	(0.59)	2.7	(0.48)	3.0	(0.53)
Outpatient[2]	24.1	(0.78)	22.5*	(0.74)	23.4*	(0.78)	24.0	(0.74)	22.4*	(0.68)	24.4	(0.84)	24.3	(0.61)	25.4	(0.63)	24.5	(0.60)	25.7	(0.59)
18-25	18.9*	(0.80)	20.3*	(0.80)	19.9*	(0.82)	20.9*	(0.84)	21.9*	(0.84)	21.0*	(0.82)	21.3*	(0.92)	20.6*	(0.82)	22.8	(0.84)	24.9	(0.86)
26-49	26.0	(0.89)	23.6*	(0.90)	24.9	(0.92)	25.1	(0.98)	23.6*	(0.89)	24.3*	(0.99)	25.8	(0.71)	26.1	(0.77)	26.0	(0.74)	26.9	(0.75)
50 or Older	23.5	(1.85)	21.9	(1.63)	22.8	(1.63)	23.8	(1.60)	21.0	(1.40)	26.1	(1.83)	23.9	(1.26)	27.0	(1.41)	23.4	(1.28)	24.4	(1.37)
Prescription Medication	35.5	(0.91)	34.8	(0.82)	36.9	(0.90)	35.6	(0.82)	35.3	(0.79)	38.9*	(0.91)	38.7*	(0.71)	36.7	(0.71)	37.1	(0.72)	35.7	(0.69)
18-25	23.3*	(0.84)	25.3*	(0.88)	25.5*	(0.89)	25.3*	(0.92)	26.8	(0.88)	27.2	(0.90)	25.5*	(1.00)	24.3*	(0.85)	27.2	(0.87)	29.1	(0.90)
26-49	35.9	(1.07)	35.3	(1.08)	37.7	(1.07)	35.6	(1.05)	37.1	(1.10)	37.7	(1.11)	38.0	(0.81)	36.4	(0.86)	36.7	(0.83)	36.1	(0.82)
50 or Older	40.8	(2.25)	38.1	(1.84)	40.7	(1.94)	39.8	(1.77)	36.7	(1.65)	45.5*	(1.92)	45.3*	(1.46)	43.2*	(1.49)	42.2	(1.54)	38.8	(1.61)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.46B Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older, by Past Year Level of Mental Illness and Age Group: 2008-2017 (continued)

Level of Mental Illness/ Mental Health Services[1]/ Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
SMI																				
Mental Health Services	65.7	(1.76)	66.5	(1.68)	67.5	(1.67)	64.9	(1.70)	62.9	(1.65)	68.5	(1.78)	68.5	(1.33)	65.3	(1.33)	64.8	(1.34)	66.7	(1.27)
18-25	45.9*	(2.28)	55.0	(2.20)	53.7	(2.32)	52.1	(2.27)	53.1	(2.14)	54.0	(2.30)	53.9	(2.13)	50.7*	(2.14)	51.5*	(2.05)	57.4	(1.94)
26-49	67.2	(2.08)	64.5	(2.06)	67.4	(2.05)	63.6	(2.20)	63.5	(2.27)	68.4	(2.29)	66.2	(1.72)	66.1	(1.68)	66.1	(1.57)	66.2	(1.60)
50 or Older	73.2	(4.33)	76.1	(3.74)	74.0	(3.74)	73.2	(3.60)	66.3	(3.62)	74.9	(3.51)	79.2	(2.59)	72.2	(3.09)	71.5	(3.16)	75.6	(3.08)
Inpatient	8.6	(1.29)	8.6	(0.98)	6.7	(0.77)	8.8	(1.11)	6.2	(0.77)	8.3	(0.93)	8.8	(0.85)	7.0	(0.71)	7.6	(0.73)	7.6	(0.65)
18-25	7.9	(1.18)	11.4	(1.81)	8.1	(1.06)	8.0	(1.19)	8.5	(1.18)	10.3	(1.27)	8.2	(1.05)	8.9	(1.17)	8.8	(1.06)	8.6	(1.10)
26-49	6.9	(1.19)	9.7	(1.44)	7.0	(1.04)	8.0	(1.17)	4.8*	(0.82)	8.4	(1.22)	8.0	(0.93)	7.3	(0.95)	8.1	(0.93)	8.3	(0.89)
50 or Older	12.4	(3.65)	4.9	(1.47)	5.5	(1.50)	10.8	(2.61)	7.3	(1.90)	7.3	(1.93)	10.2	(2.07)	5.5	(1.51)	6.0	(1.67)	5.6	(1.50)
Outpatient[2]	46.2	(1.86)	44.6	(1.97)	42.5	(1.89)	44.1	(1.78)	39.0*	(1.68)	46.9	(1.97)	44.2	(1.39)	43.6	(1.44)	42.6	(1.40)	45.3	(1.27)
18-25	33.0*	(2.05)	38.6	(2.27)	36.2	(2.30)	37.2	(2.20)	35.8	(2.08)	37.3	(2.13)	39.2	(2.12)	36.0	(2.10)	36.8	(1.88)	39.3	(1.82)
26-49	48.2	(2.23)	43.8	(2.21)	42.9	(2.13)	42.8	(2.17)	40.3*	(2.23)	47.1	(2.33)	43.8	(1.74)	44.8	(1.78)	44.8	(1.70)	46.7	(1.64)
50 or Older	49.0	(4.66)	49.0	(4.74)	44.6	(4.48)	49.6	(4.14)	38.2*	(3.62)	50.7	(4.21)	47.3	(3.15)	46.0	(3.25)	42.6	(3.56)	47.8	(3.33)
Prescription Medication	59.7	(1.81)	61.1	(1.77)	61.0	(1.80)	58.2	(1.80)	57.8	(1.65)	62.1	(1.91)	61.4	(1.42)	57.3	(1.43)	58.0	(1.42)	58.9	(1.34)
18-25	35.9*	(2.12)	43.4	(2.22)	44.0	(2.31)	41.0	(2.22)	45.5	(2.09)	46.2	(2.21)	42.4	(2.02)	40.0*	(2.03)	41.1	(2.00)	45.7	(1.91)
26-49	60.1	(2.22)	59.5	(2.17)	61.2	(2.15)	57.2	(2.26)	58.7	(2.25)	60.7	(2.42)	60.1	(1.79)	58.2	(1.78)	59.1	(1.68)	58.5	(1.68)
50 or Older	71.5	(4.32)	72.6	(4.00)	68.4	(4.10)	68.1	(3.76)	61.9	(3.66)	71.3	(3.74)	72.9	(2.89)	65.6	(3.27)	67.4	(3.29)	70.7	(3.26)

AMI = any mental illness; SMI = serious mental illness.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown mental health service information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

[1] Respondents could indicate multiple service sources; thus, these response categories are not mutually exclusive.

[2] Because of revisions in 2017 to the outpatient mental health service estimates, these 2010 to 2016 estimates may differ slightly from estimates published prior to the 2017 NSDUH.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.47A Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Level of Mental Illness and Age Group, Numbers in Thousands: 2002-2017

Level of Mental Illness/Age Group	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOTAL ADULTS	11,272*	(330)	10,781*	(317)	10,902*	(348)	11,170*	(360)	10,498*	(328)	10,974*	(330)	10,636*	(322)	12,059*	(373)	11,177*	(358)	10,768*	(338)	11,490*	(354)
18-25	2,621*	(75)	2,628*	(76)	2,614*	(75)	2,688*	(73)	2,436*	(77)	2,472*	(75)	2,618*	(84)	2,630*	(79)	2,565*	(80)	2,581*	(85)	2,565*	(79)
26-49	6,783	(251)	6,349	(236)	6,564	(250)	6,049	(230)	5,838*	(233)	6,444	(238)	6,018	(234)	6,642	(245)	5,825*	(234)	5,968	(246)	6,104	(238)
50 or Older	1,868*	(202)	1,804*	(186)	1,724*	(204)	2,432	(243)	2,225*	(216)	2,058*	(209)	1,999*	(206)	2,787	(268)	2,786	(247)	2,219*	(196)	2,821	(241)
ANY MENTAL ILLNESS	--		--		--		--		--		--		8,173*	(296)	9,092*	(328)	8,680*	(322)	8,541*	(298)	9,092*	(318)
18-25	--		--		--		--		--		--		1,839*	(75)	1,773*	(69)	1,826*	(74)	1,829*	(77)	1,898*	(81)
26-49	--		--		--		--		--		--		4,805*	(222)	5,300	(230)	4,633*	(211)	4,910	(224)	5,064	(232)
50 or Older	--		--		--		--		--		--		1,529*	(181)	2,019	(209)	2,222	(227)	1,802*	(179)	2,130	(205)
SERIOUS MENTAL ILLNESS	--		--		--		--		--		--		3,642*	(199)	3,874*	(205)	3,910*	(226)	3,883*	(204)	3,973*	(200)
18-25	--		--		--		--		--		--		617*	(40)	587*	(37)	706*	(45)	712*	(50)	709*	(42)
26-49	--		--		--		--		--		--		2,133*	(138)	2,386	(148)	2,271	(152)	2,235	(148)	2,335	(153)
50 or Older	--		--		--		--		--		--		891	(144)	901	(131)	933	(158)	936	(124)	928	(132)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.47A Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Level of Mental Illness and Age Group, Numbers in Thousands: 2002-2017 (continued)

Level of Mental Illness/Age Group	2013		2014		2015		2016		2017	
TOTAL ADULTS	10,965*	(356)	11,795*	(292)	11,238*	(281)	11,769*	(291)	13,475	(338)
18-25	2,575*	(85)	2,796*	(95)	2,917*	(95)	3,227*	(105)	3,894	(114)
26-49	5,905*	(244)	5,815*	(188)	5,708*	(181)	5,917*	(182)	6,527	(200)
50 or Older	2,485	(227)	3,185	(198)	2,613	(189)	2,625	(194)	3,054	(214)
ANY MENTAL ILLNESS	8,422*	(320)	9,037*	(252)	8,798*	(245)	9,239*	(259)	11,052	(303)
18-25	1,870*	(77)	2,021*	(84)	2,184*	(87)	2,464*	(97)	3,114	(110)
26-49	4,551*	(220)	4,654*	(172)	4,631*	(173)	4,797*	(171)	5,446	(189)
50 or Older	2,001	(207)	2,362	(172)	1,983*	(164)	1,978*	(170)	2,492	(190)
SERIOUS MENTAL ILLNESS	3,858*	(207)	4,205*	(174)	3,713*	(150)	4,104*	(178)	4,939	(192)
18-25	756*	(45)	900*	(53)	878*	(52)	1,091*	(64)	1,431	(71)
26-49	2,201	(157)	2,179*	(121)	2,118*	(113)	2,088*	(116)	2,520	(127)
50 or Older	902	(124)	1,127	(117)	717	(94)	926	(118)	989	(119)

-- not available.

NOTE: Estimates shown are numbers in thousands with standard errors included in parentheses.

NOTE: Respondents were excluded if information on their perception of unmet need was missing.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.47B Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Level of Mental Illness and Age Group, Percentages: 2002-2017

Level of Mental Illness/Age Group	2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
TOTAL ADULTS	5.4	(0.16)	5.1	(0.15)	5.1	(0.16)	5.1	(0.17)	4.8*	(0.15)	4.9*	(0.15)	4.7*	(0.14)	5.3	(0.16)	4.9*	(0.16)	4.6*	(0.15)	4.9*	(0.15)
18-25	8.5*	(0.24)	8.3*	(0.24)	8.1*	(0.23)	8.3*	(0.23)	7.5*	(0.23)	7.6*	(0.23)	8.0*	(0.25)	7.9*	(0.24)	7.6*	(0.24)	7.6*	(0.25)	7.4*	(0.23)
26-49	6.8	(0.25)	6.4	(0.24)	6.6	(0.25)	6.1	(0.23)	5.8*	(0.23)	6.5	(0.24)	6.0	(0.23)	6.7	(0.25)	5.9*	(0.24)	6.1	(0.25)	6.2	(0.24)
50 or Older	2.4	(0.26)	2.2	(0.23)	2.1*	(0.25)	2.9	(0.29)	2.5	(0.25)	2.3	(0.23)	2.2	(0.22)	3.0	(0.28)	2.9	(0.26)	2.2	(0.20)	2.8	(0.24)
ANY MENTAL ILLNESS	--		--		--		--		--		--		20.6*	(0.66)	22.1	(0.70)	21.0*	(0.70)	20.7*	(0.66)	20.8*	(0.63)
18-25	--		--		--		--		--		--		30.2*	(0.97)	29.4*	(0.94)	29.8*	(0.93)	28.8*	(0.93)	28.1*	(0.91)
26-49	--		--		--		--		--		--		23.3	(0.92)	24.8	(0.93)	22.5	(0.90)	24.6	(0.95)	24.4	(0.94)
50 or Older	--		--		--		--		--		--		11.8*	(1.32)	14.8	(1.40)	15.2	(1.44)	12.0*	(1.13)	13.2	(1.15)
SERIOUS MENTAL ILLNESS	--		--		--		--		--		--		43.7	(1.84)	46.3	(1.81)	42.0	(1.81)	43.1	(1.72)	41.6	(1.69)
18-25	--		--		--		--		--		--		50.0*	(2.31)	52.2	(2.32)	53.1	(2.27)	55.0	(2.35)	49.8*	(2.13)
26-49	--		--		--		--		--		--		44.8	(2.26)	49.2	(2.20)	44.3	(2.20)	45.2	(2.13)	46.2	(2.28)
50 or Older	--		--		--		--		--		--		38.2	(4.63)	37.5	(4.42)	32.7	(4.29)	33.9	(3.75)	30.1	(3.41)

NOTE: Footnotes and source information are shown at the end of the second half of this table.

Table A.47B Perceived Unmet Need for Mental Health Services in the Past Year among Adults Aged 18 or Older, by Level of Mental Illness and Age Group, Percentages: 2002-2017 (continued)

Level of Mental Illness/Age Group	2013		2014		2015		2016		2017	
TOTAL ADULTS	4.6*	(0.15)	4.9*	(0.12)	4.6*	(0.12)	4.8*	(0.12)	5.5	(0.14)
18-25	7.4*	(0.24)	8.0*	(0.27)	8.4*	(0.27)	9.4*	(0.31)	11.4	(0.34)
26-49	6.0	(0.25)	5.9*	(0.19)	5.8*	(0.18)	6.0	(0.18)	6.5	(0.20)
50 or Older	2.4	(0.22)	3.0	(0.19)	2.4	(0.17)	2.4	(0.18)	2.7	(0.19)
ANY MENTAL ILLNESS	19.3*	(0.65)	20.8*	(0.52)	20.3*	(0.52)	20.7*	(0.52)	23.7	(0.58)
18-25	27.8*	(0.93)	28.9*	(0.99)	29.0*	(0.95)	32.4*	(0.95)	35.3	(0.96)
26-49	21.7*	(0.93)	23.3	(0.73)	22.5	(0.74)	23.0	(0.71)	24.5	(0.74)
50 or Older	12.6*	(1.21)	14.3	(0.96)	13.0*	(1.01)	12.3*	(0.99)	16.1	(1.15)
SERIOUS MENTAL ILLNESS	38.6*	(1.80)	42.9	(1.45)	38.2*	(1.31)	39.7*	(1.44)	44.2	(1.33)
18-25	51.5	(2.08)	53.6	(2.12)	50.3*	(2.00)	53.7	(2.06)	55.9	(1.79)
26-49	42.4	(2.35)	45.4	(1.82)	43.3	(1.79)	39.7*	(1.67)	45.2	(1.60)
50 or Older	27.1	(3.49)	33.9	(2.93)	23.2*	(2.64)	30.4	(3.33)	32.5	(3.27)

-- not available.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents were excluded if information on their perception of unmet need was missing.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2017.

Table A.48B Did Not Receive Mental Health Services in the Past Year among Adults Aged 18 or Older with a Perceived Unmet Need for Mental Health Services in the Past Year, by Past Year Level of Mental Illness and Age Group: 2008-2017

Level of Mental Illness/ Age Group	2008		2009		2010		2011		2012		2013		2014		2015		2016		2017	
TOTAL ADULTS	48.9	(1.52)	50.5	(1.51)	46.6	(1.61)	45.4	(1.49)	47.1	(1.56)	46.3	(1.58)	45.2	(1.22)	46.1	(1.22)	46.9	(1.22)	48.0	(1.18)
18-25	60.5*	(1.60)	61.1*	(1.59)	58.1	(1.53)	58.2	(1.58)	57.7	(1.63)	57.4	(1.59)	56.0	(1.73)	56.3	(1.57)	56.4	(1.54)	54.2	(1.50)
26-49	46.6	(1.95)	47.4	(1.84)	43.8	(1.98)	45.3	(2.04)	47.9	(2.01)	45.4	(2.03)	47.8	(1.62)	44.8	(1.52)	46.2	(1.56)	47.5	(1.53)
50 or Older	40.3	(5.45)	47.9	(4.91)	41.9	(4.51)	30.8	(4.17)	35.8	(4.16)	37.0	(4.38)	30.9*	(2.81)	37.7	(3.78)	37.0	(3.62)	41.0	(3.48)
ANY MENTAL ILLNESS	42.1	(1.65)	44.9	(1.66)	40.1*	(1.82)	42.1	(1.65)	42.1	(1.72)	39.9*	(1.77)	40.3*	(1.43)	40.8*	(1.38)	42.5	(1.29)	44.8	(1.28)
18-25	55.3	(1.92)	56.7*	(1.98)	52.4	(1.85)	53.7	(1.86)	52.0	(1.96)	53.0	(1.92)	50.1	(2.01)	52.7	(1.94)	51.2	(1.78)	50.5	(1.66)
26-49	41.4	(2.17)	43.3	(2.05)	37.0*	(2.16)	43.2	(2.23)	44.0	(2.28)	38.5*	(2.25)	43.7	(1.87)	40.3	(1.71)	43.1	(1.69)	44.1	(1.70)
50 or Older	28.1	(5.05)	38.8	(5.05)	36.4	(4.88)	27.4*	(4.49)	28.9	(4.38)	30.8	(4.70)	25.4*	(3.19)	28.7	(4.00)	30.2	(3.71)	39.2	(3.80)
SERIOUS MENTAL ILLNESS	30.1	(2.39)	29.7	(2.21)	27.9	(2.32)	31.8	(2.31)	34.2	(2.57)	32.7	(2.49)	31.5	(2.01)	30.7	(1.81)	33.5	(1.78)	32.6	(1.67)
18-25	49.1*	(3.21)	47.5	(3.28)	42.3	(3.12)	43.5	(3.01)	41.8	(3.11)	43.6	(3.11)	40.6	(2.95)	43.3	(3.05)	44.2	(2.65)	40.8	(2.41)
26-49	27.4	(2.93)	32.8	(2.88)	26.8	(2.86)	33.8	(3.00)	36.3	(3.44)	29.6	(3.41)	34.1	(2.52)	30.7	(2.33)	32.0	(2.34)	32.4	(2.24)
50 or Older	**	(**)	**	(**)	**	(**)	**	(**)	**	(**)	**	(**)	19.3	(4.32)	**	(**)	**	(**)	21.2	(4.76)

**Low precision; no estimate reported.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown mental health service information and/or unknown perception of unmet need information were excluded.

* The difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2017.

Table A.49B Detailed Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with a Perceived Unmet Need for Mental Health Services Who Did Not Receive Mental Health Services in the Past Year, by Past Year Level of Mental Illness: 2017

Reason for Not Receiving Services[1]	Total		Any Mental Illness		Serious Mental Illness	
Could Not Afford Cost	42.2	(1.54)	44.6	(1.73)	52.5	(3.00)
Might Cause Neighbors/Community to Have Negative Opinion	11.3	(0.91)	12.3	(1.06)	15.7	(2.01)
Might Have Negative Effect on Job	11.3	(1.05)	12.1	(1.12)	16.4	(2.25)
Health Insurance Does Not Cover Any Mental Health Service	8.7	(0.91)	9.3	(1.10)	11.1	(1.96)
Health Insurance Does Not Pay Enough for Mental Health Services	13.5	(1.09)	13.1	(1.22)	15.1	(2.12)
Did Not Know Where to Go for Services	27.6	(1.34)	29.2	(1.57)	32.2	(2.78)
Concerned about Counselor Not Keeping Information Confidential	10.2	(0.95)	10.8	(1.00)	15.3	(1.93)
Concerned about Being Committed to a Psychiatric Hospital or Having to Take Medicine	11.2	(0.84)	13.0	(1.01)	20.6	(2.16)
Did Not Feel Need for Treatment at the Time	10.8	(1.01)	10.1	(1.14)	7.4	(1.43)
Thought Could Handle the Problem without Treatment	34.3	(1.57)	34.1	(1.70)	30.9	(2.86)
Did Not Think Treatment Would Help	12.3	(1.06)	12.8	(1.16)	16.1	(2.38)
Did Not Have Time	22.8	(1.39)	21.4	(1.51)	17.4	(2.25)
Did Not Want Others to Find Out	11.2	(1.14)	12.2	(1.28)	12.6	(1.81)
No Transportation/Treatment Too Far Away/Hours Inconvenient	3.8	(0.51)	4.1	(0.61)	5.0	(1.00)
Some Other Reason[2]	7.4	(0.84)	7.8	(1.01)	9.9	(1.60)

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown reason for not receiving mental health service and/or unknown perception of unmet information were excluded.

[1] Respondents could indicate multiple reasons for not receiving mental health services; thus, these response categories are not mutually exclusive.

[2] Respondents with unknown or invalid responses to the other-specify question on Some Other Reason for Not Receiving Mental Health Services were classified as not having received mental health services for Some Other Reason.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.50B Received Substance Use Treatment at a Specialty Facility and/or Mental Health Services (Specialty or Nonspecialty) in the Past Year among Youths Aged 12 to 17, by Past Year Substance Use Disorder (SUD) Status and Major Depressive Episode (MDE) Status: 2017

Past Year SUD Status/MDE Status	Received Substance Use Treatment at a Specialty Facility OR Mental Health Services		Received Substance Use Treatment at a Specialty Facility but Not Mental Health Services		Received Mental Health Services but Not Substance Use Treatment at a Specialty Facility		Received Substance Use Treatment at a Specialty Facility AND Mental Health Services	
SUD and MDE	62.7	(3.65)	**	(**)	56.8	(3.71)	5.9	(1.66)
SUD and No MDE	37.4	(2.93)	1.2	(0.65)	32.7	(2.88)	3.3	(1.10)
MDE and No SUD	54.6	(1.43)	**	(**)	54.4	(1.42)	0.2	(0.15)
No SUD and No MDE	18.5	(0.41)	0.1	(0.03)	18.3	(0.41)	0.1	(0.03)

**Low precision; no estimate reported.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown information on mental health service were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

Table A.51B Received Substance Use Treatment at a Specialty Facility and/or Mental Health Services (Specialty or Nonspecialty) in the Past Year among Adults Aged 18 or Older with Past Year Substance Use Disorder, by Past Year Level of Mental Illness and Age Group: 2017

Level of Mental Illness/Age Group	Received Substance Use Treatment at a Specialty Facility OR Mental Health Services		Received Substance Use Treatment at a Specialty Facility but Not Mental Health Services		Received Mental Health Services but Not Substance Use Treatment at a Specialty Facility		Received Substance Use Treatment at a Specialty Facility AND Mental Health Services	
ANY MENTAL ILLNESS	51.0	(1.45)	4.4	(0.60)	38.2	(1.37)	8.3	(0.76)
18-25	46.7	(1.86)	3.5	(0.73)	36.9	(1.88)	6.3	(0.91)
26-49	52.6	(1.94)	4.9	(0.81)	38.1	(1.76)	9.4	(1.01)
50 or Older	52.6	(4.54)	4.3	(1.79)	40.2	(4.46)	8.1	(2.39)
SERIOUS MENTAL ILLNESS	64.0	(2.28)	2.6	(0.71)	49.6	(2.36)	11.8	(1.42)
18-25	59.2	(3.10)	1.4	(0.66)	48.7	(3.15)	9.1	(1.92)
26-49	65.4	(3.01)	3.4	(1.07)	47.4	(2.92)	14.6	(2.01)
50 or Older	**	(**)	**	(**)	**	(**)	**	(**)

**Low precision; no estimate reported.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Respondents with unknown mental health services information were excluded.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017.

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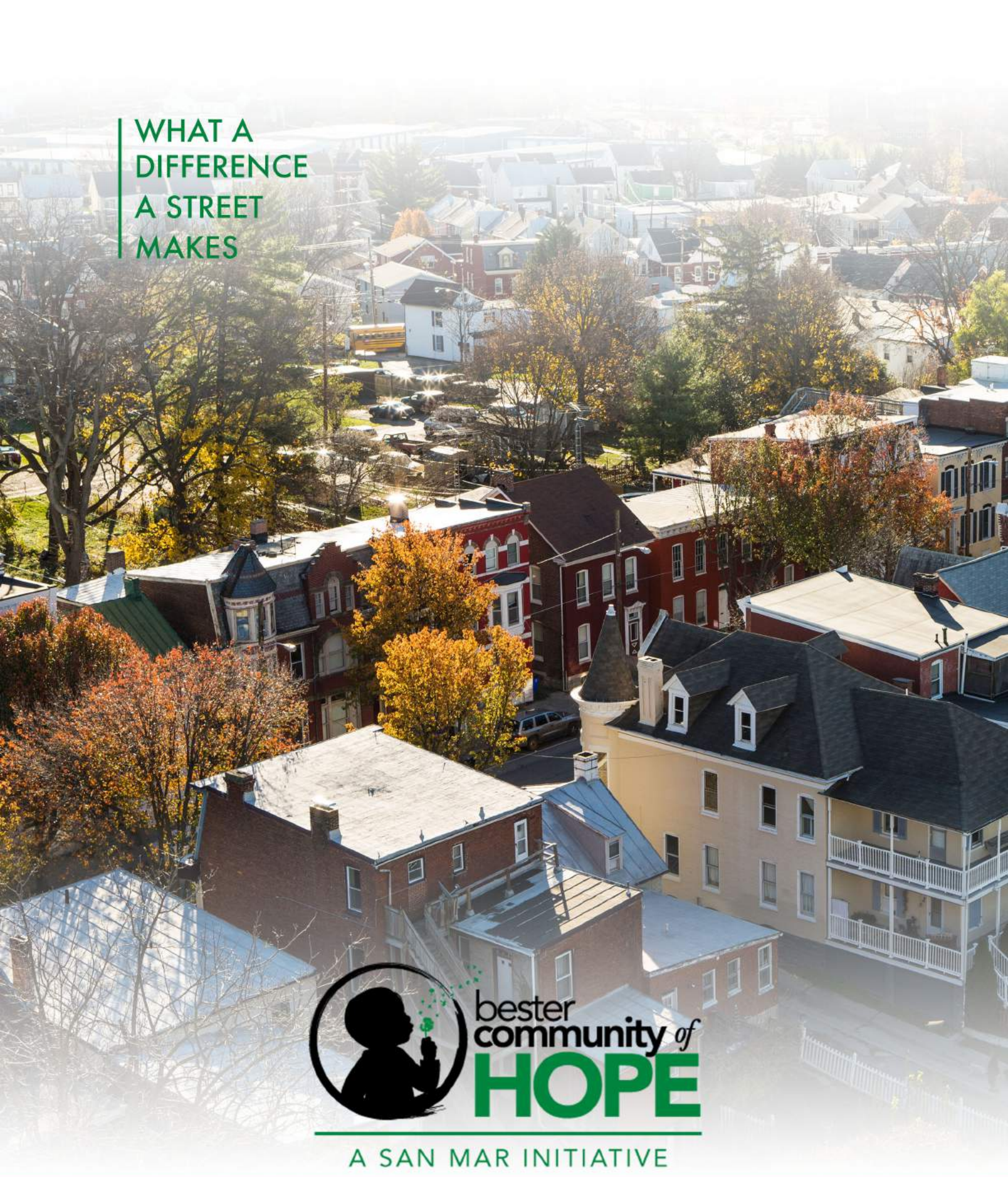
2018

U.S. Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Center for Behavioral Health Statistics and Quality

www.samhsa.gov



WHAT A DIFFERENCE A STREET MAKES

bester community of HOPE

A SAN MAR INITIATIVE

BESTER NEIGHBORHOOD SURVEY | FALL 2016

As a community driven organization, we're always trying to get our fingertips on the pulse of the neighborhood and how those realities impact the daily quality of life of its residents. After a variety of smaller data gathering activities, we decided to conduct a comprehensive neighborhood survey, a massive task for our small operation. It was a critical step for us to ensure we were being strategic with our efforts, and could have confidence that we are addressing priorities identified by the local population. We are by no means experts in research methodology and make no claims of authority over this neighborhood, but our intentions are pure and the amount of effort has been significant.

The centerpiece of our data collection was the Sense of Community Index (SCI-2), a 26 question psychological research tool developed by Community Science that we used to gauge the way residents perceived their neighborhood. We combed through seven distinct neighborhoods located within the Bester Elementary School boundary to complete 320 surveys, a representative sample of the area. A survey typically took between 15-20 minutes to complete, sometimes significantly longer, but more important than the survey questions was that it provided an opportunity to connect and listen to residents on issues that were of priority to them. Following the data collection from the SCI-2, we also gathered other demographic and related data from two national organizations, Policy Map and Mission Insite, to aid in bringing hard data next to resident perceptions.

After canvassing every single street in the catchment multiple times, we developed a familiarity with all of the resources that existed in that particular section of the neighborhood. To reflect the diverse offerings available to residents we created a chart to function as an asset map displaying a sample of several key resources. Not all assets are listed, primarily those identified by residents or of particular significance. For example, every single neighborhood had a laundromat and a car repair shop, in some sectors they presented as more of gathering point or perceived community landmark than others and thus important to convey in the asset chart. Each profile attempts to demonstrate a portion of the history of the identified geography, we believe it is very relevant to see how lasting connections over time may still impact a particular neighborhood. In addition, explaining the physical layout of the area as well as current day activities, good and bad, help to create a fuller narrative of the neighborhood.

In recent years, the City of Hagerstown utilized a consulting firm (Urban Partners) tasked with clarifying a plan to revitalize economic development in the downtown core of Hagerstown. Vibrant communities typically display not only economic strength at its core, but are surrounded by connected and supportive neighborhoods. It is our belief that one cannot exist without the other, thus our report can be viewed not only as targeting social issues but economic ones as well.

What's the point? It will be easy when reviewing this information to look at some of the difficulties facing each portion of the community and to magnify those issues. Our priority was to do our best to present the facts from the past and present ***to understand why*** positive or negative perceptions were occurring, and create this document as a tool to inform a strategic response. For each neighborhood we explored, we shared potential opportunities for consideration, which will be shared with key stakeholders in those locations and where our organization and others may be available to support implementing activities. We hope that you find this data useful and welcome your feedback.

Every day our team comes to work with a shared goal, to cultivate hope and well-being in children, families and communities, and it is our belief that this tool can help turn those dreams into action.

Elizabethtown West

The expansion of the Western Maryland Railway into Hagerstown from Baltimore was completed in 1872 and aided in the development of the west end of Hagerstown. The first roundhouse, designed as a central maintenance facility for the railway, was located just south of this neighborhood. Many of the railway workers raised their families in the area known as Elizabethtown West.[2] "It wasn't a very romantic place to work, as the working conditions weren't good. It would get cold in the winter and hot in the summer, and the railroad worked you pretty hard."[3] The roundhouse employed up to 100 workers in its heyday. It closed in 1988. There are a few residents in this neighborhood who have lived here for over thirty years and remember the importance of the railway and the roundhouse.

The majority of houses are now rentals that experience high turnover. Residents have described significant community violence pertaining to gang activity as well as multiple social concerns. In the Fall of 2016 children of this neighborhood began attending Bester Elementary School due to redistricting and the closure of Winter Street Elementary. This neighborhood has experienced the closure of several valued resources over the past few years including Corderman's Hardware and Corsi's Grocery Store.

On both sides of this neighborhood are prominent family support services in Girls Inc. to the East, and Elgin Station with Head Start to the South west. There appears to be a lack of utilized natural resources, with the old railroad line a visible border to the south. Gateway Crossing is a large and relatively new development of low income housing supported by the Hagerstown Housing Authority to the west, but that type of modernization is not present within the boundaries of the sector. Also lacking is access to fresh and nutritious food as the most significant resource is approximately two miles away.

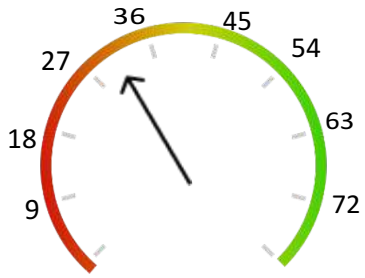
"I've lived here for 15 years. I only know my next door neighbor. People here are afraid to connect to each other, to trust each other. Too many bad things have happened around here."

"There's a lot that goes on around here that the authorities should know about and do something about. I used to respect the authority, but I just don't know anymore. By the time they get here, the problem has moved on."

	Community*	District*	City*	County**	State**
Population					
Estimated Current	715	6,318	40,188	149,270	5,930,538
6 yr Population Change	5.3%	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	291	3,373	18,641	61,111	2,410,256
Owner Occupied	27%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	73%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and/or Blighted†	14	103	602	---	---
Income					
Median Income	$24, 906	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	39.5%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	67.1%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	19.6%	18.25%	14.2%	10.7%	29.52%
Hispanic	6.2%	3.8%	5.1%	4%	9%
Other	6.9%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from City of Hagerstown, Oct. 2016

Sense of Community Scores



District Overall Score: 33.25/72
Elizabethtown West Overall Score: 31.53/72

Reinforcement of Needs:
District Average: 8.35/18 Elizabethtown West: 7.6/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 Elizabethtown West: 7.8/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 Elizabethtown West: 7.5/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line:** *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 Elizabethtown West: 8.6/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
Elizabethtown West Neighborhoods First, Elgin Station, Western Enterprise Fire Company, Hagerstown Police Department	St. Mark's Lutheran Church, United Methodist Church, First Baptist Church, Hagerstown Housing Authority	Girls Inc., Washington County Head Start, Boys and Girls Club, Red Dragon Martial Arts	Elgin Park	Bargains 4 Less, Hagerstown Laundromat & Check Cashing, Canine Cuttery, Dietrich's Auto Body

A total of 28 members of this community participated in the survey. Multiple vacant properties on Elizabeth Street and Madison Avenue were noted with boarded windows and notices from the City taped on the doors. There are two general areas of this neighborhood. The area that included Elizabeth Street and Madison Avenue had members waiting on their steps to speak with us, asking their neighbors if they had taken part, and spending a long time talking beyond the survey. It was very encouraging that residents appeared interested and engaged in the effort. The area between S. Burhans Boulevard and the intersection of West Antietam Street and West Washington Street was more challenging as many people did not answer the door or refused participation in the survey. During the course of surveying this area, we met several residents who had a long term presence in this neighborhood.

Community data of significance: most diversity by race/ethnicity and the highest density of family households by neighborhood with 60% (13% by district).

Identified Strengths: Members of this community feel that people in this neighborhood are recognizable and known to each other and that many share the same values. Members also feel that they are all working towards the same goals and priorities. The majority of those who took the survey relayed that the community was part of their identity and they care about how other people think of them. Surveyors heard many stories about times the community came together in the past through previous generations. A sense of community with other members was ranked as a priority by 75% of respondents.

Identified Challenges: Members of this community do not feel needs are being met personally or for the community as a whole. Many members discussed their difficulties with surveyors or relayed stories about their neighbors who were struggling. Members of this community also do not feel they have the ability to influence their community and do not believe that people genuinely care about each other. The majority of members do not trust each other in this neighborhood and feel there is a lack of good leaders in their community; this may be due to the wave of criminal and gang related activity. There appears to be a lack of identity as respondents had a difficult time naming expressions of belonging.

Potential: As this community is struggling with poverty related challenges and community violence, it is most important that members of this community feel safe and protected. Finding ways to connect the Hagerstown Police Department and local citizen leaders to start an important dialogue about the best ways to partner to address safety concerns is top priority. Starting this conversation will establish a process which will help the community to define local solutions to their safety concerns and define the role the Police Department can play. Exploring how local partners can infuse positive opportunities and experiences in the neighborhood could build unity.

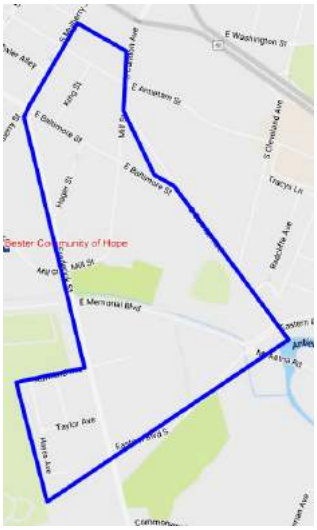
Frederick Street Corridor

The northern half of this geographic area was home to the Seminary for Young Ladies in the 1800's. An advertisement for the Seminary for Young Ladies boasts the area as "the most pleasant location in the state".[4] In 1934, this site became the Washington County Hospital, a very important factor in the area economically. Hager Mill, originally the Rochester-Stull Mill constructed in the 1790's, is located in the center of this neighborhood and is currently in disrepair. Staley Park, just outside the southern border, has hosted the successful National Little League which began play in 1949.

In December of 2010, the doors of Washington County Hospital were closed due to the newly constructed Meritus Medical Center 2.5 miles away, leaving behind a large empty lot and deteriorating vacant parking garage. Several doctors' offices remain in the area as well as Phoenix Healthcare which focuses on substance abuse treatment and mental health. In 2016, the Corner Pub also closed its doors after serving the community for 30 years and is now a liquor store. Frederick Manor in the southern most corner provides housing to 125 families through Hagerstown Housing Authority, and while there are a few other homes in this area, it remains primarily commercial.

The northern portion of this neighborhood is in transition, as long-time anchor businesses were a part of its identity. There continues to be looming uncertainty after 2018 regarding the Hagerstown Suns, which has existed in this neighborhood since the 1930's. Public efforts to consider alternate locations for the team proved unsuccessful but concerns remain with stadium improvements requested. With economic uncertainties, this community still holds several natural resources with parks, pools and recreation areas, but there is clearly a need to identify new priorities for growth.

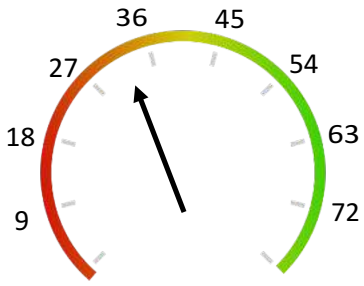
"This is a good street. We all know each other's kids and look out for them, even if we don't really know each other."



	Community*	District*	City*	County**	State**
Population					
Estimated Current	514	6,318	40,188	149,270	5,930,538
6 yr Population Change	-8%	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	208	3,373	18,641	61,111	2,410,256
Owner Occupied	27.7%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	72.3%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and Blighted†	10	103	602	---	---
Income					
Median Income	$27,249	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	29.7%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	73%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	15%	18.25%	14.2%	10.7%	29.52%
Hispanic	4.9%	3.8%	5.1%	4%	9%
Other	6.7%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from the City of Hagerstown.

Sense of Community Scores



District Overall Score: 33.25/72
Frederick Street Corridor Overall Score: 32.8/72

Reinforcement of Needs:
District Average: 8.35/18 Frederick Street Corridor: 8.9/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 Elizabethtown West: 7.9/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here*.

Influence:
District Average: 7.58/18 Elizabethtown West: 8.5/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line:** *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 Elizabethtown West: 9.1/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Neighborhood Assets

Associations	Institutions	Services	Natural and Physical	Businesses
Frederick Manor Tenant Association, Boys and Girls Club, AmVets	New Life World Ministries, Hagerstown Suns, Church of God, Lifehouse Church	Community Free Clinic, Salvation Army Thrift Store, Julia Manor, several medical offices, Ladders to Leaders, Phoenix House	Hager Park, Pottersfield Pool, Municipal Stadium, Staley Park, William Brish Planetarium	9 auto related businesses, Pope Tire, Liberty, AC&T, Community Depot, Antietam Cable, Manning Broadcasting

A total of 15 members of this community participated in the survey. During the time of the survey, the local gas company was replacing lines so parts of the main road were closed, making some homes inaccessible. Children were playing in yards and on the sidewalks and neighbors were interacting in the northern half of the area. People were friendly and approachable throughout the neighborhood. This area includes Frederick Manor, which presents as a self-contained community within this geographic area with a tenant association, Boys and Girls Club and various opportunities for residents.

Identified Strengths: Members of this area feel that their personal needs are met by living in this community. People believe that members share the same priorities, goals and needs and they have the ability to solve problems together. Members want to fit in to the community and spend enjoyable time together. People believe there is value to being an active part of the community. Many respondents replied that they feel some sense of personal influence within the community and the majority feel this community can influence other communities. There are a noticeable amount of useful community assets located in this area specifically services and natural resources. Of note, there are three grocery stores (Weis, Shop n' Save, Aldi's) located within close proximity to this sector – more than any other part of the district.

Identified Challenges: There appears to be a disconnect between residents as they are unsure of the welfare of their neighbors despite feeling their own needs are met. Respondents indicated that they do not put a lot of time and energy into being a part of the community but do value the enjoyable time spent together as a community. This indicates there is a desire to connect more with others but perhaps not enough opportunity. The loss of institutions that served as landmarks has impacted how members identify and describe this neighborhood and has created a disruption in overall sense of neighborhood identity. There have been complaints regarding the blighted Forsyth Furniture property, directly next to Hager Park where children play, as it is a known location for homeless populations and other social issues.

Potential: Facilitating a process to highlight strengths in the neighborhood will focus energy on taking advantage of underutilized neighborhood assets. Repurposing the former site of Washington County Hospital as a shared use space for community engagement should be considered. As Frederick Manor appears to be a community within the community, finding ways to connect to the larger area may be beneficial. Finally, exploring with the City of Hagerstown the identified concern of the Forsyth property as an opportunity for revitalization and development should be considered.

Historic City Park

In 1739, Jonathan Hager built the first home in this neighborhood which is now a museum in City Park. In the early 1800's, the Heyser family bought the property which consisted of hundreds of acres. The Heyser's permitted the Hagerstown Fair to be held on the property until the Civil War.[4] After purchasing the property in 1915, the City of Hagerstown later developed City Park, which currently includes a lake and waterway, playgrounds, band shell and the Washington County Museum of Fine Arts. This neighborhood was home to Surrey Elementary School for 75 years which became The Learning Center in the 1980's, a childcare program designed for employees of the Washington County Memorial Hospital. This resource provided childcare for many neighborhood families' but closed in 2015.

Hagerstown City Park presents as a beautiful natural resource with many offerings throughout the year, however some respondents commented that it is underutilized. More than any other neighborhood, residents appeared to be more engaged with each other and proud of it. There were some concerns expressed about the speed of traffic on Summit Avenue in the midst of an otherwise quiet neighborhood.

Virginia Avenue is the main corridor on the western boundary of this neighborhood leading to the Valley Mall, one of the largest commercial areas in the region. The neighborhood itself is primarily residential with the architecture of the original buildings being well preserved. It includes a group of factory buildings dating back to 1890 and a middle class residential area with 203 buildings listed on the National Register of Historic Places.[5] In 2015, the redistricting of elementary school district boundaries sent some families who traditionally went to Bester to a new school.

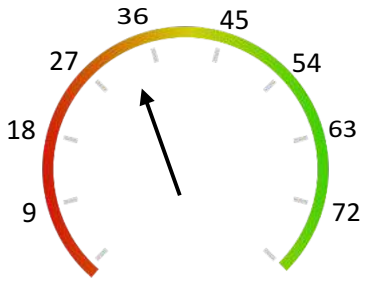
"Why aren't there events here? Why do I go to Leitersburg or the Ag Center? It's silly."

"Community is your general area. Everyone around here pretty much gets along. I feed my neighbor's cat and he feeds mine. We have cookouts together, I enjoy living here. I know the kids and their parents."

	Community*	District*	City*	County**	State**
Population					
Estimated Current	997	6,318	40,188	149,270	5,930,538
6 yr Population Change	1.66%	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	498	3,373	18,641	61,111	2,410,256
Owner Occupied	46.9%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	53.1%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and/or Blighted†	22	103	602	---	---
Income					
Median Income	$57,894	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	9.8%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	83.5%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	6.7%	18.25%	14.2%	10.7%	29.52%
Hispanic	5.1%	3.8%	5.1%	4%	9%
Other	4.9%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from the City of Hagerstown.

Sense of Community Scores



District Overall Score: 33.25/72
Historic City Park Overall Score: 33.43/72

Reinforcement of Needs:
District Average: 8.35/18 Historic City Park: 8.3/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 Historic City Park: 8.5/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 Historic City Park: 7.9/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line:** *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 Historic City Park: 8.6/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
Historic City Park Neighborhoods First, Washington County Museum of Fine Arts	Emmanuel United Methodist Church, Centro Comunitario Jesus Pan de Vida, New Joy Fellowship	Park Circle Animal Hospital, Head Start of Washington County, Alternative Drug and Alcohol Counseling, Partners in Pediatrics	Hagerstown City Park	Culligan Water, Gibney Florist, Brother's Pizza, Rigers Laundry, Fanfare Hair, Yearkle's Heating and Air Conditioning, several auto services

A total of 50 members of this community participated in the survey. The majority of members were available in the later hours of the day therefore much of the surveying done in this area was in the early evening.

Community data of significance: lowest poverty rate at 9.8%, highest median income at $57,894, and the second highest rate of home ownership at 47%.

Identified Strengths: Members of this community feel they share priorities, needs, goals and values with their neighbors and there is a general sense of trust. Many feel that some of their personal needs are met within the community. There are perceived common symbols or expressions of membership within the community and they can share problems with other members with the expectation that the community can work together for solutions. Respondents felt others in the community know them and they can recognize other members. There is value in being a part of the community and spending time together and overall, members suggest that living here makes them feel good.

Identified Challenges: About one third of members consistently replied more negatively to questions regarding connections to other members and the community itself, suggesting a disconnected population. When asked if members of this community care about each other, 20% responded "not at all" and 37% responded "somewhat". Nearly 70% said they do not spend enjoyable time with other community members. In general, members do not feel a sense of personal influence within the community despite feeling the community as a whole is capable of finding solutions to problems.

Potential: In reality, the challenges facing this neighborhood appear limited to social connections and influence. Although these indicators are less tangible than social problems such as crime, they are important factors in buffering stress and building resilience. The natural resource of City Park is seen as a major asset to the community, but utilization by its residents doesn't present as high based on respondent feedback. Involving more residents in the City Park event planning process will empower them and provide a greater sense of influence. In addition to the smaller events that currently take place, the City could consider some signature events that would draw more attendance. In order to maximize this resource for the region, parking should be addressed. The closure of The Learning Center was identified as a significant loss, but it could be an opportunity to engage residents in a conversation about repurposing the property.

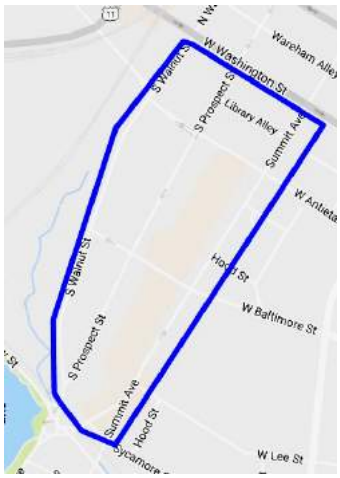
Historic Heights

Rich with architecture in the style of Neoclassical, Classical Revival, Gothic Revival, Italianate, Second Empire and Queen Anne, this area of Hagerstown was established in the 1830's. This neighborhood was where "high placed and important people" such as the Pangborn's, Lane's and Admiral Fairfax made their homes.[2] Over time, many of these large homes have been broken into smaller apartments, but the exterior has remained. The first Washington County Free Library was built on Summit Avenue in the Fall of 1901.[4] Walnut Towers, a two building high rise with a total of 150 units, was built in 1969 to provide housing for elderly and disabled individuals.

The western side of this neighborhood is bordered by an underdeveloped section of City Park. Vested residents on Prospect Street, who want to maintain the quality of life in this community, have expressed concern regarding homeless individuals passing through to gain access to railroad property on the backside of City Park. In the northern section is Walnut Towers where most of the social interactions for residents are internal and typically organized by the tenant association, limiting integration into the neighborhood. Residents on Summit Avenue identified that a positive infusion of resources and activities for children would benefit the neighborhood.

In 2016, at the base of Summit Avenue, the community came together to design a mural with the support of the City of Hagerstown. There have been growing attempts to build connections amongst neighbors on Prospect Street, including "Porchfest" and the "Summer Slide Festival". These efforts have worked to promote pride and camaraderie in the neighborhood.

"If we could keep kids involved in activities, they wouldn't get in trouble. Giving needs to be better coordinated. Things just can't be handouts but they can't sit on the shelf and collect dust either."

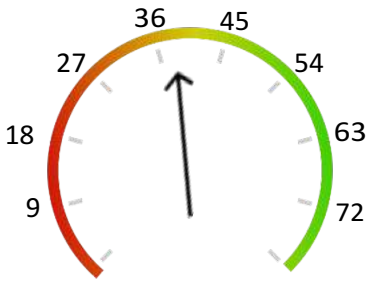


"The kids is my biggest thing, there is not a whole lot for them, and then you have all these kids on the block in trouble. One street over is a whole different neighborhood, those kids have no guidance."

	Community*	District*	City*	County**	State**
Population					
Estimated Current	379	6,318	40,188	149,270	5,930,538
6 yr Population Change	-5.96	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	235	3,373	18,641	61,111	2,410,256
Owner Occupied	4.7%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	95%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and Blighted†	7	103	602	---	---
Income					
Median Income	$16,332	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	30.4%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	75%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	17%	18.25%	14.2%	10.7%	29.52%
Hispanic	3.2%	3.8%	5.1%	4%	9%
Other	4.8%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. † Data from the City of Hagerstown

Sense of Community Scores



District Overall Score: 33.25/72
Historic Heights Overall Score: 38.40/72

Reinforcement of Needs:
District Average: 8.35/18 Historic Heights: 9.5/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 Historic Heights: 9.68/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 Historic Heights: 9.28/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line**: *My voice matters*.

Shared Emotional Connection:
District Average: 8.93/18 Historic Heights: 9.94/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
Historic Heights Neighborhoods First, Women's Club, Walnut Towers tenant association	Hagerstown Bible Church, St. John's Episcopal Church, Presbyterian Church of Hagerstown	Hope Pregnancy Center, CASA, Washington County Community Action Coalition, Community Rescue/Fire Co. 2	City Park	Maloo's Pub and Grill, Chic's Seafood, D&P Coin Op, Widymeyer Real Estate, Wright Gardner Insurance, Park Circle Veterinary, Park Circle Service Ctr

A total of 50 members of this community participated in the survey with 12 being residents of Walnut Towers. Vacant properties on lower Prospect Street were noted as there were eight in one section and several locked apartment buildings presented challenges. There appears to be three separate and unique areas to this neighborhood – Walnut Towers, South Prospect Street, and Summit Avenue.

Community data of significance: lowest density of families by neighborhood 27% and by district 4%.

Identified Strengths: Overwhelmingly, members of this neighborhood feel good about where they live. When asked if their personal needs were met by being a member of this community, the majority replied favorably. Respondents stated they feel that members value the same things and they share goals, needs and priorities. More than half of respondents feel they are able to talk with other members of the community when they have a personal problem. There is recognition of other members and respondents feel known by their neighbors. There is belief that this neighborhood as a whole can influence other areas. People in this neighborhood want to belong, value conformity, and there is a belief that members care for each other on some level. Residents have hope for the future of the community, plan to remain a member of it, and find importance in their membership.

Identified Challenges: Survey data collected indicates that there is a lack of personal connection within this community. Respondents were unsure if their neighbors personal needs were being met and only 28% stated they spend enjoyable time with other members of the community. When asked if they could trust other people in the community, 64% responded negatively. Although members believe the community has influence over other communities, individual members do not feel empowered. The data indicates that community members feel connected to the environment, but not necessarily to each other.

Potential: Opportunities for members of this community to connect with neighbors will increase familiarity and trust as well as enhance the sense of community overall. Finding ways to bring the three unique areas of this sector together will increase the sense of unity and accountability. Considerations could include establishing opportunities for residents of Walnut Towers to contribute to program offerings in the neighborhood which would be mutually beneficial. Additionally, investing in grass roots beautification efforts on Summit Avenue, a main thoroughfare into downtown, could promote a sense of ownership and empowerment.

North Central

This southern portion of this geographic area was primarily marsh land until the mid to late 1800's when the rail system came to Hagerstown. The area then became rail yard and is now an industrial area.[2] In 1883, The Washington County Orphan's Home (San Mar) opened in response to the significant need of children after the Civil War and was located on the corner of S. Potomac Street and Sycamore Street. In 1918, orphanage Superintendent Walter Esmer expressed concerns for the welfare of children due to swamp lands and industrialized areas impacting their success due to less than desirable conditions, ultimately leading to relocation in 1927.[7] The Washington County Administrative Annex, formerly a Grand Union grocery store which closed in 1982, is in the northern half of this community. The Hagerstown Housing Authority constructed the first of 3 properties in this area in 1994, commonly referred to as Potomac Towers.

Today, much of the area is business and industrial property. Columbia Gas occupies much of the southern portion while Ellsworth Electric, Beaver Mechanical Engineering and others are located in more of the central area. As you move closer to the center of the City, legal offices and the court house are prominent. Apartment buildings and some single family houses appear more in the outskirts of this geographic area whereas Potomac Towers represents the center. As a part of a larger urban revitalization plan, the City has planned to put one of their catalyst projects, an arts and cultural trail, with a path that exists almost completely within this sector. The City has expressed the hope that among other positive benefits, it will encourage the building of new townhomes and other development near the corridor.

"They know where the issues are, we have told the police. Nothing is done. Why is nothing done? Very disheartening…" in relation to social concerns that exist in this area.

Potomac Towers Snapshot[6]

November 2016: 326 occupied units

Length of residency:

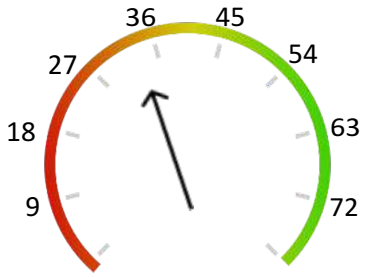
0 – 1 yr: 28%	2-5 yrs: 23%
6-10 yrs: 28%	11-20 yrs: 17%

More than 20 years: 4%

	Community*	District*	City*	County**	State**
Population					
Estimated Current	799	6,318	40,188	149,270	5,930,538
6 yr Population Change	-6.6%	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	581	3,373	18,641	61,111	2,410,256
Owner Occupied	4.8%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	95.2%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and Blighted†	11	103	602	---	---
Income					
Median Income	$18,302	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	34%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	76.1%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	16.8%	18.25%	14.2%	10.7%	29.52%
Hispanic	3.8%	3.8%	5.1%	4%	9%
Other	3.3%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from the City of Hagerstown.

Sense of Community Scores



District Overall Score: 33.25/72
North Central Overall Score: 34.14/72

Reinforcement of Needs:
District Average: 8.35/18 North Central: 8.7/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line**: *We have what we need.*

Membership:
District Average: 8.26/18 North Central: 8.2/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 North Central: 8.1/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line**: *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 North Central: 9.0/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
HHA Tenants Association	Hagerstown Housing Authority, District Court, Washington County Admin. Annex, Full Life Family Ministries	Hagerstown Children's School, Gimmerman Chiropractic	Memorial Park, Cultural Trail	Herald Mail Media, BB&T, Columbia Gas, Ellsworth Electric, The Auto Spa, Beaver Electric, Mountain Screen-printing

A total of seven members of this geographical area participated in this survey. This number appears low as the Housing Authority buildings are listed as one physical address on the City listing of residential addresses. In this area, there is a limited number of residential properties outside of Potomac Towers. These residents were able to provide feedback on their experiences, but it was not reflective of the dominant population in this community.

The reality of this neighborhood is it largely encompasses industry and Potomac Towers whereas individual families account for a very small portion of the population. This is also a reflection of the boundaries created for our survey. It is likely that the smaller number of individual families go outside of this sector to have their needs met and may possibly to be more connected to nearby neighborhoods.

Identified Strengths: Residential portions of this geographic area are grouped together either by design of the Housing Authority or the borders of businesses and industrial areas. This creates the opportunity for familiarity amongst neighbors. There are some members who stand out to others as possessing leadership qualities which was not the case in every neighborhood surveyed. Members in this area feel it is important to fit in and care how others view them. Respondents feel that being a part of the community is important and feel hopeful about the future of this area.

Identified Challenges: Does this community identify residents living in Potomac Towers as permanent vested members of their neighborhood and if so, which neighborhood? Residents here do not personally identify with the area and are not investing personal time in the community. This may be a reflection of some elderly and disabled individuals moving into the neighborhood out of necessity rather than desire, but it appears to be community wide. Which neighborhood organization is advocating and supporting the individual families who reside here?

Potential: Feedback in the professional community has been that strong leadership at the Hagerstown Housing Authority has improved their organizational operation. Knowing this, how can the significant number of long term residents partner with other individual families in this sector to create a safe and supportive neighborhood? As membership was identified as below the district average, how can the Arts and Culture trail project, housing authority and neighborhood residents come together in a way that has meaning for them? Next steps could include reviewing existing survey information from Hagerstown Housing Authority to respond to their identified resident needs with community partners. Linking smaller individual families to nearby neighborhood groups such as Neighborhoods 1st could provide ongoing advocacy support.

South End Neighborhoods

This neighborhood lies to the west of South Potomac Street and historic Rose Hill Cemetery, established in 1866 and the final resting place for thousands of Confederate soldiers.[8] Much of this area was not developed as residential until the mid to late 1800's when the Industrial Era brought manufacturing and mills to the southern part of Hagerstown. Victor Products produced roll top counter coolers, Maryland Silk Company, Crawford Automobile Company were all based in this neighborhood.[2] Superior Dairy, a popular ice cream spot, closed in 2015 and J&M Grill, a neighborhood diner, closed in 2016.

This neighborhood has a median income of $54,976, second only to its neighbor to the immediate west, Historic City Park. Despite some residents' concerns about perceived upticks in crime, this area presents as a quiet, working class neighborhood. The streets were mostly litter free and properties are fairly well maintained. Many residents commented on the increase in rental properties. Respondents told stories about supporting their immediate neighbors but not necessarily connecting to the larger neighborhood.

Today, notable businesses in the area are Hartle's Subs, Rocky's Pizza and Krumpe's Do-nuts, the last of which hosts a variety of popular community events. Recent redistricting of school catchment areas has sent some families with children historically in Bester Elementary to a new school. South End Neighborhoods First group actively focuses on creating a welcoming environment and would like to improve upon Maryland Avenue for aesthetics and traffic control as well as identify potential property to create green space. The southern portion of this neighborhood has greater access to commercial areas as well as E. Russell Hicks Middle School and South Hagerstown High School.

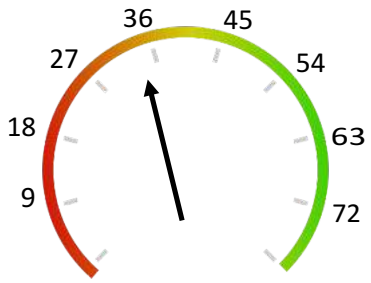
"This area has changed a lot. There's so many people who come in and out now it can be hard to know who's who."

"These kids need more, us adults need to try to help out. Children need to come first, they get left behind…whenever I retire, which is sooner than later, I'll leave."

	Community*	District*	City*	County**	State**
Population					
Estimated Current	934	6,318	40,188	149,270	5,930,538
6 yr Population Change	1%	-9.78%	1.12%	2.01%	unkn
Housing					
Number of Occupied Units	429	3,373	18,641	61,111	2,410,256
Owner Occupied	51.3%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	48.7%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and/or Blighted†	14	103	602	Unkn	unkn
Income					
Median Income	$55,073	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	12.2%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	83.3%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	8.1%	18.25%	14.2%	10.7%	29.52%
Hispanic	4.2%	3.8%	5.1%	4%	9%
Other	4.3%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from the City of Hagerstown

Sense of Community Scores



District Overall Score: 33.25/72
South End Overall Score: 35.63/72

Reinforcement of Needs:
District Average: 8.35/18 South End: 8.9/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 South End: 8.6/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 South End: 8.2/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line:** *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 South End: 9.2/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
South End Neighborhoods First	Sgt. Shriver Center/Head Start, Emmanuel UMC, Victory Chapel	First Street Fire Department, Columbia Bank	Memorial Park, Doub's Woods Park, Community Garden	Krumpe's Donuts, South End Shopping Plaza, Startzman's Hardware, Hartle's Subs, Rocky's Pizza, Clean & Bright Laundromat, several auto service busineses

A total of 50 members of this community participated in the survey. Much of this neighborhood was canvassed in the late afternoon and early evenings as we had difficulty finding people home during the day. In general, people were welcoming and willing to talk about their neighborhood. There were fewer complaints than in other neighborhoods giving the perception that residents were more comfortable.

Community data of significance: second lowest poverty rate at 12.2%, highest rate of home ownership 51%, and the second highest median income at $55,073.

Identified Strengths: Members of this community described a sense of belonging and commonality and feel members are familiar to each other. People indicated their personal needs were not entirely met but that the community as a whole does a better job at meeting the needs of its population. Members feel the community has a defined identity and that they belong. Members value fitting in and believe that residents care about each other. The majority of respondents plan to remain members of this neighborhood for a long time.

Identified Challenges: Members of this community indicated they do not feel they have personal influence and that problem solving as a community is lacking. Additionally, members indicated their personal needs are not being fully met. Many do not tie their personal identity to the community which may be a reflection of the increasing number of renters adding to ambivalence overall. When asked if they enjoy spending time with other community members often, 70% replied negatively. Due to the geography of this neighborhood, residents go elsewhere for recreation, socializing or shopping creating a lack of opportunity to interact within their neighborhood.

Potential: Creating more opportunities for members to gather in enjoyable ways closer to their home will increase connections and opportunity for expression. The natural and physical resources listed as assets are located outside of the boundary of this community. Creation of a shared use space in the neighborhood could draw people together in positive ways. Structurally, the Shriver Center, managed by Head Start, has the potential to function as a convening point in the neighborhood if there was interest and additional resources. Considering a community art project could increase vibrancy and deepen the connection to the environment.

Locust Point

Prior to the Civil War, this geographic area held few residential properties. In 1863, General J.H. Kilpatrick's cavalry stormed through this area to the center of the town – then known as Elizabethtown – to the First Battle of Hagerstown.[9] After the war, Hagerstown began growing out from the center and expanding south around 1900 and the neighborhood was primarily working class families.[2] Early in the 20th century, Willow Lane Park was built as the stadium for Hagerstown's class D division baseball league. In 1930, South Potomac Junior High School was built in its place once the new Municipal Stadium was constructed just down the road. In 1966, the building became Bester Elementary School.

Today, the narrow streets are lined with residential properties and some businesses as well. We encountered people who have lived in this neighborhood, if not in their home, for their whole lives and who told stories of how the neighborhood has changed with the increasing number of rentals over home ownership. Demographically, this area has the highest rate of households living below the poverty guidelines in the district and transiency is problematic.

There have been recent important investments on the southern border of this sector, with a large new elementary school in 2014, new Memorial Park, and new community garden, and to the north the large public library opened in October 2013. "What a difference a street makes" was a comment made more than once regarding this densely populated part of the city. The Locust Street and Potomac Street corridors are heavily utilized pathways into the downtown portion of the City of Hagerstown, but the majority of travelers are just passing through.

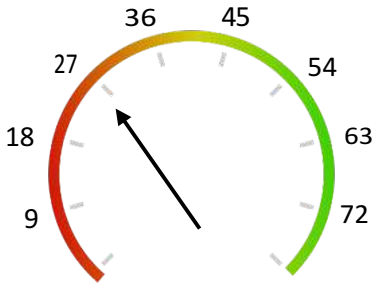
"I've been here for 50 years and now it's only me and one other original home owner, everyone else is gone. Now it's all renters, low income, absent landlords. No respect for other people's property or quality of life."

"Politics of this town suck. They are not about kids, the poor or people. And those that are unfortunately stuck dealing with them. If you don't have hope, you don't have nothing."

	Community*	District*	City*	County**	State**
Population					
Estimated Current	1,303	6,318	40,188	149,270	5,930,538
6 yr Population Change	-11%	-9.78%	1.12%	2.01%	---
Housing					
Number of Occupied Units	725	3,373	18,641	61,111	2,410,256
Owner Occupied	22%	22.87%	46.5%	64.17%	66.82%
Renter Occupied	73%	77.13%	53.5%	35.83%	33.18%
Identified as Vacant and/or Blighted†	30	103	602	---	---
Income					
Median Income	$20, 224	$27,079	$39,611	$56, 228	$90,089
Below Poverty Guidelines	42%	28%	21.5%	12.89%	12.89%
Diversity					
White, non-Hispanic	77%	77.59%	75%	84.8%	57.6%
Black, non-Hispanic	13%	18.25%	14.2%	10.7%	29.52%
Hispanic	3.8%	3.8%	5.1%	4%	9%
Other	5.1%	>1%	5.7%	>1%	3.72%

*Data from Mission Insite, December 2016. **Data from Policy Map, January 2016. †Data from the City of Hagerstown

Sense of Community Scores



District Overall Score: 33.25/72
Locust Point North Overall Score: 26.84/72

Reinforcement of Needs:
District Average: 8.35/18 Locust Point North: 6.2/18
This element examines the person-environment fit and how well the individual member's needs are fulfilled through the resources available within the community. Needs are more than basic for this index as this element looks at more intimate needs such as status, shared values, and mutual benefit. **Bottom line:** *We have what we need.*

Membership:
District Average: 8.26/18 Locust Point North: 6.8/18
This element explores the community and individual definition of boundaries, identification with the community, personal investment and emotional safety. Boundaries, in terms of membership, are not about geographical lines but rather who belongs and who does not. It also examines if there are expressions of membership or a symbol system that codes belonging. **Bottom line**: *I belong here.*

Influence:
District Average: 7.58/18 Locust Point North: 6.1/18
This element examines the flow of influence. Each individual member has the potential to sway the community one way or another and the community as a whole has the potential to impact each individual. Both perceived power and conformity play a role in influence. **Bottom line:** *My voice matters.*

Shared Emotional Connection:
District Average: 8.93/18 Locust Point North: 7.1/18
This element explores the frequency of interaction among members, the quality of the interaction, and how deeply members connect with the history of the community, however recent, and with each other.
Bottom Line: *We are connected.*

Sample of Community Assets

Associations	Institutions	Services	Natural and Physical	Businesses
Bester Communities First, Mason Lodge	First Church of God, Bridge of Life Church, Fundamental Baptist Church, Congregation B'nai Abraham, Trinity Bible Church, St. John's Episcopal Church	Holly Place, Julia Manor, Easter Seals, Award Beauty School, Coffman Funeral Home, Washington County Free Library		Locust Point Market, G&G Grill, Frederick Seibert & Associates, Tri State Printing, Graphic Response, Elmo's,

A total of 120 members of this community participated in the survey, the largest representative sample in our survey efforts. Overall, members of this community were open and welcomed the opportunity to share their opinions and thoughts. Children were intrigued by our door to door activity and would ask if we would talk with their mother or father next. Several residents expressed concerns for surveyor safety, especially as evening drew closer. Members of the community raised concerns about drugs, gang and criminal activity and the number of vacant properties.

Community data of significance: comprises 20% of district population (highest), highest poverty rate in the district at 42%, and the highest percent of family households in the district with 20% (43% by neighborhood population).

Identified Strengths: Members of this community are able to recognize other members and feel they are known by their neighbors. People here have a general belief that it is important to be a part of the community and for those that did not agree, it appeared to be more of a reflection of their displeasure with the community than a true conviction. More than half of respondents feel hopeful about the future of their neighborhood and that there is a level of influence the community can have over other communities.

Identified Challenges: Respondents in this community are concerned that needs are met for those who live here and feel the majority are struggling on a daily basis. People do not trust each other in this community and do not feel there are shared values, priorities, needs or goals. There is little belief that the community can work together to solve problems and respondents did not feel they had influence within the community. Respondents indicated a lack of good leaders and opportunities for members to spend time together in an enjoyable manner. Many respondents did not identify with the neighborhood and were not planning on staying in the community any longer than necessary. Overall, data collected suggests members are greatly disconnected from each other as well as from supports. The majority of members have a negative view about the neighborhood as a whole, thus they are reluctant to be agents of change.

Potential: This geographic area is densely populated and experiencing significant challenges. Breaking the larger area into smaller, more manageable neighborhoods for focused efforts could be helpful. Identifying locations for safe common spaces will create opportunities for residents to become positively engaged in direct proximity to their home, an option not currently available. The commitment of core service providers to meet people where they are and provide concrete resources and services could significantly increase opportunities for success.

Focus Groups Summary, CHNA FY2019

QUALITY OF LIFE

“A good quality of life is living in a safe environment, with good schools, good jobs and quality healthcare.”

Very important, strong families, strong communities, and healthy strong neighbors

Having healthy relationships, decent income, maintaining a family, happy, wellbeing = content

Helping one another

A happy meaningful life

Have enough time and money to do the things we want to do, good health

Living in a safe environment, good education, healthy living environment

Being healthy no matter the "shape" you are

Peaceful neighborhoods

Security and health

To live life good in society & have good health

What makes a community Healthy?

Healthy relationships, health opportunities (gym, healthy market), practicing the education of the effects of drugs, fair treatment to all

That everyone's safe and well

Emphasis on outdoor activities-walking, biking, playing

Offering a clean safe environment, offer opportunities for community gatherings and learnings

Supporting each other, good economic opportunities, strong culture, good healthy recreational activities

Having healthy food, & maintain clean streets and communities

Avoid contamination in the environment, being responsible and keeping the environment clean

What do you like most about living in Washington County?

"Washington County has so much to offer! It's a great place to live!"

Proximity to other areas/central location

The people

Numerous activities, access to outdoors

Traffic is not bad

Cost of living is good

Scenery

Great schools!

Access to golf

Diversity

What concerns you most about living here?

Interstate flow of human and drug trafficking seems to be getting worse

Increasing crime

Traffic starting to be more congested

Increased numbers of deaths from drugs

Drug abuse / addictions

Sedentary lifestyles, poor nutrition, lack of exercise

SPECIFIC HEALTH CHALLENGES

Diabetes

High rate of obesity and pre-diabetes

"There is a huge need for people to have better nutritional information in our community"

Socioeconomic considerations; "fast food is cheap and easy"

Lack of knowledge of resources available

Lack of motivation, not in "crisis"

Location of health services are not convenient

Cost of care, especially co-pays for treatment, medication and education

Weight Status

"Fast food doesn't cost much and is generally unhealthy"

Not enough time to cook healthy meals

Not enough time to exercise

Screen time / electronics

Lack of knowledge and lack of motivation to make changes

Healthy food costs more

"Dietary counseling is not a benefit that is covered by most insurances"

"Why don't we have medical weight loss services?"

"We have an obesity problem because of poor nutrition, a lack of physical activity and over-eating."

Mental Health

Stigma and denial

"Treatment isn't always available when the person is ready for help."

Depression symptoms are minimized

Cost; uninsured, high deductibles, co-pays

Federal rules around confidentiality

Can be a long wait for new patient intake

Shortage of psychiatry providers

There are a generally a lack of behavioral health and addiction services

I can't get patients seen timely

Unsure of resources

Few options for medication management

Substance Use Disorders

”Drugs are everywhere.”

Timely treatment is not readily available

No inpatient beds or “detox” services

Pain management by doctors are the problem

Stigma

“Someone with a drug problem is seen as having a weakness instead of a disease.”

Sometimes viewed as a moral problem, or “weakness”

Associated with crime

Socioeconomic factors contribute

“I wasn’t able to get into treatment when I needed it the most”

Location of services / transportation to outpatient treatment

BARRIERS TO HEALTHCARE

Seniors

Balance problems

Health /endurance problems

Fatigue

Depression

Getting in for an appointment

Seeing a physician assistant instead of my physician

Insurance and pharmaceutical needs and costs—do I eat or purchase my med?

Transportation when needed

Physicians

Food security and proper nutrition

Need for more after school programs

Increase mental health counseling and psychiatry

Lower the barriers to access home health services

More affordable housing

Can't education

African Americans

"There are places that people can go for help but they just don't know about them."

More Urgent Care centers needed (location)

Mental health

Medication awareness

Hispanic

Lack of insurance

Cost of care

Time

Cost of dental procedures

BARRIERS TO MAKING CHANGES

Seniors

Can't stop smoking

Lack of knowledge

Don't want to change

Too late

Physicians

Meet them where they are and start small with reasonable goals and try to understand their limitations and life experiences

In general patients don't think there is a reason to improve

Make them feel like they matter and increase their value

If you don't feel you matter they aren't motivated to do anything. They need to love themselves and help themselves

African Americans

Stress

Don't take the time to eat right

Working long hours and getting tired at work

Time schedule

Lost motivation

Physical limitations

Men

Work

Time

Sweets

Being lazy at times

Health

Weather, too much rain

Age

Income

Hispanics

Time

Cost

Healthy diet

SOLUTIONS / IDEAS

Hispanic

Offer safe recreational activities/opportunities (gym, healthy markets, recycling, biking/walking trails)

Education!! Start early with a push in the schools

Create safer environments

Services to help those in need who don't have health insurance

More public exercise and recreation outlets

Healthier food choices in restaurants

Provide outreach

Educate people living in the community – what is available

Obtain more information in Spanish

Lower cost of medication

Case Management

"Help educate, equip and empower individuals to become self-efficacious."

Educational outreach stressing the importance of PCP follow up

Require patients to attend educational courses to receive certain benefits as an incentive.

Prevention, have more physicians make house calls

Better support for mental health/substance abuse

Promote wellness in a way that reaches patient on their level

Offer education and resources earlier and in an out of box thinking way

Go to the community, don't wait for patients to come to us

Break down barriers

Provide easy access to health care resources

Group education to connect peers with similar health concerns

Providing more free services

Transportation programs

Physicians

Move to a reimbursement system and favors quality and safety and not volumes

Decrease inappropriate emergency department visits

Develop palliative and supportive care resources that focus on quality of life

Help patients determine what is most important to them (patient-centered)

Having meaningful discussions around patient wishes and preparation for end of life

Everybody needs to be involved in caring for the patients, including them.

Better engagement with the patient

African Americans

Do more for our seniors

Lower cost of medication

Transportation for elderly

Mobile services dentist, eye care, mental health close by

Getting through phone prompts to make appointments – let me talk to a person

Farmers' market in community park or a Mobile Farmers' market

Health Education in the community

Men

Better availability of healthcare for those in need

Reasonable healthcare costs

By offering people who have no insurance, or insurance that does not cover all costs free care

Healthcare in general is little too costly

Too many urgent care centers

Cheaper medicines

Community Organizations Using the CHNA

Commission on Aging

The Commission on Aging is a non-profit 501(c)(3) that provides over 50 programs and services to those we serve in Washington County. Seniors are the fastest growing segment of our population. Many have multiple comorbidities necessitating a greater level of support and services. Currently there are waiting lists for many COA programs ranging from two weeks to over two years, to help meet basic needs like food and safe housing. Supports services such as personal care, homemaker, chore and respite care also have waiting lists. Because isolation is a growing concern among seniors, we offer connections through our congregate sites, senior center, Meals on Wheels program and evidence based education programs. Majority of those we serve are low income and have appreciated our support through education and resources for economic security. We connect those we serve and their caregivers to valuable local resources. We are constantly looking at opportunities to collaborate and for innovative ways to serve our complex clients in this ever-changing home and community based service model. There are true basic needs going unmet in our senior population due to lack of funding and necessary resources. Currently, one year of food costs alone for one client on Meals on Wheels is approximately $1,760. To provide meals to 50 people for a year would take $88,000 just for food. That does not account for any other expenses to manage the program or services that are also a part of the Meals on Wheels program. Meals on Wheels is much more than a meal. It provides education, socialization and is a safety check for the client. Capacity limits our ability to reach additional rural areas beyond our current scope. We believe that need is greater than our assessment, as clients may refuse to go on the waiting list or the community may not even know about the services available.

Community Free Clinic

The Community Free Clinic (CFC) makes health care accessible to all uninsured citizens of Washington County, Maryland. CFC has been in operation since February 1990 serving as a "safety net" organization for citizens who find themselves without insurance. CFC collaborates with many community organizations in order to meet the needs of our patients. We are committed to delivering medical services at the greatest value to our patients. Available care at CFC includes but is not limited to Primary Care, Urgent Care, Chronic Disease Management, Women's Health, Blood Pressure Monitoring, Diabetic Monitoring, Rheumatology, Neurology, Podiatry, Pulmonary, Orthopedic, Laboratory Testing, Young Adult Sexual Health Services, Psychiatry and Mental Health Therapy. Washington County's CHNA Action Plan verified that

CFC was on the right path when the Community Mental Health Care was created to expand on our mental health services to meet the growing needs of our community.

Family Healthcare of Hagerstown

Family Healthcare of Hagerstown is a Federally Qualified Health Center that provides medical care, mental health services, dental care and support services to 7,850 residents of Washington County. Guided by its mission, FHH strives to promote a healthy community by providing affordable, accessible, and compassionate healthcare to families and individuals of all ages, races and economic backgrounds regardless of ability to pay. As in years past, FHH is pleased to support the Community Health Needs Assessment process; it has proven invaluable in helping FHH understand the needs of the community, identify deficits in local community resources that affect the patient population, and leverage resources to meet needs. For instance, per the Community Health Needs Assessment, obesity, diabetes, and hypertension continue to be top health priorities and the patient population certainly reflects this. Nearly 1 in 3 patients are Diabetic and 2 in 3 patients are Hypertensive. FHH has responded by providing increased staffing and free educational groups to support better patient outcomes.

Hospice of Washington County (HWC)

Hospice of Washington County provides end of life care for those who are seeking comfort care. This organization is the only licensed hospice in Washington County and has been serving this community for 39 years. The services include physician care, nursing care, nursing aide care, social work and spiritual care. Patients are provided services wherever they live – at home, in an assisted living, in a nursing home, or in a group home. Hospice services are a fully paid benefit for Medicare and Medicaid patients; it is also a covered benefit of most commercial insurances. The services include four levels of care as a patient demonstrates a need for a change in care; the four levels of care are routine home care, respite care, continuous care, and general inpatient care; the respite care and general inpatient care are usually taken care of in the general inpatient unit know as Doey's House, the only hospice house in Washington County. Please call 301-791-6360 to learn more about Hospice of Washington County and how we can support your and your family.

LifeCare of Washington County (LCWC)

As a subdivision of the services provided by Hospice of Washington County, LifeCare is the palliative care service known as LifeCare of Washington County. LifeCare began in 2015 when the hospice team recognized the need for our expertise in pain and symptom management for

patients who are **not** terminally ill. The practice is a nurse-practitioner run practice who works closely with a patient's primary care physician and other specialists to make sure the patient is being treated for any symptoms that are interfering with the patient's quality of life. The Nurse Practitioner is able to coordinate care, work on symptoms to improve quality of life, and has the time to help a patient and family work through areas of care that are difficult. The nurse practitioner will be able to help a patient access the help that is in the community. Any patient who has a chronic illness or a serious illness that is becoming difficult to manage would benefit from these services. To learn more about LifeCare of Washington County, please call 301-671-2171.

Meritus Community Health Education and Outreach

Based on the Community Health Needs Assessment, the Community Health Education and Outreach Program will plan, implement and evaluate effective programs, act as health education resources, and advocate for health and wellness within targeted populations. Our ultimate goal is that persons that attend the planned programs will make voluntary changes in their health behavior that will positively impact their wellness. As a program, we believe that good health is based upon knowledge and its promotion thereof. We aim to address our community's health needs by focusing on the goals of strengthening a person's skills and capabilities (self-management, self- actualization, and empowerment) as well as supporting environmental, regulatory and organizational mechanisms that support healthy living.

Strategies to help meet our goals include community organization and building so that together we will motivate individuals and families towards making the changes necessary to live healthier lives. Education classes, health fairs and events will be offered throughout the county, in collaboration with other community organizations. Some direct partners include Walmart, Walgreens, Pepsico, Martins, Kelloggs, Danone, General Mills, Colgate-Palmolive, Mondelez, Barilla, Johnson & Johnson, Nestle, AARP, YMCA Hagerstown, Washington County Health Department, Washington County Chamber of Commerce, the City of Hagerstown Parks and Recreation, Community Free Clinic, Washington County Commission On Aging, Zion Baptist Church, area farmers, and Meritus Health are a few of the stakeholders in this endeavor to improve the health of people living in Washington County. Together, we aim to increase participation rates in health-related community-based activities; develop an effective communications outreach tool to connect citizens to healthy community resources; Increase access to healthier choices available to consumers and improve the built environment by the development of additional physical activity resources by focusing on 4 pillars of Wellness: Healthy Nutrition; Medication Adherence; Smoking Cessation and Physical Activity. Evaluation of outcomes will be an ongoing process so that adaptations can be made as needed.

The Mental Health Center

The Mental Health Center of Western Maryland, Inc. (MHC) is a CARF accredited private not-for-profit community mental health center providing comprehensive psychiatric outpatient, rehabilitative and mobile treatment services to children, adolescents, adults, and their families. The Mental Health Center's Board of Directors is fully supportive of the goals established by the Washington County's Community Health Needs Assessment (CHNA).

All programs have enhanced services in response to the priority community needs identified in the Washington County CHNA. Recently the Center was awarded a grant from the Washington County Public Schools (WCPS) to provide school-based mental health services on an as needed basis for elementary students throughout WCPS. This grant is intended to provide therapy for children struggling with emotional and behavioral issues and reduce the stigma of seeking mental health treatment.

MHC's Outpatient Program has established "open-access" services that allow patients to obtain initial evaluations on a walk-in basis. Our team of psychiatric prescribers and nurses collaborate extensively with primary care physicians and other medical specialists to provide comprehensive medical services to our patients. Nurses serve as educators for patients regarding medications and how to incorporate healthier lifestyle choices.

MHC's Psychiatric Rehabilitation Program (PRP) for Minors has enhanced the parenting education component of the program to better serve families with poor coping skills, under distress from poverty and mental illness. The Adult PRP program has expanded to included home visits as an option to serve adults struggling with access to services. PRP provides education and life skill building opportunities to help participants prevent and manage chronic health conditions. In addition, through a staff initiative, an effort to revitalize a Washington County Chapter of the National Alliance on Mental Illness (NAMI) has begun.

MHC's Mobile Treatment Program has developed new groups to help participants gain support from each other, learn effective ways to manage mental illness, and deal with chronic health conditions through developing healthier lifestyle habits.

One for Good

One for Good is a partnership between Healthy Washington County and the Consumer Goods Forum's Collaboration for Healthier lives. The partnership brings together retailers, manufacturers, and public health organizations to support wellness, a Healthy Washington

County priority, through the empowerment of citizens to make healthier choices. One for Good promotes four enablers of wellness: healthier food choices, exercise, smoking cessation and medication adherence. A combination of regular programming at local retail stores and community-led programs offer health screenings, pharmacist consultations, nutrition store tours, cooking demonstrations and classes, and healthier product promotions. The initiative is supported by the following organizations and companies: AARP, Alhold Delhaize, Barilla, Campbell Soup Company, Colgate-Palmolive, Danone NA, EnsembleIQ, General Mills, Healthy Washington County, Hagerstown-Washington County Chamber of Commerce, Johnson & Johnson, Kellogg Company, Martin's, Merck, Meritus Health, Nestlé, Numerator, Oliver Wyman, US Chamber of Commerce Foundation, PepsiCo, Walgreens Boots Alliance, Walmart, Washington County Health Department and the YMCA Hagerstown.

Washington County Public Schools

Obesity and weight loss/Diabetes/Healthy lifestyles and nutrition/Heart disease and hypertension

- Schools' school improvement plans include that all students will be healthy, informed and productive citizens
- WCPS updated the wellness policy and has both a student wellness committee and employee wellness committee
- Wellness programs and champions are encouraged at each school for students and staff
- WCPS is meeting /exceeding benchmarks for meals for the percent of fat and sodium in foods served
- The nutritional content of student meal items is on the website-called Nutrislice (ex-calories, carbs, sugar, sodium)
- Breakfast is available in all schools except Barbara Ingram-this will be implemented when new building is completed
- More than half of our schools offer free breakfast
- Schools offers a share table of food at breakfast and lunch
- We have several school food pantries, mica's backpack program and the summer food mobile program offering healthy food options to students
- New schools (Barbara Ingram and Sharpsburg) will trial unlimited fruit and vegetable bar
- Students participate in physical education and have opportunities to participate in school sports/clubs
- 3 school based health centers for students to receive additional services beyond scope of health room services
- WCPS offers an employee health and wellness fair
- Wellness activities are offered to staff such as heated massages, mindfulness, exercise classes, weight watchers, healthy food samplers with recipes, sponsors walks/runs

Mental Health

- EAP (employee assistance program) available for staff
- SAP (student assistance program) available for students
- Handle With Care program implemented for students
- WCPS has a crisis team available to staff and students
- School counselors are in every school; some schools also have a social worker; proposed budget increases positions
- Mental Health First Aid training, trauma training, Applied Suicide Intervention Skills training, Safe Talks-Suicide Alert classes are offered for staff
- Brooklane is contracted and provides 6 hours/week of free mental health triage service by license social workers at every secondary school and 4 elementary schools through the local management board
- We have contract's with mental health providers that come in to the schools to see students
- Received grant offering 10 free counseling sessions to all schools through Villa Marie, San Mar and Mental Health Authority
- Classroom presentations/curriculum by counselors/teachers on topics such as bullying, suicide, stress reduction
- Schools have presentations/speakers/assemblies on mental health issues, such as stigma, anxiety and depression, and mental health fair
- Student government had presenter/panel on mental health
- Schools participate in mental health awareness week
- Middle and High School student participation in Maryland Youth Risk Behavior Survey

Substance Abuse

- WCPS has a mental health committee and mental health coordinator
- Schools have presentations/speakers/assemblies, such as MD Heroin Awareness Advocates
- Participation on county overdose review fatality team
- Participate in Washington Goes Purple
- Stock Naloxone in every school, staff trained
- Opioid grant for opioid awareness, training, and naloxone

Tri-State Community Health Center

Tri-State Community Health Center is a Federally Qualified Health Center serving almost 20,000 residents at five primary care sites in Hancock and Cumberland, MD; Berkeley Springs, WV; McConnellsburg, PA, and a Women's OB/GYN Health Center in Cumberland, MD. Tri-State provides quality, affordable, patient-centered comprehensive health care and prevention services; patient education; disease/chronic disease management for everyone regardless of their ability to pay. To assure that everyone receives the holistic services they need, Tri-State

provides enhancement services including case management and care navigation, a Medication Assistance Program, and a 340B lower cost Pharmacy Program. 70% of Tri-State's community-based Board of Directors are patients which assures strong community-orientation in the four communities served.

Tri-State is already focused on patients with the concerns identified by the Washington County CHNA. Performance outcome measures for those concerns are reported annually to the Health Resources and Services Administration, U.S. Department of Health and Human Services. Tri-State provides a Living Well Program and refers patients to pre-diabetes and diabetes education programs and other needed community programs. To improve the health of our patients and Washington County residents, Tri-State collaborates with Washington County providers to enhance prevention and patient engagement efforts, to coordinate patient care among the continuum of providers, to collect and share data, and to share best practices and resources. For further information, please contact Susan Walter, MSW, CEO, at swalter@tschc.com.

United Way of Washington County

United Way of Washington County will use this report as another tool that helps us determine if we are appropriately funding local programs that are tackling pressing community issues. We begin with our funding strategies that are formulated with data, and input from multiple community members, businesses and nonprofit organizations. Data is very important to us and is used to set our goals that help us meet our mission: "United Way of Washington County inspire collaborations to impact community improvement. To do this, we function as a rallying point for attracting and fostering leadership to advance collective action."

Others:

Brook Lane Health Services

Meritus Medical Center

Washington County Health Department

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin addiction	Meritus Community Health
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line
		Decrease number of opioid prescriptions by 25%	Determine data	TBD	TBD	TBD	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line
							Support county-wide effort to obtain funding for a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach
		Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health
		Children self-report an increase in physical activity and a decrease in screen time by a minimum of 50% each year	Determine data	50% or <	50% or <	50% or <	Partner with area organizations to promote and participate in physical activity events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of the population that report food insecurity by 5%	2018 12% MD BRFSS	10%	9%	7%	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health
Wellness #4	Improve health-related quality of life and well-being for all	Medicare annual wellness visits at rate of > 90% to beneficiaries	10%	25%	50%	75%	Provide an annual Medicare Annual Wellness Visit to each eligible Medicare beneficiary	Outpatient RN Care Managers to begin completing Medicare AWVs in MMG Primary Care Offices in 2019, transitioning the AWV to MMG office teams over the next year.	ACO, CTO, MPA
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept.**, Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Diabetes #5	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2%	10.7 per 100 adults MD Vital Stats 2015	10%	9.4%	8.7%	Make the evidenced-based Diabetes Prevention Program widely available in Washington County	Partner with the local **Dept. of Healt**h to provide diabetes prevention program and **community providers** and **pharmacists** to identify at-risk patients	Meritus Community Health
		Decrease the diabetes mortality rate by 2% over three years	35.9 per 100,000 MD Vital Stats 2016	< 35.7	< 35.5	< 35.2	Increase availability of diabetes education and support to primary care practices	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO
		Reduce # of ED visits for diabetes by 5%	FY18 778 visits Meritus	< 764	< 752	< 739	Provide diabetes education, dietary counseling and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	Partner with the **Hagerstown Parks & Rec, the Health Dept and the Senior Center** to provide Living Well and outreach services	Meritus Community Health
		ACO measure: 90% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%.	Determine data			90% pts HbA1c < 9 %	Provide individualized Diabetes Education and 1:1 Self-Management support to high risk patients to improve disease control and decrease unnecessary hospital utilization.	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO
Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1%	194 per 100,000 MD Vital Stats 2016	193	192	< 192	Provide community and employer health education events to increase heart health awareness	Partner with the **Health Department, Meritus Cardiac Services** to promote healthy lifestyle education and evironments	Meritus Community Health
		Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months	2%	10%	20%	25%	Provide evidence-based smoking cessation program to teens and adults	Partner with the **Meritus School Health** and **Health Department** to provide smoking cessation programs and support	Meritus Community Health
		Decrease the # of ED visits for hypertension by 5%	FY18 375 visits Meritus	368	362	< 356	Provide heart health screening and educational interventions at the community level	Partner with **local churches** to provide blood pressure screening and education	Meritus Parish Nursing Program
							Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	Partner with **Zion Baptist, Wash. Co. Parks and Rec** and the **Senior Center** in the provision of screenings and cardiac health education to their populations	Meritus Community Health
		ACO Measure: 90% of patients age 18-75 with a diagnosis of HTN will have a BP < 140/90.	Determine data			90% pts BP 140/90 or <	Provide individualized hypertension education and 1:1 self-management support to improve blood pressure control	Utilize Meritus outpatient care managers to provide education, discharge follow up, transition of care, and chronic disease management services	MPA, ACO, CTO
Cancer #7	Reduce the mortality of cancer cases and improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10%	475	459	443	428	Earlier detection of lung cancer	Low dose CT screening, Physician education, Utilize EHR reminders	Oncology Service Line
		Increase 5 yr. survival rates for head and neck cancer diagnosis by 5%	Stage 3 65% Stage 4 28%			Stage 3 70% Stage 4 33%	Improve coordination of care for head & neck cancer patients	Create head & neck dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator
		Reduce Stage III & IV diagnosis of colon cancer by 10%	136	132	126	122	Earlier detection of colon cancer	Increase colonoscopy screening awareness, provide physician education, utilize EHR reminders	Oncology Service Line
		Increase 5 yr. survival rates for colon cancer by 5%	Stage 3 59% Stage 4 10%			Stage 3 64% Stage 4 15%	Improve coordination of care for colon patients	Create colon dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
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HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin addiction	Meritus Community Health
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line
		Decrease number of opioid prescriptions by 25%	Determine data	TBD	TBD	TBD	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line
							Support county-wide effort to fund and operationalize a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO

Community Health Needs Assessment
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HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach
		Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health
		Children self-report an increase in physical activity and a decrease in screen time by a minimum of 50% each year	Determine data	50% or <	50% or <	50% or <	Partner with area organizations to promote and participate in physical activity events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of the population that report food insecurity by 5%	2018 12% MD BRFSS	10%	9%	7%	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health
Wellness #4	Improve health-related quality of life and well-being for all	Medicare annual wellness visits at rate of > 90% to beneficiaries	10%	25%	50%	75%	Provide an annual Medicare Annual Wellness Visit to each eligible Medicare beneficiary	Outpatient RN Care Managers to begin completing Medicare AWVs in MMG Primary Care Offices in 2019, transitioning the AWV to MMG office teams over the next year.	ACO, CTO, MPA
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept.**, Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program

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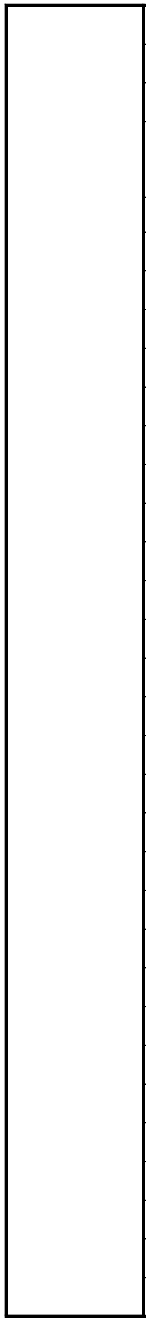
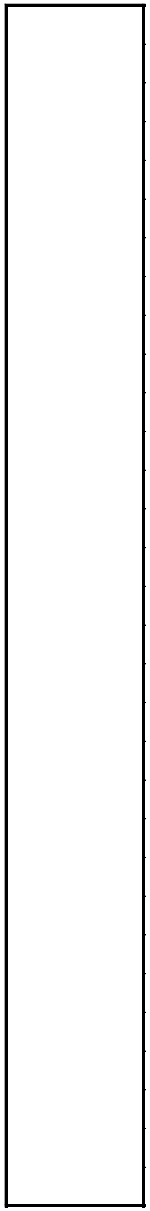
Community Health Needs Assessment
Brook Lane Action Plan FY2020 - FY2022

Health Need	Objective	Goal	Strategies	Tactics
Substance Abuse #1	Lessen substance abuse to safeguard the health, safety and welfare of all	Grow the InSTEP Program to provide more treatment services	Monitor volumes of service	Track numbers of individuals assessed for treatment Track numbers of individuals that completed treatment
		Increase community education on substance abuse	Offer professional continuing education	Hold at least two seminars related to substance abuse
			Increase referrals of family members to the Concerned Persons Group	Track referral numbers to the group
			Offer community programs related to substance abuse	Provide two community pro-grams on substance abuse
			Support/partner with community agencies and programs to provide education on prevention and treatment	Particpate in six health or resource fairs Partner/promote Washington Goes Purple Attend and participate in the Local Addiction Authority Provider Council Meetings Collaborate with Healthy Washington County

Health Need	Objective	Goal	Strategies	Tactics
Mental Health #2	Improve mental health through prevention, early intervention and education	Hold eight Mental Health First Aid trainings annually	Provide quarterly Mental Health First Aid trainings (Youth and Adult) to decrease stigma, promote education and increase awareness	Train 120 individuals each year in Mental Health First Aid
		Screen 400 people in the community for depression annually	Utilize the PHQ-9 self depression screening tool	Distribute the PHQ-9 at health fair events Keep the Screening tool available on our website
			Organize a community depression screening event	Hold a screening event for the public to educate and provide resource information
		Hold four community education events per year focused on mental health	Provide four free community programs for the public by 6/30/2020	Schedule programs for spring and fall
		Provide professional continuing education seminars	Hold ten professional seminars annually	Plan programs on a regular basis
		Collaborate with community groups and organizations	Support/partner with community agencies and programs to provide education on prevention and treatment	Particpate in six health or resource fairs Collaborate with Healthy Washington County





Community Health Needs Assessment
Brook Lane Action Plan FY2020 - FY2022

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