



Behavioral Health Barometer

United States, Volume 4

Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services



Substance Abuse and Mental Health Services Administration

SAMHSA

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Acknowledgments

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FOREWORD



The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA is pursuing this mission at a time of significant change.

The *Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services*, is one of a series of national and state reports that provide a snapshot of behavioral health in the United States. The reports present a set of substance use and mental health indicators as measured through the National Survey on Drug Use and Health (NSDUH) and the National Survey of Substance Abuse Treatment Services (N-SSATS), sponsored by SAMHSA. This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking change and trends over time. Because of the partial redesign of the 2015 NSDUH (the source of much of the data included in this report), it is not possible to compare certain measures based on 2015 NSDUH data with the corresponding measures using prior years of NSDUH data. These measures include any illicit drug use, misuse of prescription drugs, perceived risk from substance use, binge and heavy alcohol use, and substance use treatment among those with a substance use disorder (for more information, please see <https://www.samhsa.gov/data/sites/default/files/NSDUH-TrendBreak-2015.pdf>). The 2015 report does include data on the misuse of specific types of prescription pain relievers in the past year and the main reasons given for misuse of prescription pain relievers, data that were first available in NSDUH in 2015. This report also includes single-day counts of the number of people in substance use treatment from N-SSATS. These data are included in N-SSATS every other year and thus were not available for last year's report. The Behavioral Health Barometers provide critical information in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities.

Behavioral Health Barometers for the nation and for all 50 states and the District of Columbia* are published as part of SAMHSA's larger behavioral health quality improvement approach.

Kana Enomoto, MA, Acting Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration

INTRODUCTION



Purpose of this Report. *Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services* provides an annual update on a series of topics that focus on substance use and mental health (collectively referred to as *behavioral health*) in the United States. SAMHSA selected specific topics and indicators in this report to represent a cross-section of the key behavioral health indicators that are assessed in SAMHSA surveys, including NSDUH and N-SSATS. This report is intended to provide a concise, reader-friendly summary of key behavioral health measures for a wide variety of lay and professional audiences. The graphics and text include data on the nation as a whole and for subgroups based on demographics (age, gender, and race/ethnicity) and other factors (poverty status, health insurance status, and metropolitan statistical area status).

Organization of this Report. This report is divided into sections based on content areas and age groups. It begins with sections on substance use, mental health, and mental health treatment among youths aged 12 to 17, followed by a section on mental health and mental health service use among adults aged 18 or older. Next are sections on substance use, misuse, use disorders, and treatment among youths and adults.

Figure titles are included above all graphics, including callouts for figure notes that are included on pages 21–22. These figure notes include additional information about the measures, populations, and analyses presented in the graphics and text. Definitions of key measures and terms included in the report are presented on pages 23–25.

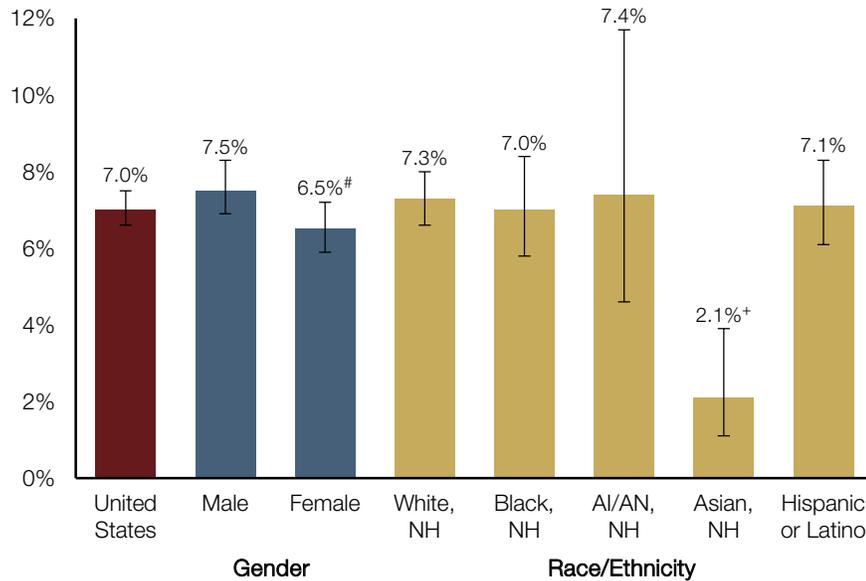
Methodological Information. Statistical tests (t-tests) have been conducted for all statements appearing in the text of the report based on NSDUH data that compare estimates between years or population subgroups. Unless explicitly stated that a difference is not statistically significant, all statements based on NSDUH data that describe differences are significant at the .05 level. Standard NSDUH suppression rules have been applied for all NSDUH estimates in this report. Pages 17 and 19 present N-SSATS data, and because N-SSATS provides counts of people enrolled at all treatment facilities (as opposed to providing estimates based on a sample of treatment facilities), conducting significance tests is not necessary.

Tables that display all data points included in this report, including tests of statistical significance and standard errors, are available by request. To request these tables or to ask any questions regarding how to use or interpret the data included in this report, please contact CBHSQRequest@samhsa.hhs.gov.

YOUTH SUBSTANCE USE MARIJUANA USE



Past Month Marijuana Use Among Adolescents Aged 12–17 in the United States, by Gender and Race/Ethnicity (2015)¹



7.0%

In 2015, 7.0% of adolescents aged 12–17 in the United States (an estimated 1.8 million adolescents) used marijuana in the past month.

In 2015, the percentage of past month marijuana use among adolescents aged 12–17 in the United States was lower for female adolescents than for male adolescents. This percentage was lower than the national average for Asian adolescents. There were no statistically significant differences in adolescent past month marijuana use by poverty status, health insurance status, or metropolitan versus nonmetropolitan areas.

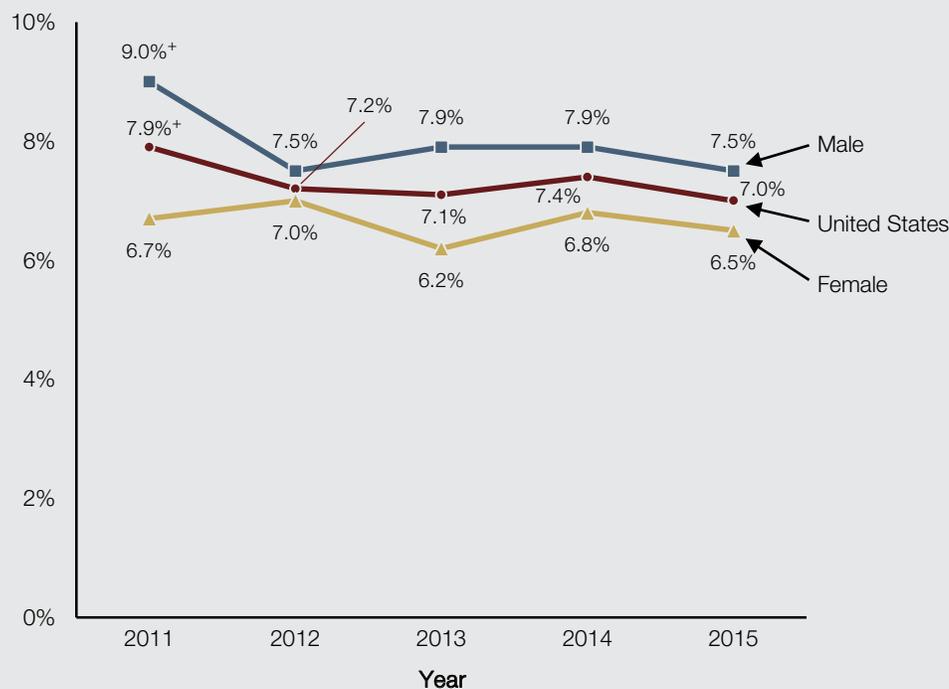
AI/AN = American Indian or Alaska Native; NH = non-Hispanic.

[#] Estimate is significantly different from the estimate for males ($p < .05$).

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Month Marijuana Use Among Adolescents Aged 12–17 in the United States, by Gender (2011–2015)



The percentage of adolescents aged 12–17 who used marijuana in the past month was lower in 2015 (7.0%) than in 2011 (7.9%). This percentage was lower in 2015 than in 2011 for males but not for females.

⁺ Estimate is significantly different from the estimate in 2015 ($p < .05$).

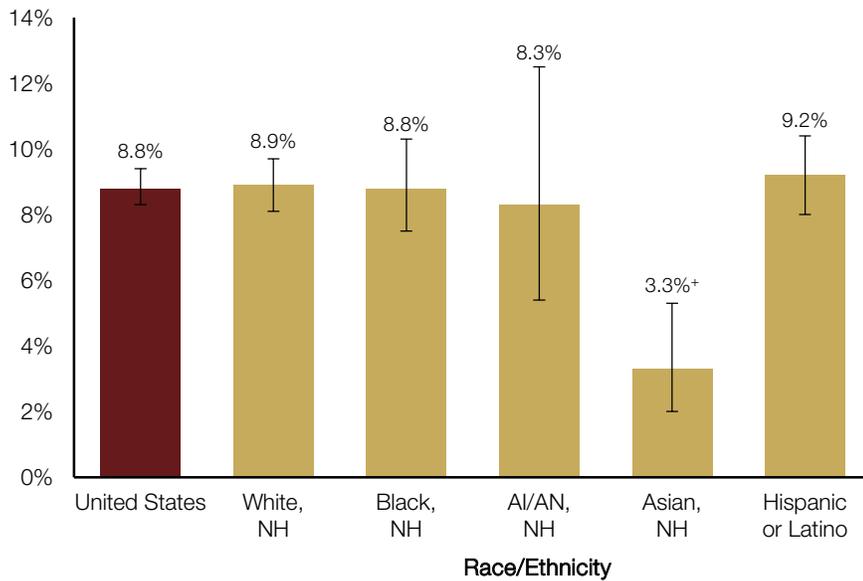
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

YOUTH SUBSTANCE USE

ILLCIT DRUG USE



Past Month Illicit Drug Use Among Adolescents Aged 12–17 in the United States, by Race/Ethnicity (2015)¹



8.8%

In 2015, 8.8% of adolescents aged 12–17 in the United States (an estimated 2.2 million adolescents) used illicit drugs in the past month.

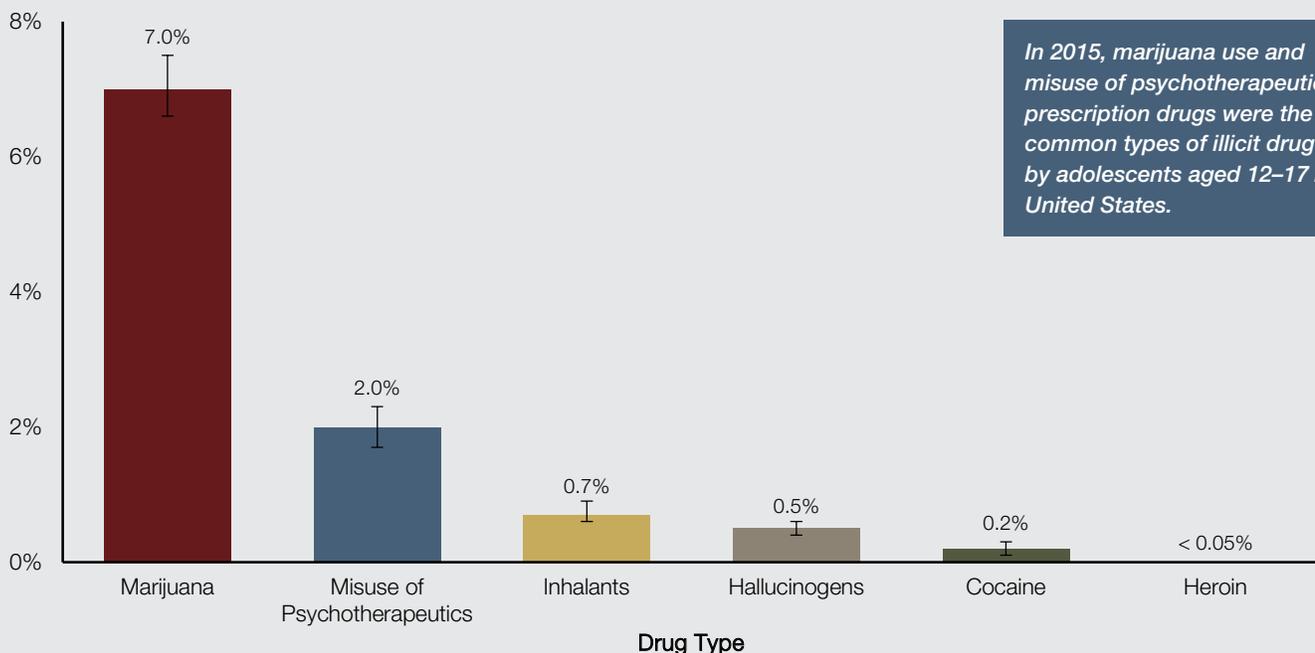
In 2015, the percentage of adolescents aged 12–17 in the United States who used illicit drugs in the past month was lower than the national average for Asian adolescents.

AI/AN = American Indian or Alaska Native; NH = non-Hispanic.

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Month Illicit Drug Use Among Adolescents Aged 12–17 in the United States, by Drug Type (2015)²



In 2015, marijuana use and misuse of psychotherapeutic prescription drugs were the most common types of illicit drug use by adolescents aged 12–17 in the United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

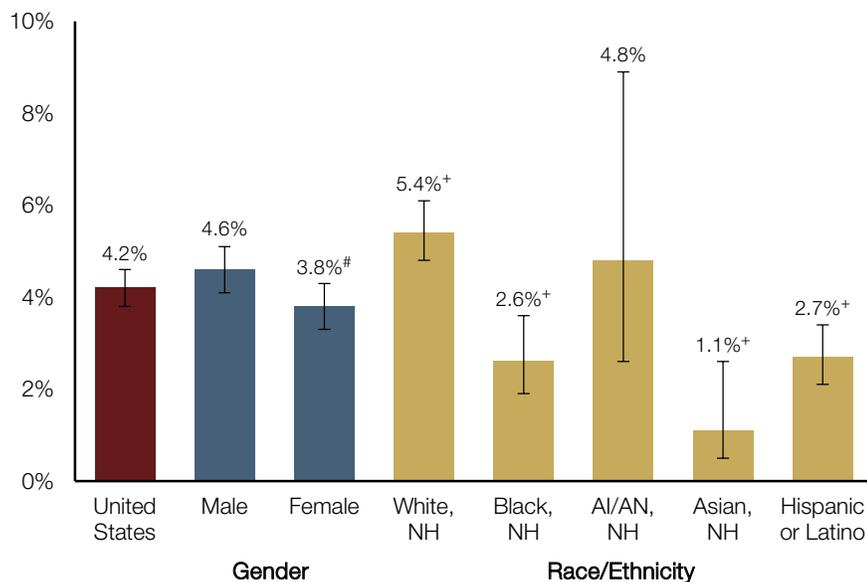
Because of changes to the 2015 NSDUH, estimates from 2015 of any illicit drug use, misuse of psychotherapeutics, inhalant use, and hallucinogen use included on this page cannot be compared with estimates from previous years.

YOUTH SUBSTANCE USE

CIGARETTE USE



Past Month Cigarette Use Among Adolescents Aged 12–17 in the United States, by Gender and Race/Ethnicity (2015)¹



4.2%

In 2015, 4.2% of adolescents aged 12–17 in the United States (an estimated 1.0 million adolescents) used cigarettes in the past month.

In 2015, the percentage of past month cigarette use among adolescents aged 12–17 in the United States was lower for female adolescents than for male adolescents. This percentage was higher than the national average for White adolescents and was lower than the national average for Black adolescents, Asian adolescents, and Hispanic or Latino adolescents.

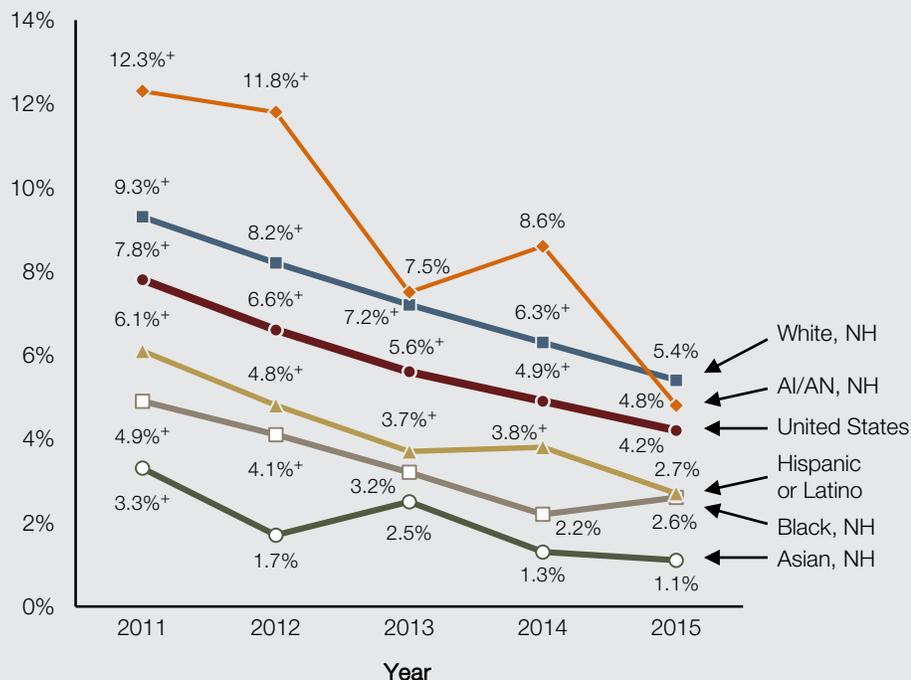
AI/AN = American Indian or Alaska Native; NH = non-Hispanic.

[#] Estimate is significantly different from the estimate for males ($p < .05$).

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Month Cigarette Use Among Adolescents Aged 12–17 in the United States, by Race/Ethnicity (2011–2015)¹



From 2011 to 2015, the percentage of past month cigarette use among adolescents aged 12–17 in the United States decreased from 7.8% to 4.2%. This percentage was lower in 2015 than in 2011 for each racial/ethnic group.

In 2015, the percentage of past month cigarette use among adolescents aged 12–17 in the United States was higher among those living in nonmetropolitan areas (7.3%) than among those living in metropolitan areas (3.7%). There were no statistically significant differences in adolescent past month cigarette use by health insurance status or poverty status.

AI/AN = American Indian or Alaska Native; NH = non-Hispanic.

⁺ Estimate is significantly different from the estimate in 2015 ($p < .05$).

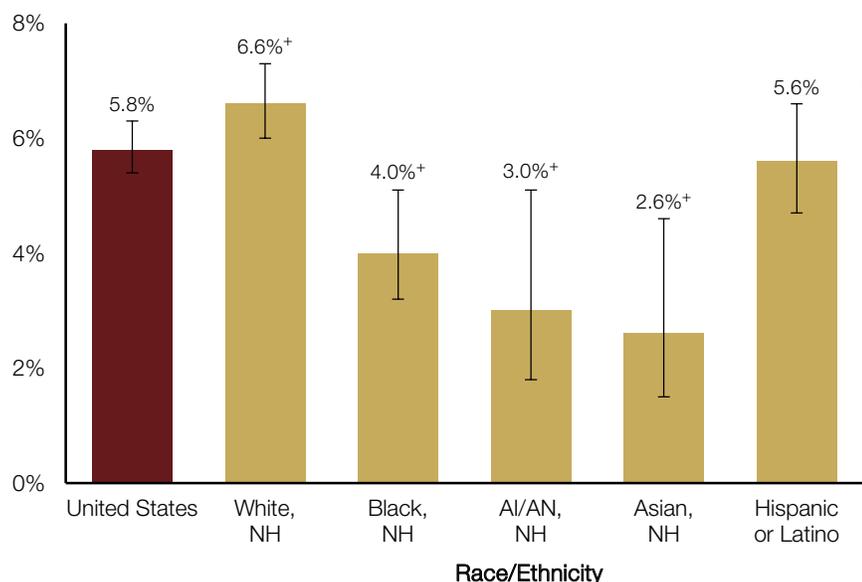
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

YOUTH SUBSTANCE USE

BINGE ALCOHOL USE



Past Month Binge Alcohol Use Among Adolescents Aged 12–17 in the United States, by Race/Ethnicity (2015)¹



5.8%

In 2015, 5.8% of adolescents aged 12–17 in the United States (an estimated 1.4 million adolescents) engaged in binge alcohol use in the past month.

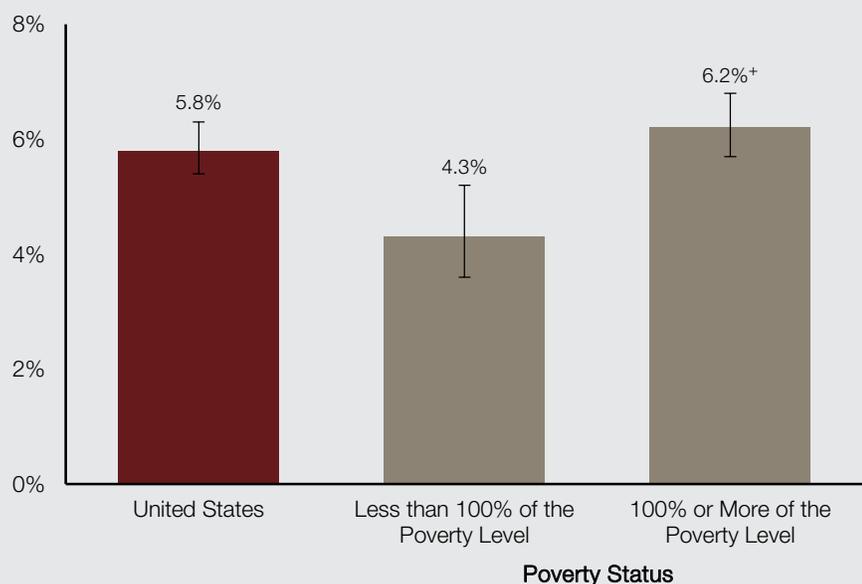
In 2015, the percentage of adolescents who engaged in past month binge alcohol use was higher than the national average for White adolescents and was lower than the national average for Black adolescents, American Indian or Alaska Native adolescents, and Asian adolescents.

AI/AN = American Indian or Alaska Native; NH = non-Hispanic.

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Month Binge Alcohol Use Among Adolescents Aged 12–17 in the United States, by Poverty Status (2015)³



In 2015, the percentage of past month binge alcohol use among adolescents aged 12–17 in the United States was higher for those living in households whose income was 100% or more of the poverty level than for those living in households whose income was less than 100% of the poverty level.

⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).

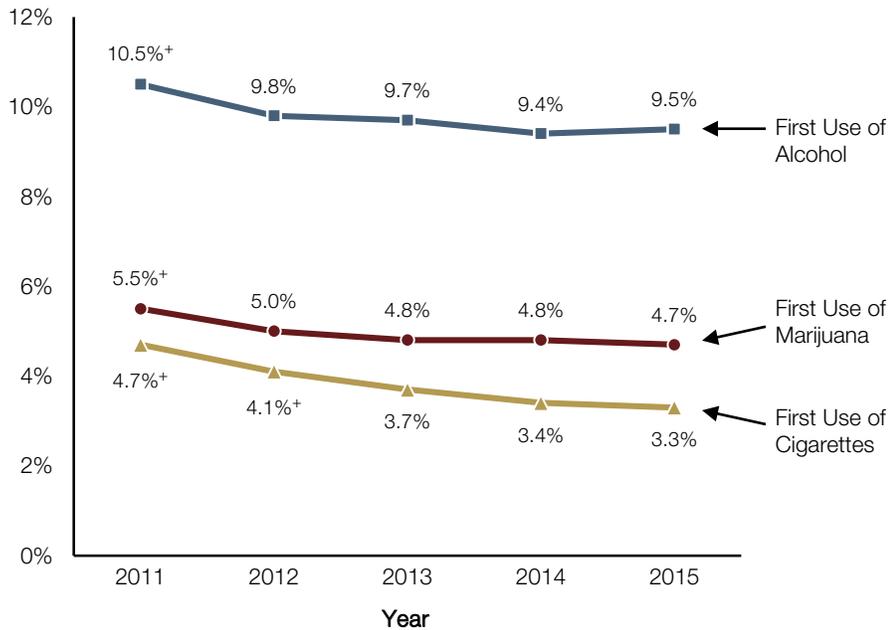
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

YOUTH SUBSTANCE USE

INITIATION OF SUBSTANCE USE



Past Year Initiation (First Use) of Selected Substances Among Adolescents Aged 12–17 in the United States (2011–2015)

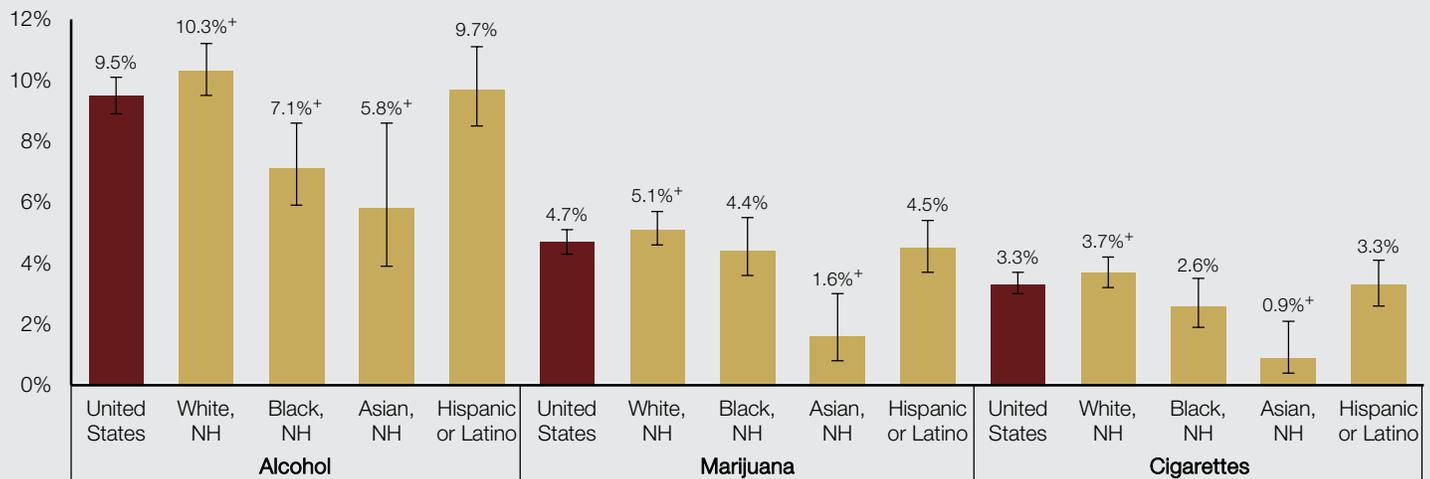


In the United States, the percentage of adolescents aged 12–17 who initiated alcohol use, the percentage of adolescents aged 12–17 who initiated marijuana use, and the percentage of adolescents aged 12–17 who initiated cigarette use (i.e., used the substance for the first time in the past year) were all lower in 2015 than the percentages in 2011. In 2015, nearly 1 in 10 adolescents (9.5%) used alcohol for the first time in the past year.

⁺ Estimate is significantly different from the estimate in 2015 ($p < .05$).
 Because of changes to the 2015 NSDUH, estimates from 2015 of the initiation of misuse of psychotherapeutics cannot be compared with estimates from previous years and thus are not included in this figure.
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

Past Year Initiation (First Use) of Selected Substances Among Adolescents Aged 12–17 in the United States, by Race/Ethnicity (2015)⁴

In 2015, the percentage of White adolescents aged 12–17 in the United States who initiated alcohol use, marijuana use, or cigarette use in the past year was higher than the national average, and the percentage of Asian adolescents who initiated alcohol use, marijuana use, or cigarette use was lower than the national average. The percentage of Black adolescents aged 12–17 who initiated alcohol use in the past year was also lower than the national average.



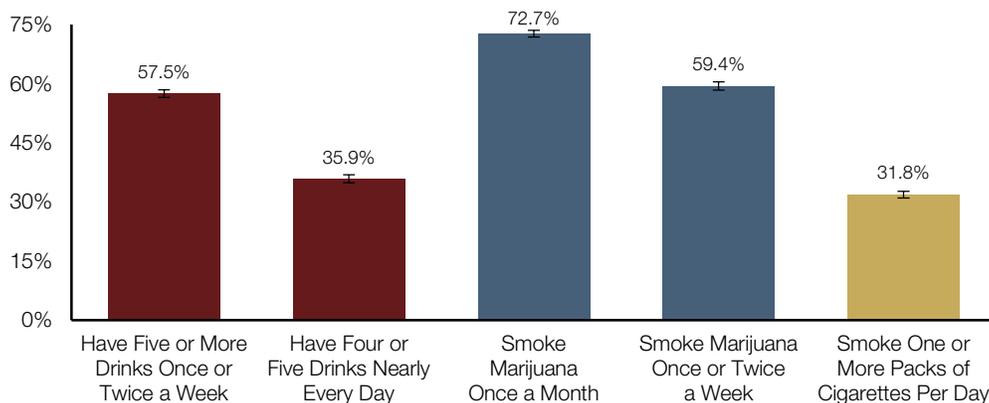
NH = non-Hispanic.
⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

YOUTH SUBSTANCE USE RISK PERCEPTIONS



Adolescents Aged 12–17 in the United States Who Did Not Perceive Great Risk of Harm from the Use of Selected Substances (2015)⁵



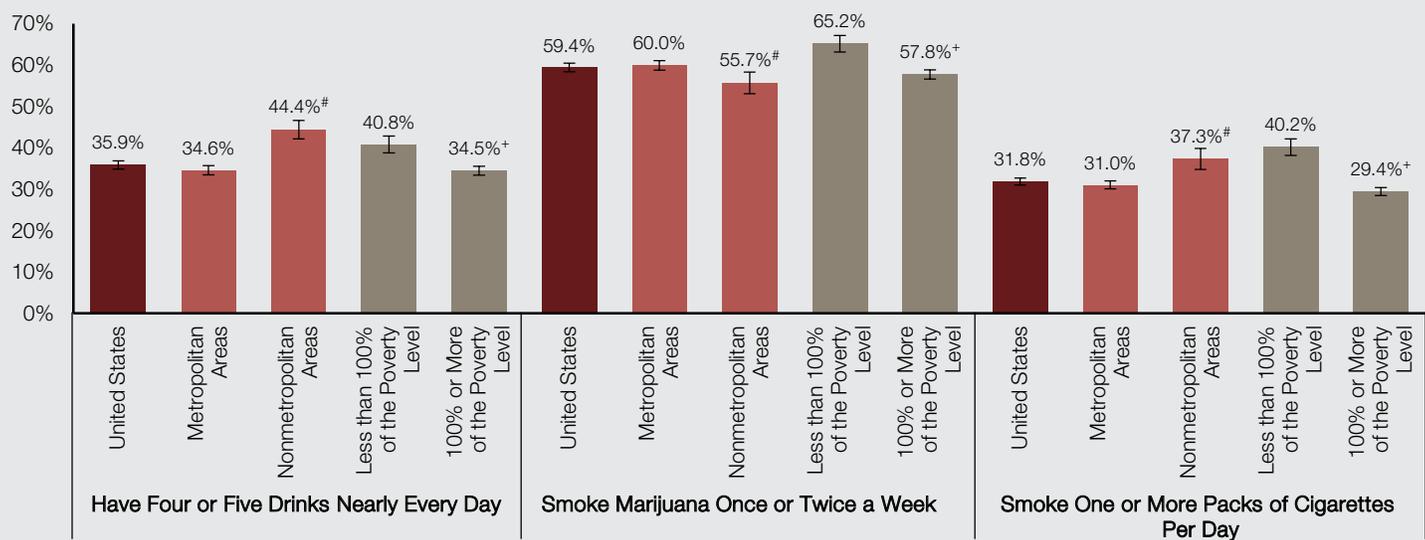
In 2015, a majority of adolescents aged 12–17 in the United States did not perceive great risk of harm to themselves physically and in other ways from monthly or weekly marijuana use or from having five or more drinks once or twice a week. In 2015, about one in three adolescents did not perceive great risk of harm from smoking one or more packs of cigarettes per day or from having four or five drinks nearly every day.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Adolescents Aged 12–17 in the United States Who Did Not Perceive Great Risk of Harm from the Use of Selected Substances, by County Type and Poverty Status (2015)^{3,5,6}

Compared with adolescents living in nonmetropolitan areas, a lower percentage of adolescents living in metropolitan areas did not perceive great risk of harm to themselves physically and in other ways from having four or five drinks nearly every day or from smoking one or more packs of cigarettes per day. Compared with adolescents living in nonmetropolitan areas, a higher percentage of adolescents living in metropolitan areas did not perceive great risk from smoking marijuana once or twice a week.

Compared with adolescents living in households whose income was 100% or more of the poverty level, a higher percentage of adolescents living in households whose income was less than 100% of the poverty level did not perceive great risk from having four or five drinks nearly every day, smoking marijuana once or twice a week, or smoking one or more packs of cigarettes per day.



[#] Estimate is significantly different from the estimate for Metropolitan Areas ($p < .05$).

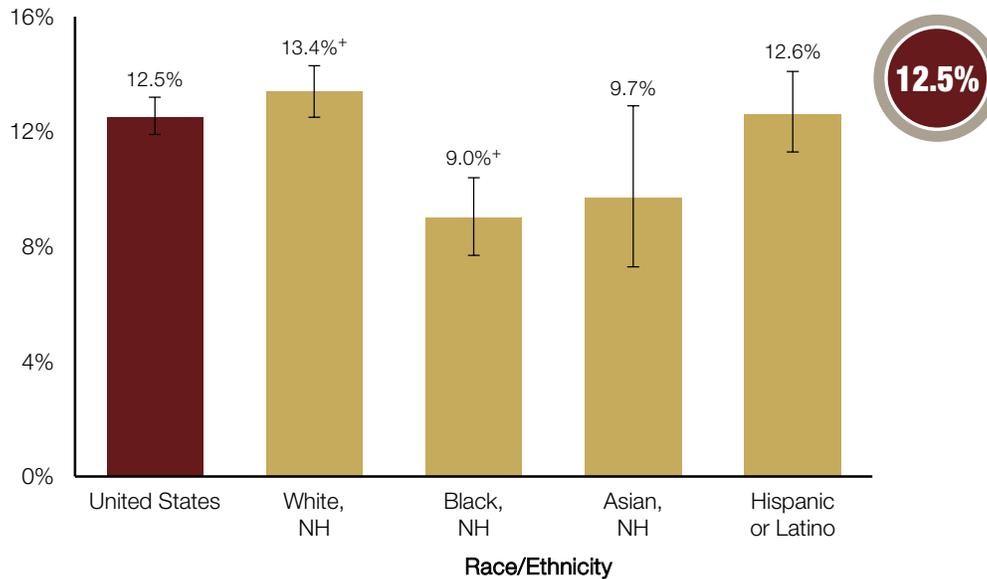
⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

YOUTH MENTAL HEALTH AND SERVICE USE DEPRESSION



Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in the United States, by Race/Ethnicity (2015)^{4,7}



In 2015, 12.5% of adolescents aged 12–17 in the United States (an estimated 3.0 million adolescents) had at least one major depressive episode (MDE) in the past year. This percentage was higher than the national average for White adolescents and was lower than the national average for Black adolescents.

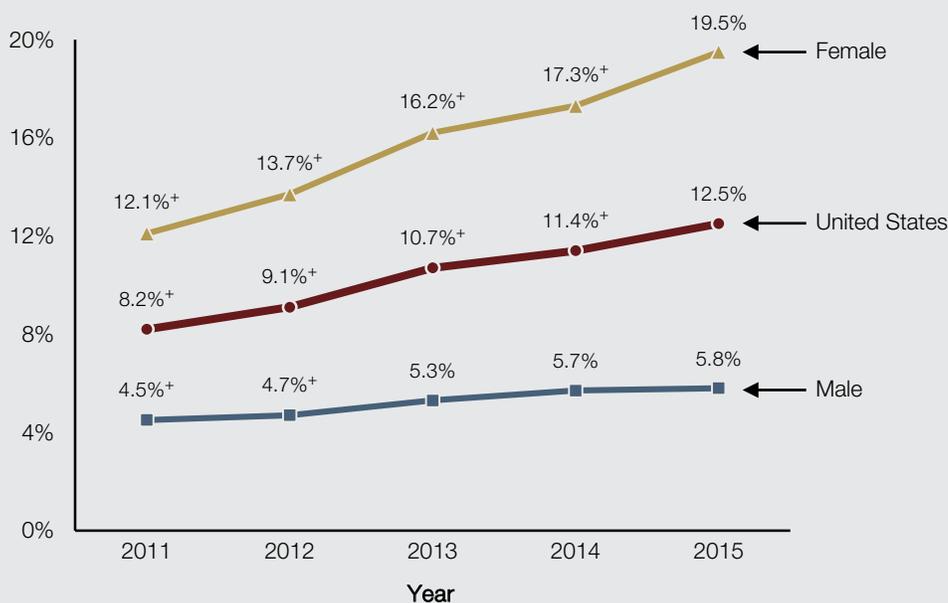
In 2015, the percentage of MDE among adolescents aged 12–17 in the United States was about 3 times higher for female adolescents (19.5%) than for male adolescents (5.8%). Nearly one in five adolescent females had an MDE in the past year.

NH = non-Hispanic.

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in the United States, by Gender (2011–2015)⁷



In 2015, the percentage of MDE among female adolescents aged 12–17 in the United States was higher than the percentage in any year from 2011 to 2014. The percentage of MDE among male adolescents in 2015 was higher than the percentages in 2011 and 2012 but was not significantly different from the percentages in 2013 and 2014.

⁺ Estimate is significantly different from the estimate in 2015 ($p < .05$).

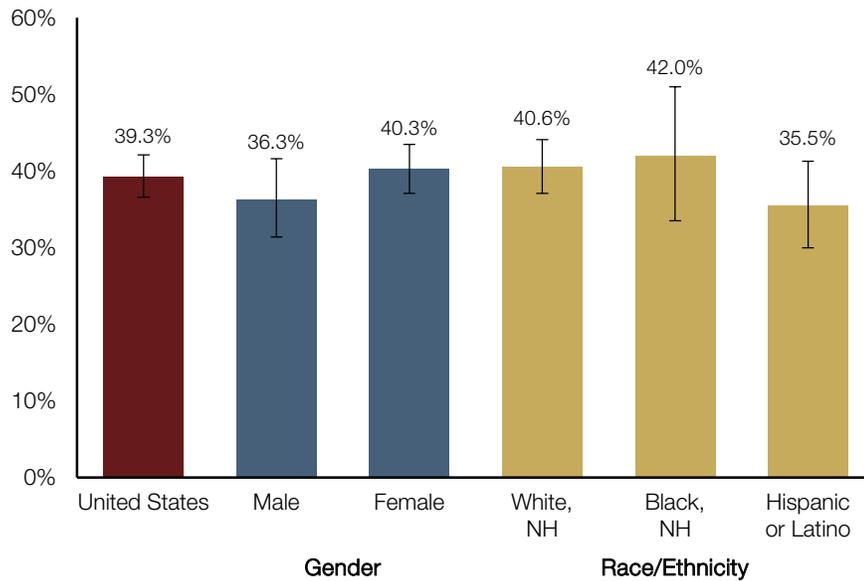
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

YOUTH MENTAL HEALTH AND SERVICE USE

TREATMENT FOR DEPRESSION



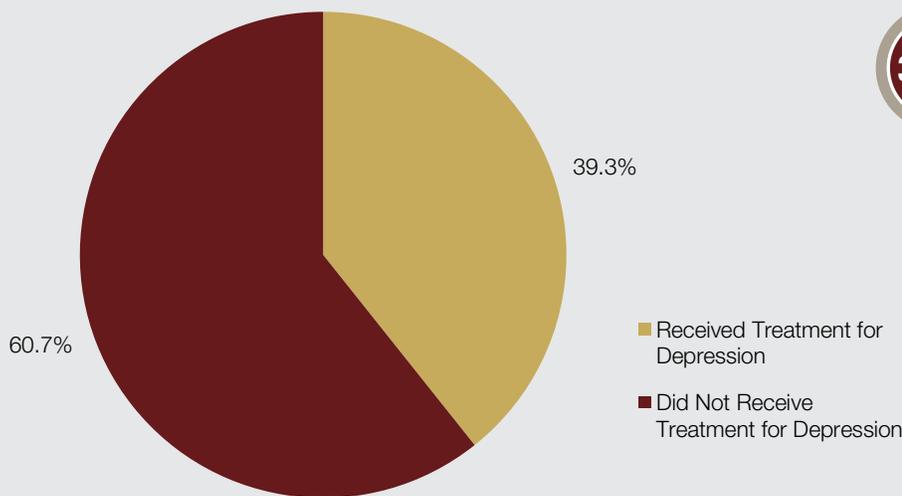
Past Year Treatment for Depression Among Adolescents Aged 12–17 with Past Year Major Depressive Episode (MDE) in the United States, by Gender and Race/Ethnicity (2015)^{8,9}



In 2015, among adolescents aged 12–17 in the United States with MDE in the past year, there was no statistically significant difference between male and female adolescents in receipt of treatment for depression in the past year. This percentage was not significantly different from the national average for White, Black, and Hispanic or Latino adolescents with MDE.

NH = non-Hispanic.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Treatment for Depression Among Adolescents Aged 12–17 with Past Year Major Depressive Episode (MDE) in the United States (2015)⁹



3.0 Million Adolescents with MDE

39.3%

In 2015, 39.3% of adolescents aged 12–17 in the United States with past year MDE (an estimated 1.2 million adolescents) received treatment for depression in the past year. This percentage was not significantly different from the percentage in 2011 (38.4%).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

ADULT MENTAL HEALTH AND SERVICE USE

SERIOUS THOUGHTS OF SUICIDE

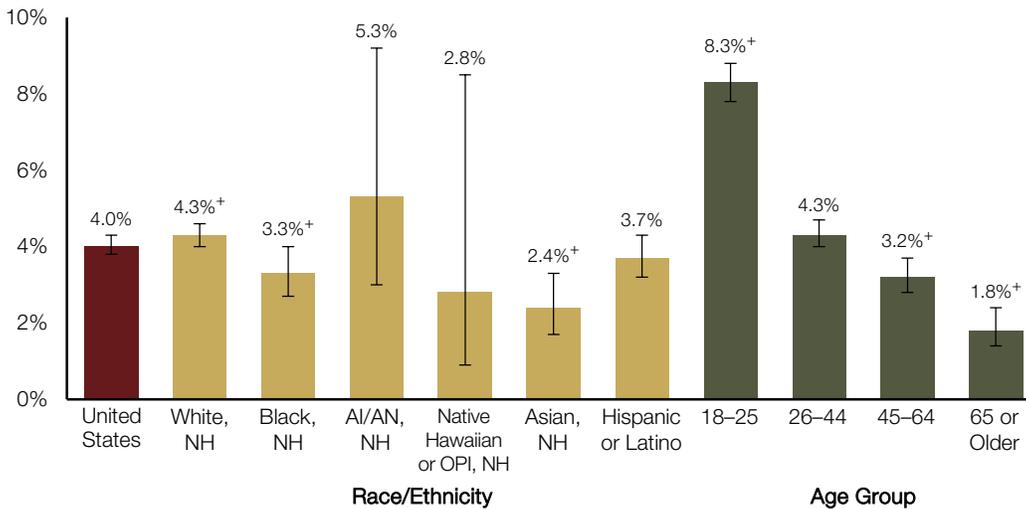


Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in the United States, by Race/Ethnicity and Age Group (2015)¹⁰

In 2015, the percentage of adults aged 18 or older in the United States who had past year serious thoughts of suicide was higher than the national average for Whites and those aged 18–25 and was lower than the national average for Blacks, Asians, those aged 45–64, and those aged 65 or older. There was no statistically significant difference between males and females in the percentage of serious thoughts of suicide in the past year.

4.0%

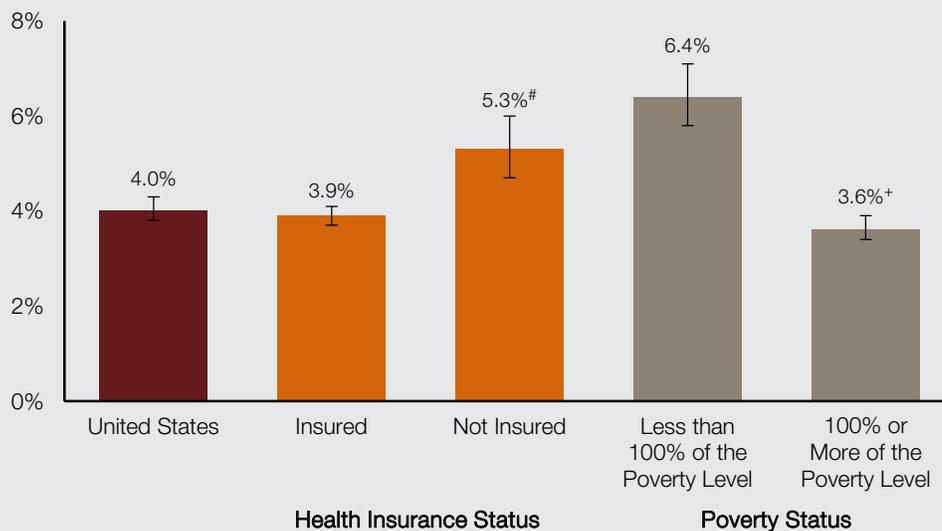
In 2015, 4.0% of adults aged 18 or older in the United States (an estimated 9.8 million adults) had serious thoughts of suicide in the past year. This was a statistically significant increase from the percentage in 2011 (3.7%), but it was not significantly different from the percentages in 2012, 2013, and 2014.



AI/AN = American Indian or Alaska Native; NH = non-Hispanic; OPI = other Pacific Islander.
⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in the United States, by Health Insurance Status and Poverty Status (2015)^{3,10}



In 2015, the percentage of adults aged 18 or older in the United States who had serious thoughts of suicide in the past year was higher among those without health insurance and those living in households whose income was less than 100% of the poverty level. There was no statistically significant difference between those living in metropolitan and nonmetropolitan areas in the percentage of serious thoughts of suicide.

[#] Estimate is significantly different from the estimate for those with health insurance ($p < .05$).

⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

ADULT MENTAL HEALTH AND SERVICE USE

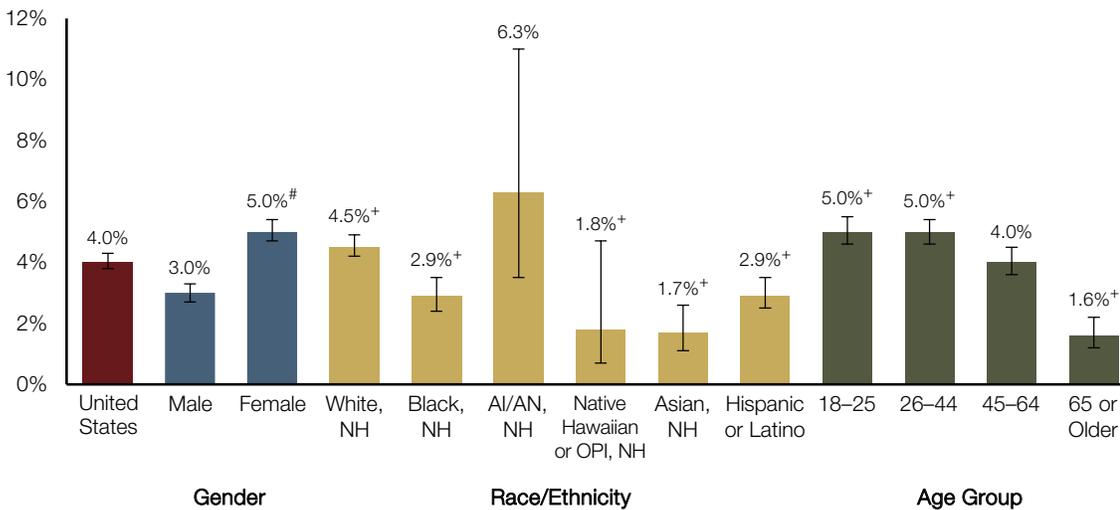
SERIOUS MENTAL ILLNESS



Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in the United States, by Gender, Race/Ethnicity, and Age Group (2015)¹¹

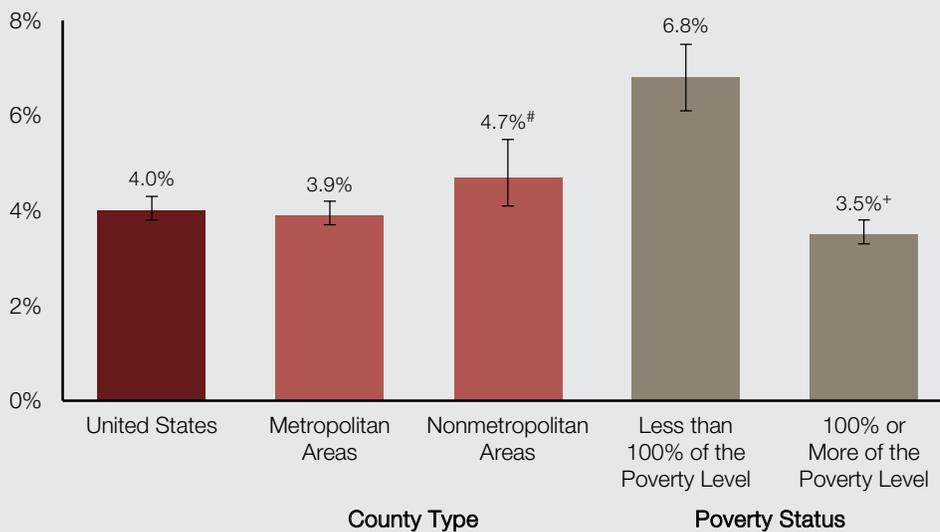
In 2015, 4.0% of adults aged 18 or older in the United States (an estimated 9.8 million adults) had a serious mental illness (SMI) in the past year. This percentage was not significantly different from the percentage in 2011 (3.9%).

In 2015, the percentage of adults aged 18 or older in the United States with past year SMI was higher for females than for males. This percentage was higher than the national average for Whites, and for those aged 18–25 or aged 26–44. This percentage was lower than the national average for those who were Black, Native Hawaiian or other Pacific Islander, Asian, or Hispanic or Latino. This percentage was also lower than the national average for adults aged 65 or older.



AI/AN = American Indian or Alaska Native; NH = non-Hispanic; OPI = other Pacific Islander.
[#] Estimate is significantly different from the estimate for males ($p < .05$).
⁺ Estimate is significantly different from the national average ($p < .05$).
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in the United States, by Poverty Status and County Type (2015)^{3,11}



In 2015, the percentage of adults aged 18 or older in the United States with past year SMI was higher among those living in households whose income was less than 100% of the poverty level and among those living in nonmetropolitan areas.

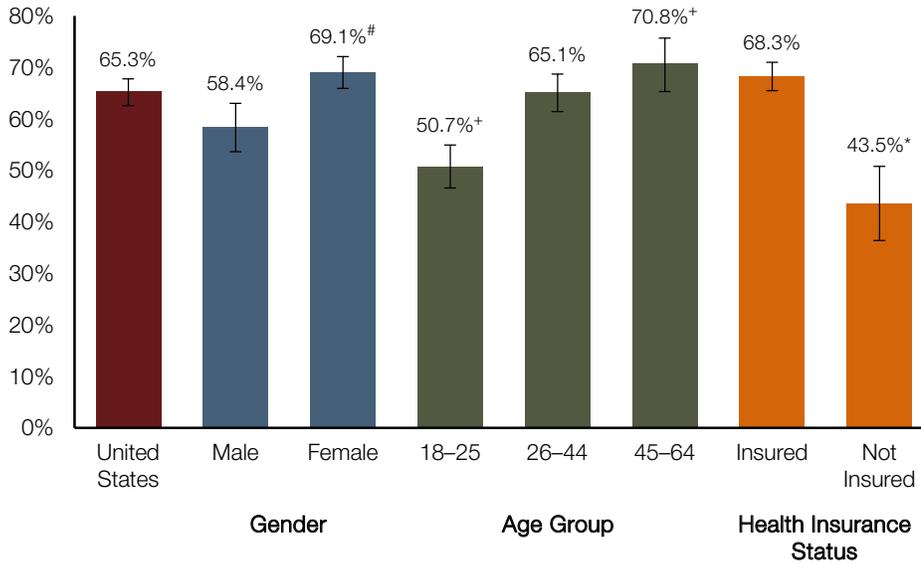
[#] Estimate is significantly different from the estimate for those living in metropolitan areas ($p < .05$).
⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

ADULT MENTAL HEALTH AND SERVICE USE

MENTAL HEALTH SERVICE USE AMONG ADULTS WITH SERIOUS MENTAL ILLNESS



Past Year Mental Health Service Use Among Adults Aged 18 or Older with Serious Mental Illness (SMI) in the United States, by Gender, Age Group, and Health Insurance Status (2015)^{11,12,13}

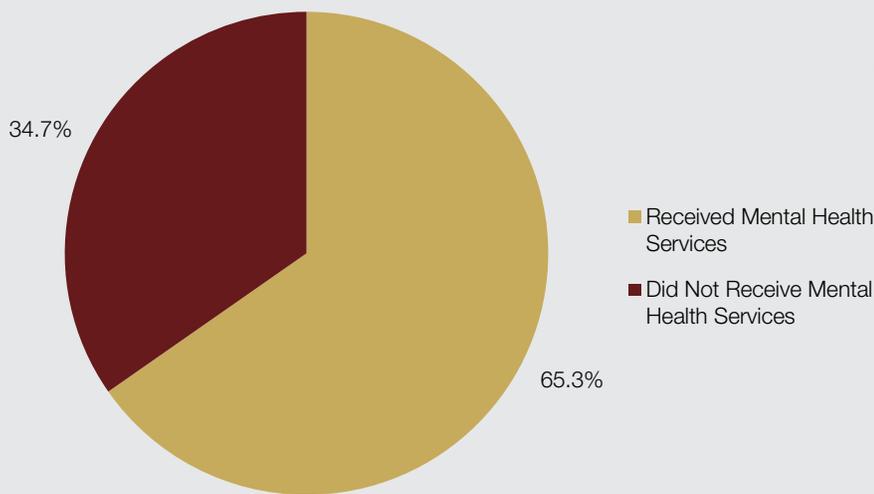


In 2015, the percentage of adults aged 18 or older in the United States with SMI who received mental health services in the past year was lower for males with SMI than for females with SMI. The percentage of adults with SMI who received mental health services was higher than the national average for adults aged 45–64 with SMI and was lower than the national average for adults aged 18–25 with SMI.

In 2015, adults aged 18 or older in the United States with SMI were less likely to have received mental health services if they did not have health insurance.

[#] Estimate is significantly different from the estimate for males ($p < .05$).
⁺ Estimate is significantly different from the national average ($p < .05$).
^{*} Estimate is significantly different from the estimate for those who had health insurance ($p < .05$).
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Mental Health Service Use Among Adults Aged 18 or Older with Serious Mental Illness (SMI) in the United States (2015)^{11,13}



9.8 Million Adults with SMI

65.3%

In 2015, 65.3% of adults aged 18 or older in the United States with SMI (an estimated 6.4 million adults) received mental health services in the past year. This percentage was not significantly different from the percentage in any year from 2011 to 2014.

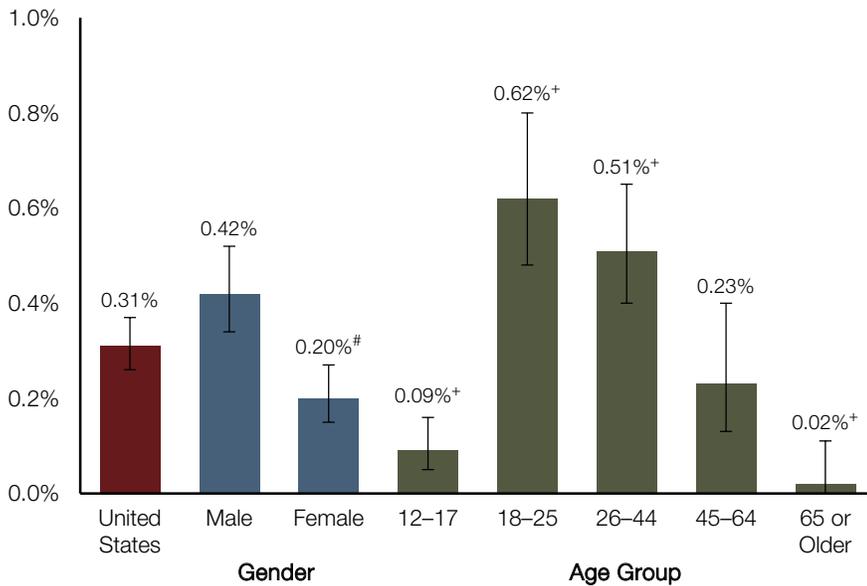
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE, MISUSE, AND SUBSTANCE USE DISORDERS

HEROIN USE



Past Year Heroin Use Among Individuals Aged 12 or Older in the United States, by Gender and Age Group (2015)



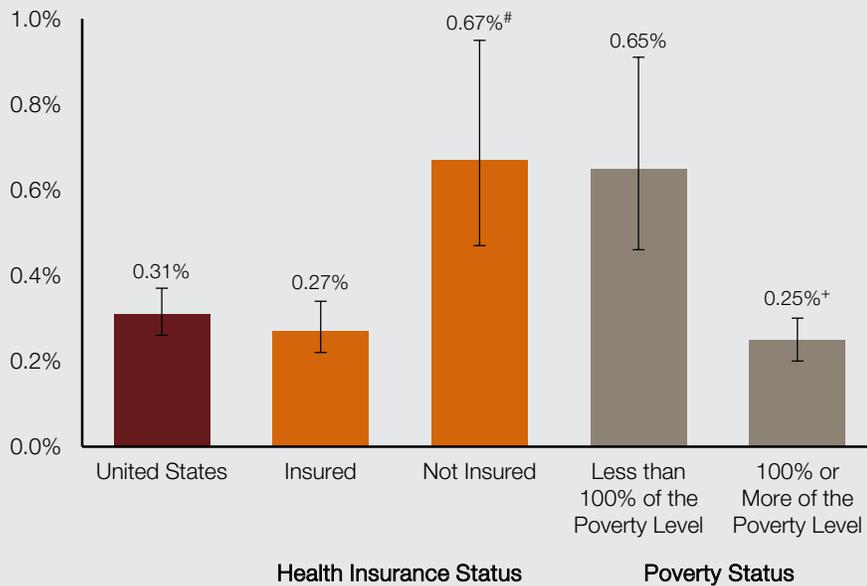
0.31%

In 2015, 0.31% of individuals aged 12 or older in the United States (an estimated 828,000 individuals) used heroin in the past year.

In 2015, the percentage of individuals aged 12 or older in the United States who used heroin in the past year was higher for males than for females. This percentage was higher than the national average for those aged 18-25 or 26-44 and was lower than the national average for those aged 12-17 or 65 or older.

[#] Estimate is significantly different from the estimate for males ($p < .05$).
⁺ Estimate is significantly different from the national average ($p < .05$).
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Heroin Use Among Individuals Aged 12 or Older in the United States, by Health Insurance Status and Poverty Status (2015)³



In 2015, the percentage of individuals aged 12 or older in the United States who used heroin in the past year was higher among those without health insurance and those living in households whose income was less than 100% of the poverty level.

[#] Estimate is significantly different from the estimate for those with health insurance ($p < .05$).
⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).
 Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE, MISUSE, AND SUBSTANCE USE DISORDERS

MISUSE OF PRESCRIPTION PAIN RELIEVERS

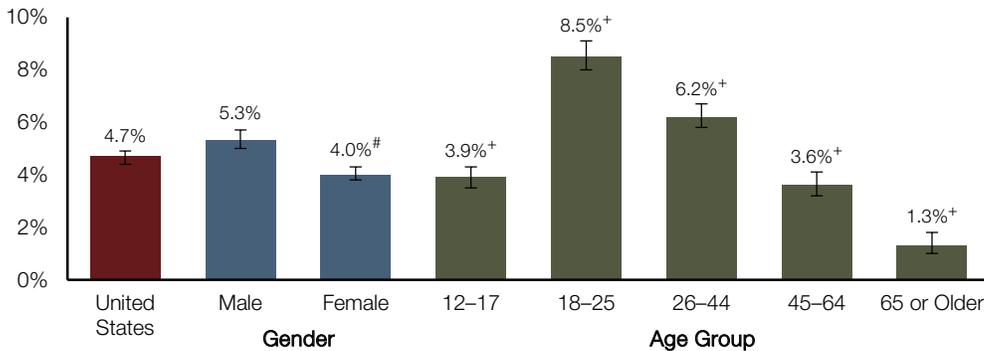


Past Year Misuse of Prescription Pain Relievers Among Individuals Aged 12 or Older in the United States, by Gender and Age Group (2015)

In 2015, the percentage of individuals aged 12 or older in the United States who misused prescription pain relievers in the past year was higher for males than for females. This percentage was higher than the national average for those aged 18–25 or 26–44 and was lower than the national average for those aged 12–17, 45–64, or 65 or older. This percentage was lower than the national average for Asians (1.8%).

4.7%

In 2015, 4.7% of individuals aged 12 or older in the United States (an estimated 12.5 million individuals) misused prescription pain relievers in the past year.

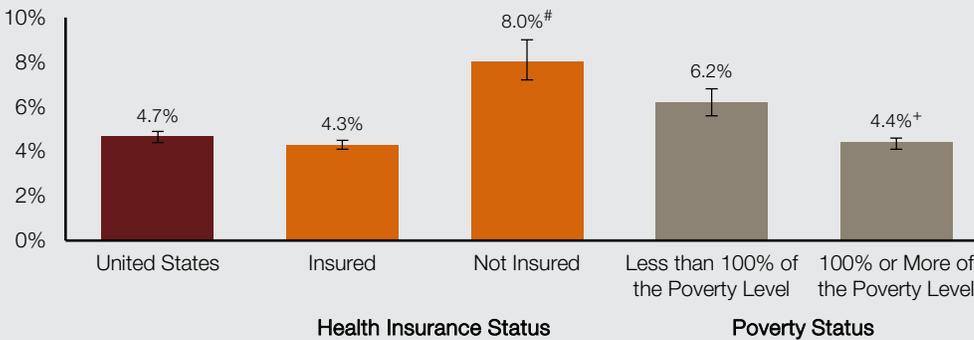


[#] Estimate is significantly different from the estimate for males ($p < .05$).

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Misuse of Prescription Pain Relievers Among Individuals Aged 12 or Older in the United States, by Health Insurance Status and Poverty Status (2015)³



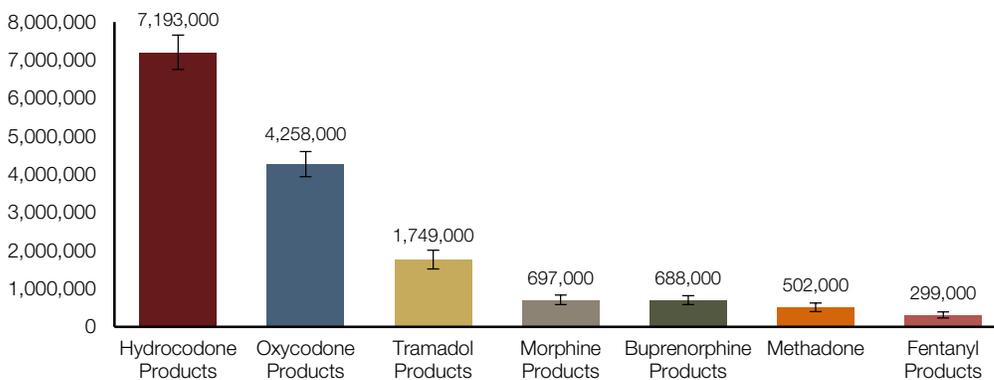
In 2015, the percentage of individuals aged 12 or older in the United States who misused prescription pain relievers in the past year was higher among those without health insurance and those living in households whose income was less than 100% of the poverty level.

[#] Estimate is significantly different from the estimate for those with health insurance ($p < .05$).

⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Number of Individuals Aged 12 or Older in the United States Who Misused Prescription Pain Relievers in the Past Year, by Pain Reliever Subtype (2015)²



In 2015, the subtypes of pain relievers misused most often by individuals aged 12 or older were hydrocodone products (misused by 2.7% or an estimated 7.2 million individuals), oxycodone products (misused by 1.6% or an estimated 4.3 million individuals), and tramadol products (misused by 0.7% or an estimated 1.8 million individuals).

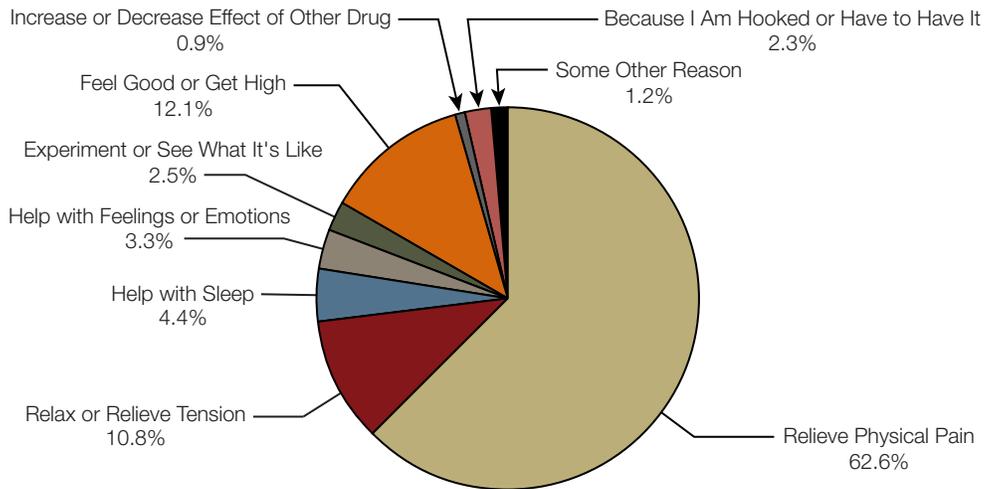
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE, MISUSE, AND SUBSTANCE USE DISORDERS

MISUSE OF PRESCRIPTION PAIN RELIEVERS



Main Reasons for Prescription Pain Reliever Misuse for Most Recent Misuse Among Individuals Aged 12 or Older in the United States Who Misused Prescription Pain Relievers in the Past Year (2015)¹⁴

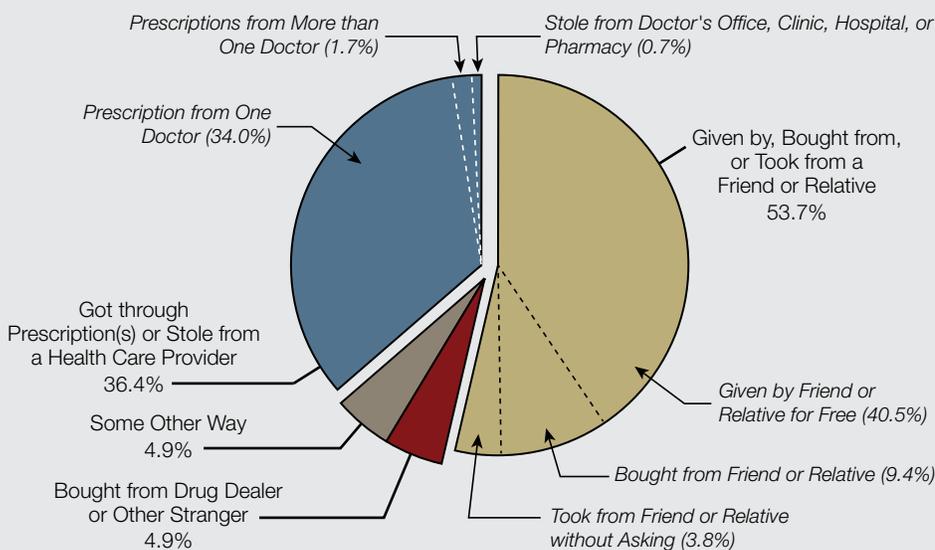


In 2015, among individuals aged 12 or older in the United States who misused prescription pain relievers in the past year, the most frequently indicated reasons for their last misuse were to relieve physical pain (62.6%), to feel good or get high (12.1%), and to relax or relieve tension (10.8%).

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

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Source Where Pain Relievers Were Obtained for Most Recent Misuse Among Individuals Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year (2015)^{14,15}



In 2015, among individuals aged 12 or older who misused prescription pain relievers in the past year, the most commonly indicated source for the most recent pain reliever that was misused was from a friend or relative (53.7%), with 40.5% getting them from a friend or relative for free. About one in three individuals who misused pain relievers in the past year indicated that they obtained pain relievers the most recent time through a prescription or health care provider (36.4%).

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

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE, MISUSE, AND SUBSTANCE USE DISORDERS

ALCOHOL USE DISORDER

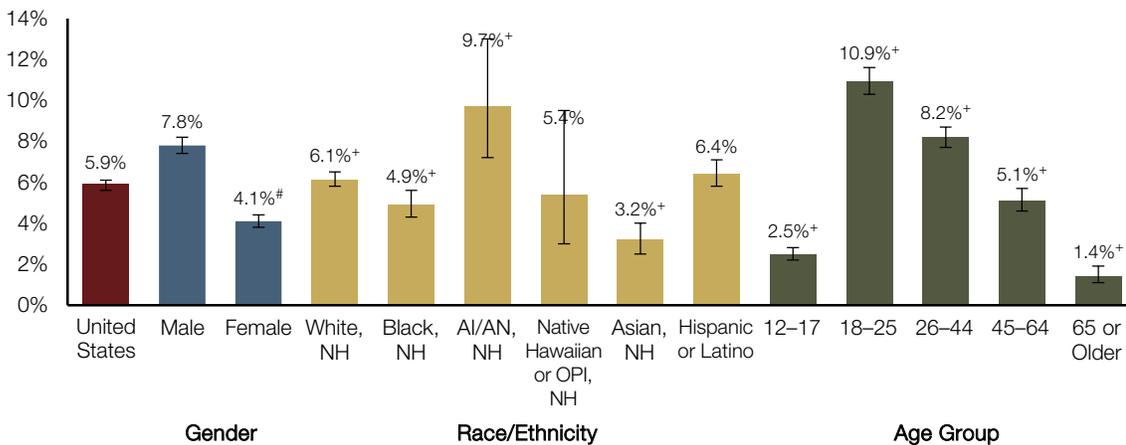


Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in the United States, by Gender, Race/Ethnicity, and Age Group (2015)

In 2015, the percentage of individuals aged 12 or older in the United States with an alcohol use disorder in the past year was higher for males than for females. This percentage was higher than the national average for Whites and American Indians or Alaska Natives and for those aged 18–25 or 26–44. This percentage was lower than the national average for Blacks and Asians and for those aged 12–17, 45–64, or 65 or older.

5.9%

In 2015, 5.9% of individuals aged 12 or older in the United States (an estimated 15.7 million individuals) had an alcohol use disorder in the past year.



AI/AN = American Indian or Alaska Native; NH = non-Hispanic; OPI = other Pacific Islander.

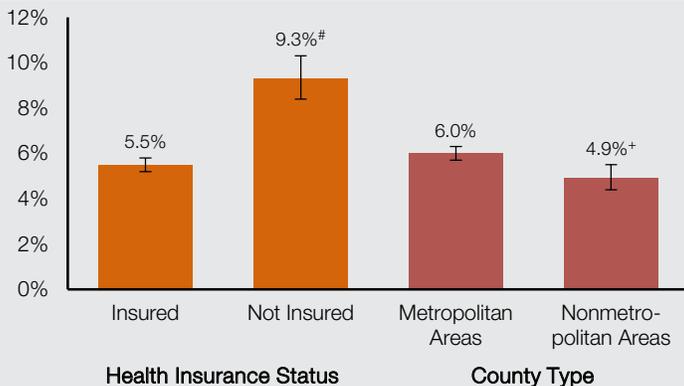
[#] Estimate is significantly different from the estimate for males ($p < .05$).

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in the United States, by Health Insurance Status and County Type (2015)

In 2015, the percentage of individuals aged 12 or older in the United States with a past year alcohol use disorder was higher among those without health insurance and those living in metropolitan areas. There was no statistically significant difference in past year alcohol use disorder by poverty status in 2015.



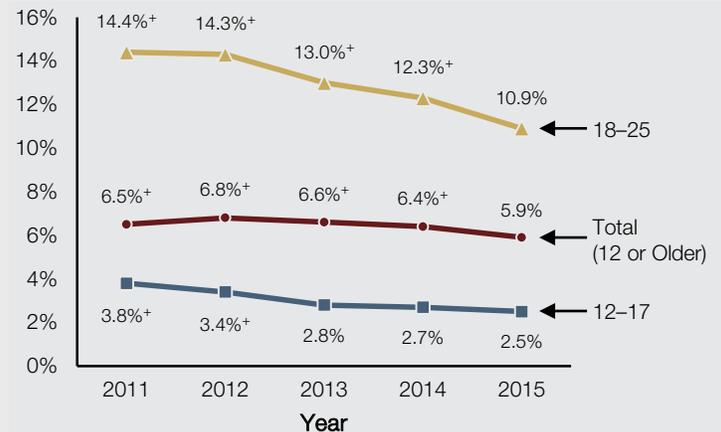
[#] Estimate is significantly different from the estimate for those with health insurance ($p < .05$).

⁺ Estimate is significantly different from the estimate for those who lived in metropolitan areas ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in the United States, by Age Group (2011–2015)¹⁶

From 2011 to 2015, the percentage of individuals aged 12 or older in the United States with a past year alcohol use disorder decreased from 6.5% to 5.9%. A decrease was found for adolescents aged 12–17 and for young adults aged 18–25 but not for those in older age groups.



⁺ Estimate is significantly different from the estimate in 2015 ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

SUBSTANCE USE, MISUSE, AND SUBSTANCE USE DISORDERS

ILLICIT DRUG USE DISORDER

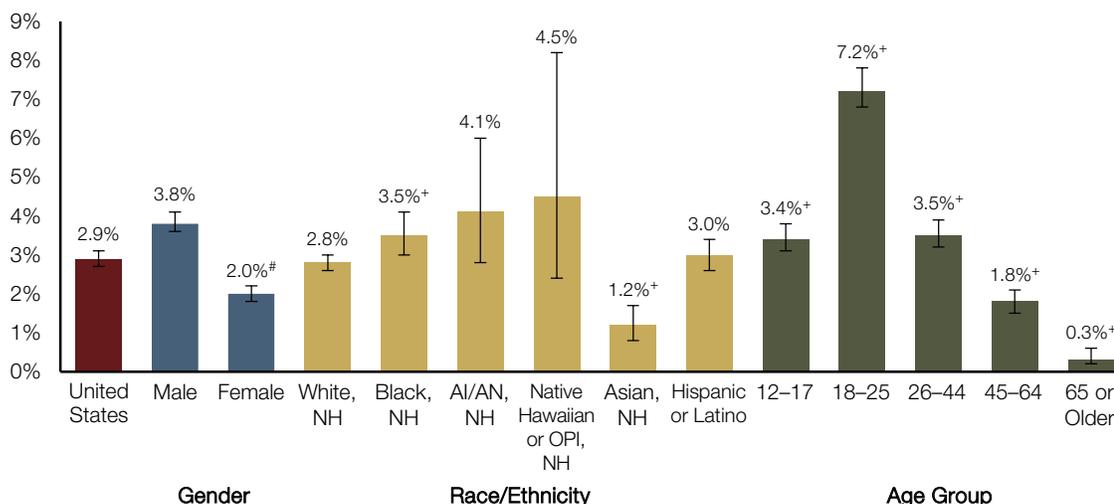


Past Year Illicit Drug Use Disorder Among Individuals Aged 12 or Older in the United States, by Gender, Race/Ethnicity, and Age Group (2015)

In 2015, the percentage of individuals aged 12 or older in the United States with a past year illicit drug use disorder was higher for males than for females. This percentage was higher than the national average for Blacks and for those aged 12–17, 18–25, or 26–44 and was lower than the national average for Asians and for those aged 45–64 or 65 or older.

2.9%

In 2015, 2.9% of individuals aged 12 or older in the United States (an estimated 7.7 million individuals) had an illicit drug use disorder in the past year.



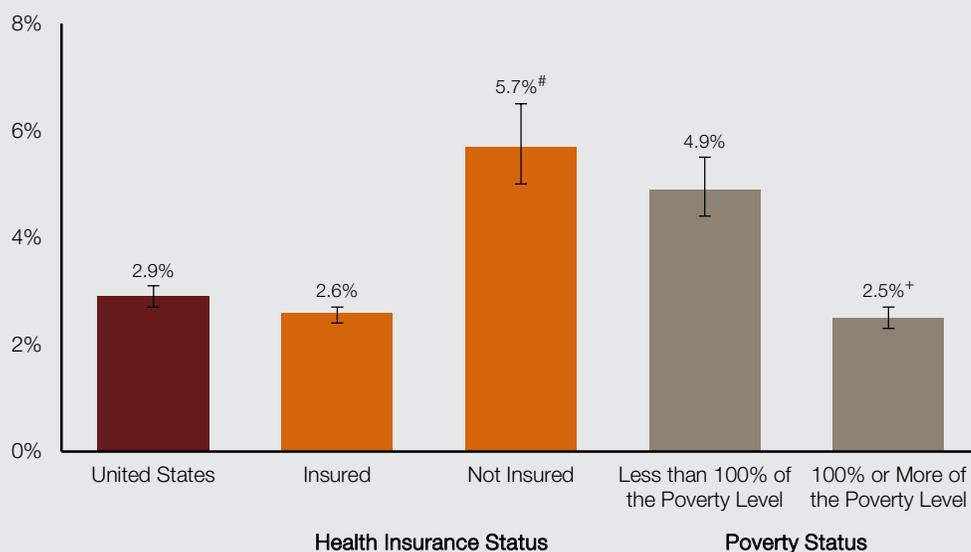
AI/AN = American Indian or Alaska Native; NH = non-Hispanic; OPI = other Pacific Islander.

[#] Estimate is significantly different from the estimate for males ($p < .05$).

⁺ Estimate is significantly different from the national average ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Illicit Drug Use Disorder Among Individuals Aged 12 or Older in the United States, by Health Insurance Status and Poverty Status (2015)³



In 2015, the percentage of individuals aged 12 or older in the United States with a past year illicit drug use disorder was higher among those without health insurance and those living in households whose income was less than 100% of the poverty level. There was no statistically significant difference in past year illicit drug use disorder between those living in metropolitan and nonmetropolitan areas.

[#] Estimate is significantly different from the estimate for those with health insurance ($p < .05$).

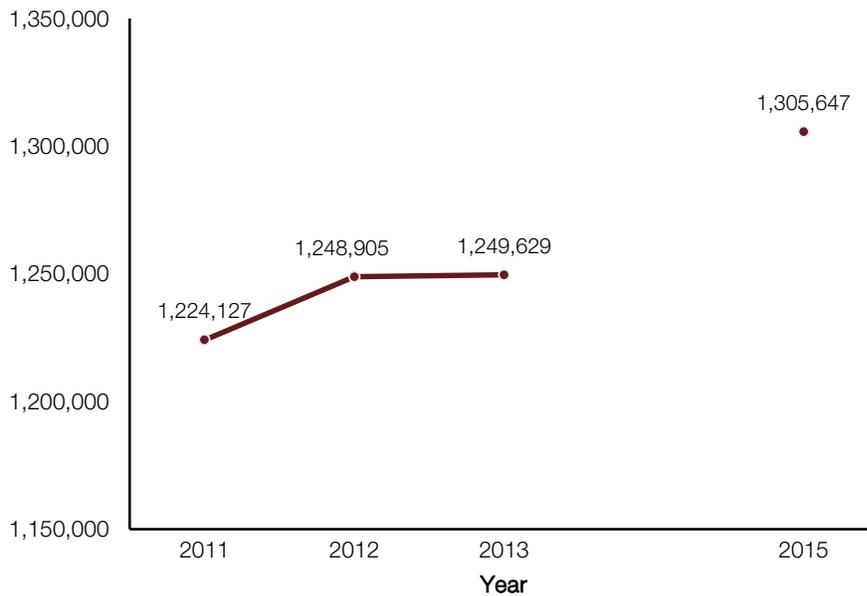
⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE TREATMENT ENROLLMENT AND TREATMENT FOCUS



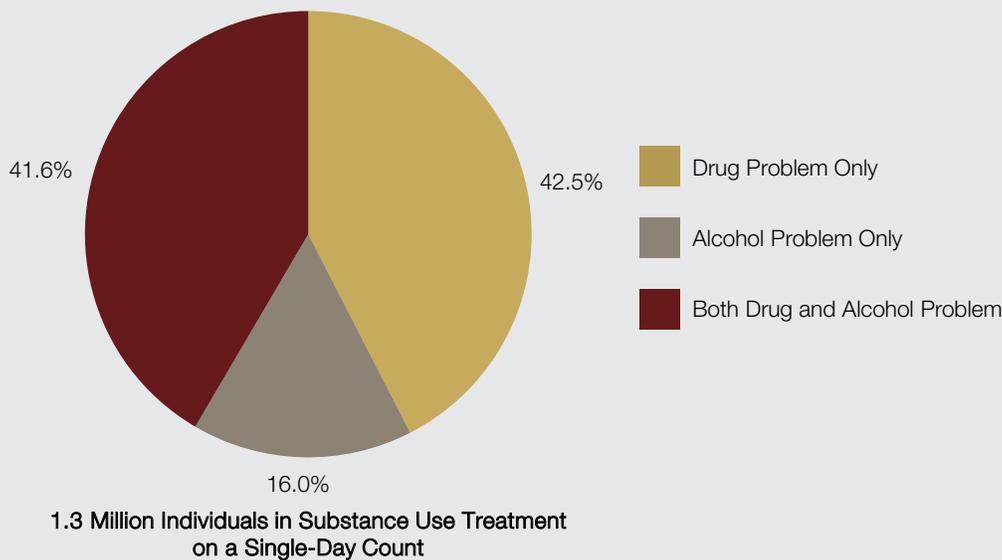
Number of Individuals Enrolled in Substance Use Treatment in the United States: Single-Day Counts (2011–2013, 2015)¹⁷



In 2015, in a single-day count, 1.3 million individuals in the United States were enrolled in substance use treatment—an increase from 1.2 million individuals in 2011.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

Substance Use Problems Among Individuals Enrolled in Substance Use Treatment in the United States: Single-Day Count (2015)^{14,17,18}



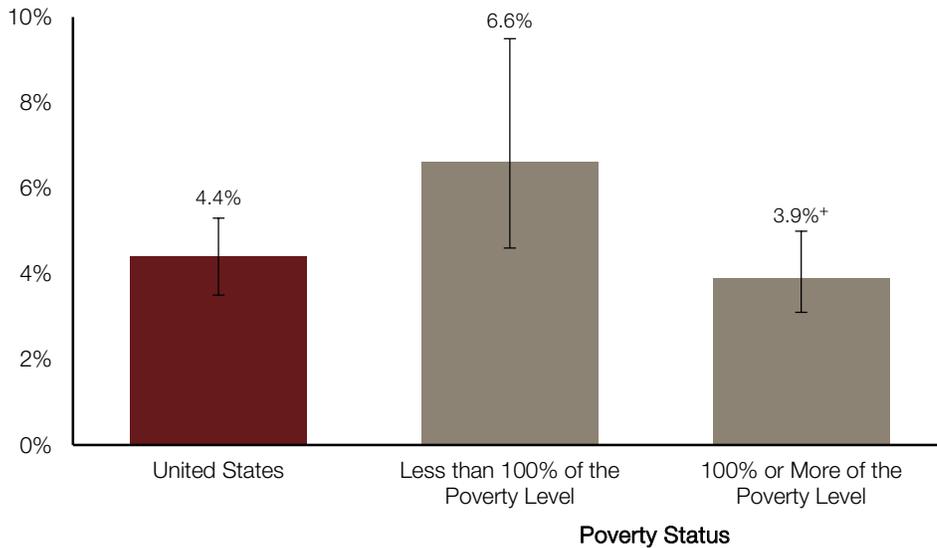
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015.

SUBSTANCE USE TREATMENT

ALCOHOL



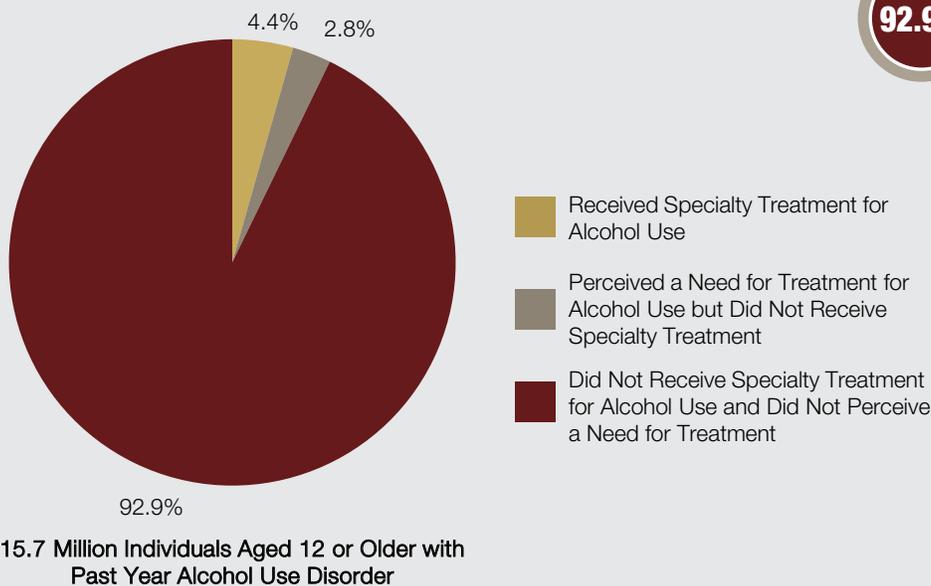
Past Year Specialty Treatment for Alcohol Use Among Individuals Aged 12 or Older with an Alcohol Use Disorder in the United States, by Poverty Status (2015)³



In 2015, the percentage of individuals aged 12 or older in the United States with a past year alcohol use disorder who received specialty treatment for alcohol use was higher for those living in households whose income was less than 100% of the poverty level than for those living in households whose income was 100% or more of the poverty level.

⁺ Estimate is significantly different from the estimate for Less than 100% of the Poverty Level ($p < .05$).
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Specialty Treatment for Alcohol Use and Perception of Treatment Need for Those Who Did Not Receive Specialty Treatment Among Individuals Aged 12 or Older with a Past Year Alcohol Use Disorder in the United States (2015)¹⁴



92.9%

In 2015, 4.4% of individuals aged 12 or older in the United States with an alcohol use disorder (an estimated 685,000 individuals) received specialty treatment for their alcohol use in the past year. About 9 in 10 individuals (92.9%) with a past year alcohol use disorder did not receive specialty treatment and did not perceive a need for treatment for their alcohol use.

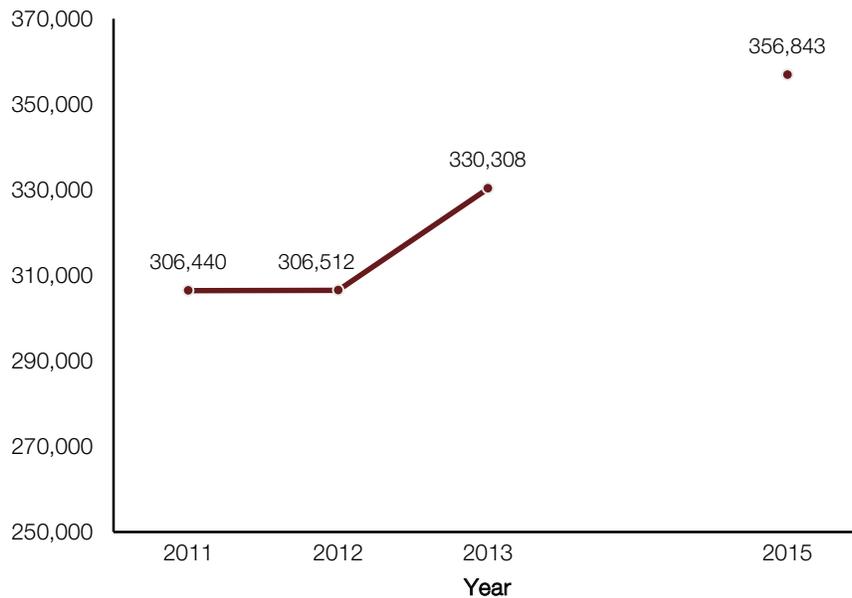
In 2015, there were no statistically significant differences in the receipt of specialty alcohol treatment among those with an alcohol use disorder by gender, race/ethnicity, age group, health insurance status, or metropolitan versus nonmetropolitan areas.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

SUBSTANCE USE TREATMENT OPIOIDS (MEDICATION-ASSISTED THERAPY)



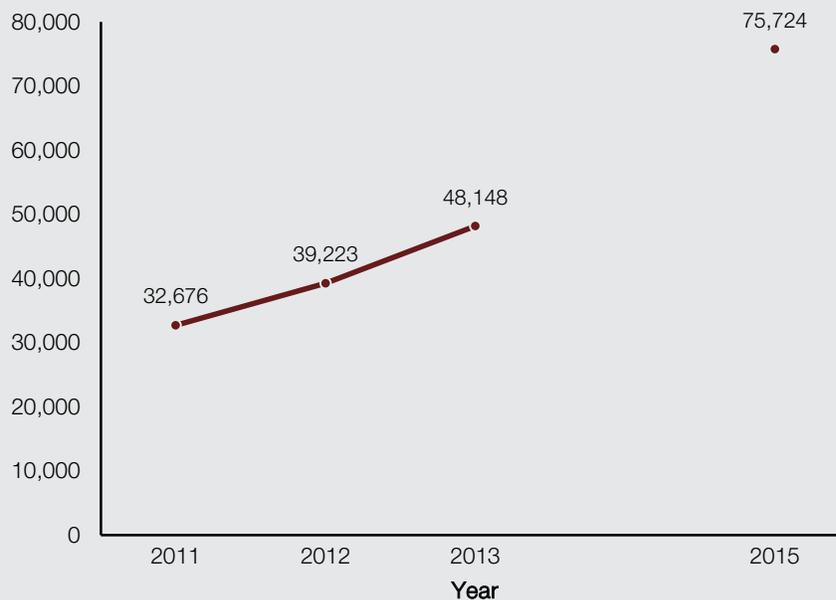
Number of Individuals Enrolled in Opioid Treatment Programs in the United States Receiving Methadone: Single-Day Counts (2011–2013, 2015)^{17,19}



From 2011 to 2015, the number of individuals in the United States who received methadone in opioid treatment programs as part of their substance use treatment increased by about 16%.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

Number of Individuals Enrolled in Substance Use Treatment at Substance Abuse Treatment Facilities in the United States Receiving Buprenorphine: Single-Day Counts (2011–2013, 2015)^{17,19,20}



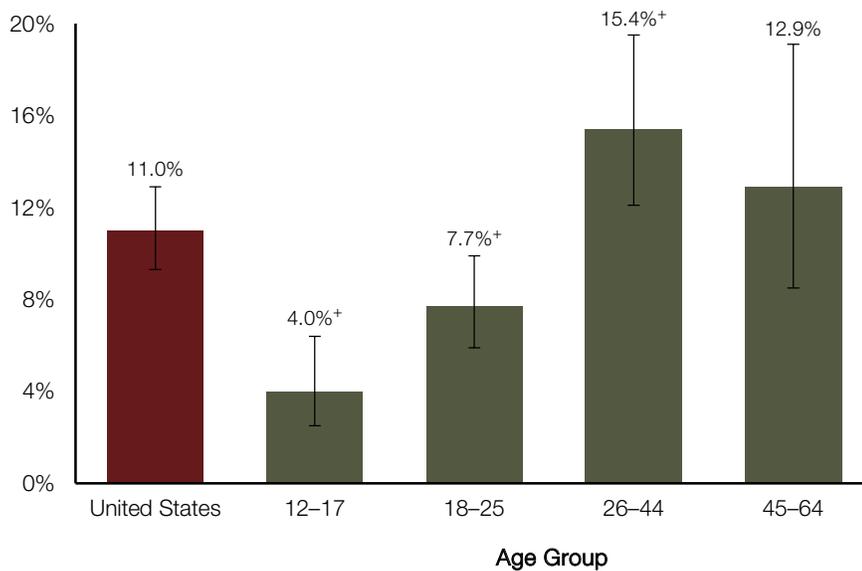
From 2011 to 2015, the number of individuals in the United States who received buprenorphine as part of their substance use treatment more than doubled.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

SUBSTANCE USE TREATMENT ILLICIT DRUGS



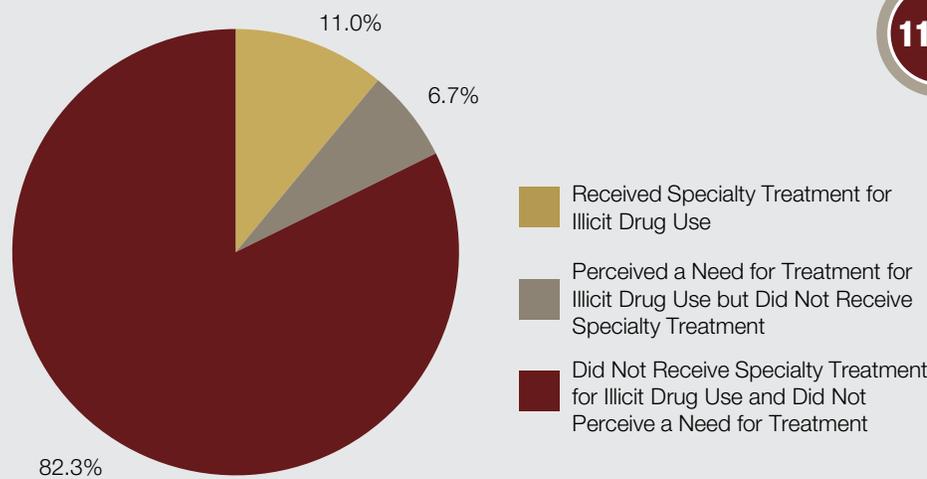
Past Year Specialty Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with an Illicit Drug Use Disorder in the United States, by Age Group (2015)¹²



In 2015, the percentage of individuals aged 12 or older in the United States with a past year illicit drug use disorder who received specialty treatment for their illicit drug use was lower than the national average for those aged 12-17 or 18-25 and was higher than the national average for those aged 26-44.

⁺ Estimate is significantly different from the national average ($p < .05$).
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Past Year Specialty Treatment for Illicit Drug Use and Perception of Treatment Need for Those Who Did Not Receive Specialty Treatment Among Individuals Aged 12 or Older with a Past Year Illicit Drug Use Disorder in the United States (2015)



11.0%

In 2015, 11.0% of individuals aged 12 or older in the United States with an illicit drug use disorder (an estimated 850,000 individuals) received specialty treatment in the past year. About 8 in 10 individuals (82.3%) with an illicit drug use disorder did not receive specialty treatment and did not perceive a need for treatment for their illicit drug use.

In 2015, there were no statistically significant differences in the receipt of treatment for illicit drug use among those with a past year illicit drug use disorder by gender, race/ethnicity, health insurance status, metropolitan versus nonmetropolitan areas, or poverty status.

7.7 Million Individuals Aged 12 or Older with Past Year Illicit Drug Use Disorder

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

FIGURE NOTES



- ¹ The category of Native Hawaiian or other Pacific Islander was omitted because of suppression from low precision of data.
- ² The drug categories or subtypes included in this figure are not mutually exclusive, so individuals who used more than one type of drug are included in the estimates for multiple categories or subtypes.
- ³ Estimates based on poverty status are based on a definition of poverty level that incorporates information on family income, size, and composition and are calculated as a percentage of the U.S. Census Bureau's poverty thresholds. When estimates are presented for respondents aged 18 or older based on poverty status, respondents aged 18–22 who were living in a college dormitory were excluded.
- ⁴ The categories of American Indian or Alaska Native and Native Hawaiian or other Pacific Islander were omitted because of suppression from low precision of data.
- ⁵ Risk perceptions were measured by asking respondents to assess the extent to which people risk harming themselves physically and in other ways when they use various illicit drugs, alcohol, and cigarettes with various levels of frequency. Response options were (1) no risk, (2) slight risk, (3) moderate risk, and (4) great risk. Respondents with unknown risk perception data were excluded.
- ⁶ The estimates for “did not perceive great risk of harm from having five or more drinks once or twice a week” and for “smoking marijuana once a month” were omitted to simplify the presentation.
- ⁷ Respondents with unknown past year major depressive episode (MDE) data were excluded.
- ⁸ The categories of American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and Asian were omitted because of suppression from low precision of data.
- ⁹ Respondents with unknown past year MDE or unknown treatment data were excluded.
- ¹⁰ Estimates were based only on responses to suicide items in the National Survey on Drug Use and Health (NSDUH) Mental Health module. Respondents with unknown suicide information were excluded.
- ¹¹ Estimates of serious mental illness (SMI) presented in this publication may differ from estimates in other publications as a result of revisions made to the NSDUH mental illness estimation models in 2012. Other NSDUH mental health measures presented were not affected. Note that the 2013, 2014, and 2015 Barometer reports include the revised SMI estimates. For further information, see *Revised Estimates of Mental Illness from the National Survey on Drug Use and Health*, which is available on the SAMHSA Web site at <https://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf>.

FIGURE NOTES



- ¹² The category of 65 or older was omitted because of low precision of data.
- ¹³ Respondents were not to include treatment for drug or alcohol use. Respondents with unknown service use information were excluded. Estimates were based only on responses to items in the NSDUH Adult Mental Health Service Utilization module.
- ¹⁴ The percentages do not add to 100% because of rounding.
- ¹⁵ 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.
- ¹⁶ The categories of 26–44, 45–64, and 65 or older were omitted to simplify the presentation.
- ¹⁷ Single-day counts reflect the number of individuals who were enrolled in substance use treatment on March 31, 2011; March 30, 2012; March 29, 2013; and March 31, 2015. Single-day counts of the number of individuals enrolled in substance use treatment were not included in the 2014 National Survey of Substance Abuse Treatment Services (N-SSATS).
- ¹⁸ Enrollees whose substances were unknown were excluded.
- ¹⁹ These counts reflect only individuals who were receiving these specific medication-assisted therapies as part of their opioid treatment; they do not include counts of individuals who were receiving other types of treatment for their opioid use on the reference dates.
- ²⁰ Physicians who obtain specialized training may prescribe buprenorphine. Some physicians are in private, office-based practices; others are affiliated with substance abuse treatment facilities or programs and may prescribe buprenorphine to clients at those facilities. Additionally, opioid treatment programs (OTPs) may also prescribe and/or dispense buprenorphine. The buprenorphine single-day counts include only those clients who received/were prescribed buprenorphine by physicians affiliated with substance abuse treatment facilities such as OTPs or Drug Addiction Treatment Act (DATA) 2000–waivered physicians; they do not include clients from private practice physicians.

DEFINITIONS



Alcohol use disorder and **illicit drug use disorder** are defined using diagnostic criteria for dependence or abuse specified within the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which include symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

Binge alcohol use is defined in the National Survey on Drug Use and Health (NSDUH) for females as drinking four or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days and for males as drinking five or more drinks on the same occasion. Before the 2015 NSDUH, binge alcohol use was defined for both males and females as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days.

Health insurance coverage is defined as having any type of coverage, including private insurance, Medicare, Medicaid, military health care coverage, or any other type of coverage.

Illicit drug use is defined as the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Major depressive episode (MDE) is defined as in the DSM-IV, which specifies a period of at least 2 weeks in the past year when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

Mental health service use is defined in NSDUH for adults aged 18 or older as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs.

Metropolitan areas refer to counties that are part of a Metropolitan Statistical Area (MSA). Nonmetropolitan areas refer to counties that are outside of MSAs. Because the 2013 Rural-Urban Continuum Codes were used in creating the county type variables, estimates may differ from previously published estimates.

Misuse of psychotherapeutics is defined in NSDUH as use of prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) 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. Over-the-counter drugs are not included.

Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.

DEFINITIONS



Prescription pain relievers include the following subcategories of pain relievers: *hydrocodone products* (Vicodin[®], Lortab[®], Norco[®], Zohydro[®] ER, or generic hydrocodone); *oxycodone products* (OxyContin[®], Percocet[®], Percodan[®], Roxicet[®], Roxicodone[®], or generic oxycodone); *tramadol products* (Ultram[®], Ultram[®] ER, Ultracet[®], generic tramadol, or generic extended-release tramadol); *codeine products* (Tylenol[®] with codeine 3 or 4 or generic codeine pills); *morphine products* (Avinza[®], Kadian[®], MS Contin[®], generic morphine, or generic extended-release morphine); *fentanyl products* (Actiq[®], Duragesic[®], Fentora[®], or generic fentanyl); *buprenorphine products* (Suboxone[®] or generic buprenorphine); *oxymorphone products* (Opana[®], Opana[®] ER, generic oxymorphone, or generic extended-release oxymorphone); Demerol[®]; *hydromorphone products* (Dilaudid[®] or generic hydromorphone, or Exalgo[®] or generic extended-release hydromorphone); methadone; or any other prescription pain reliever.

Race/ethnicity is used to refer to a respondent's self-classification of racial and ethnic origin and identification, in accordance with federal standards for reporting race and ethnicity data (Office of Management and Budget, 1997). For Hispanic origin, respondents were asked, "Are you of Hispanic, Latino, or Spanish origin or descent?" For race, respondents were asked, "Which of these groups describes you?" Response options for race were (1) White, (2) Black/African American, (3) American Indian or Alaska Native, (4) Native Hawaiian, (5) Guamanian or Chamorro, (6) Samoan, (7) Other Pacific Islander, (8) Asian, and (9) Other. The categories for Guamanian or Chamorro and for Samoan have been included in the NSDUH questionnaire since 2013. Respondents were allowed to choose more than one of these groups. Categories for a combined race/ethnicity variable included Hispanic (regardless of race); non-Hispanic groups where respondents indicated only one race (White, Black, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Asian); and non-Hispanic groups where respondents reported two or more races (estimates specific to those who reported two or more races are not included in this report). However, respondents choosing more than one category from among Native Hawaiian, Guamanian or Chamorro, Samoan, and Other Pacific Islander but no other categories are classified as being in the "Native Hawaiian or Other Pacific Islander" category instead of the "two or more races" category. These categories are based on classifications developed by the U.S. Census Bureau.

Serious mental illness (SMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. The estimation of SMI covers any mental disorders that result in serious impairment in functioning such as major depression, schizophrenia, and bipolar disorders. However, NSDUH data cannot be used to estimate the prevalence of specific mental disorders in adults. For details on the methodology, see Section B.4.4 in Appendix B of the *2014 National Survey on Drug Use and Health: Methodological Summary and Definitions* (<https://www.samhsa.gov/data/sites/default/files/NSDUH-MethodSummDefs2014/NSDUH-MethodSummDefs2014.htm>). It should be noted that SAMHSA has recently updated the definition of SMI for use in mental health block grants to include mental disorders as specified in the DSM-5.

DEFINITIONS



Specialty substance use treatment is defined in NSDUH as treatment received at a drug or alcohol rehabilitation facility (inpatient or outpatient), a hospital (inpatient only), or a mental health center. Starting in 2015, the measure of the receipt of treatment at a specialty facility took into account changes to the computer-assisted interviewing logic in 2015 for determining who was asked questions about the receipt of treatment for a substance use problem based on the addition of the new module for methamphetamine and changes to the modules for hallucinogens, inhalants, and misuse of prescription psychotherapeutic drugs (pain relievers, tranquilizers, stimulants, and sedatives).

Treatment for depression is defined in NSDUH as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

REFERENCES AND SOURCES



American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population aged 12 years or older and includes mental health issues and mental health service utilization for adolescents aged 12–17 and adults aged 18 or older. Conducted by the federal government since 1971, NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The data used in this report are based on information obtained from approximately 67,500 individuals aged 12 or older per year in the United States. Additional information about NSDUH is available at <https://www.samhsa.gov/data/population-data-nsduh>.

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census designed to collect information from all public and private treatment facilities in the United States that provide substance abuse treatment. The objectives of N-SSATS are to collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services, to analyze general treatment services trends, and to generate the Behavioral Health Treatment Services Locator (<https://findtreatment.samhsa.gov/>). Additional information about N-SSATS is available at <https://www.samhsa.gov/data/substance-abuse-facilities-data-nssats>.

Office of Management and Budget. (1997). Revisions to the standards for the classification of federal data on race and ethnicity. *Federal Register*, 62(210), 58781–58790.



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