

The CBHSQ Report

Short Report

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STATE ESTIMATES OF PAST YEAR COCAINE USE AMONG YOUNG ADULTS: 2014 AND 2015

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INTRODUCTION

Cocaine is a powerfully addictive stimulant made from the leaves of a coca plant native to South America. Cocaine use has serious short- and long-term health effects, and the risk of harm increases when cocaine is taken in combination with alcohol, heroin, or other substances.¹ Some of the most frequent and severe health consequences of cocaine use and overdose include heart attacks and strokes, which can be fatal.¹

Recent findings suggest that cocaine use may be reemerging as a public health concern in the United States. For example, the National Survey on Drug Use and Health (NSDUH) indicates that in 2015, 968,000 people aged 12 or older initiated cocaine use in the past year (0.4 percent of the population), which was higher than in each of the years from 2008 to 2014. The 2015 estimate represented a 26 percent increase compared with 2014, with 766,000 new cocaine users in the past year (0.3 percent of the population), and a 61 percent increase compared with 2013, with 601,000 new cocaine users in the past year (0.2 percent of the population). The Office of National Drug Control Policy estimates that the potential cocaine production from Colombia was 420 metric tons in 2015,² which is the highest level of Colombian cocaine production since 2007 and an increase of more than 100 percent compared with 2013.² In addition, the number of deaths from cocaine overdose has increased steadily between 2012 and 2015 (4,400 in 2012, 4,900 in 2013, 5,400 in 2014 and 6,800 in 2015). The number of cocaine deaths in 2015 was the second highest since 1999, with only 2006 being higher when there were 7,400 deaths.³

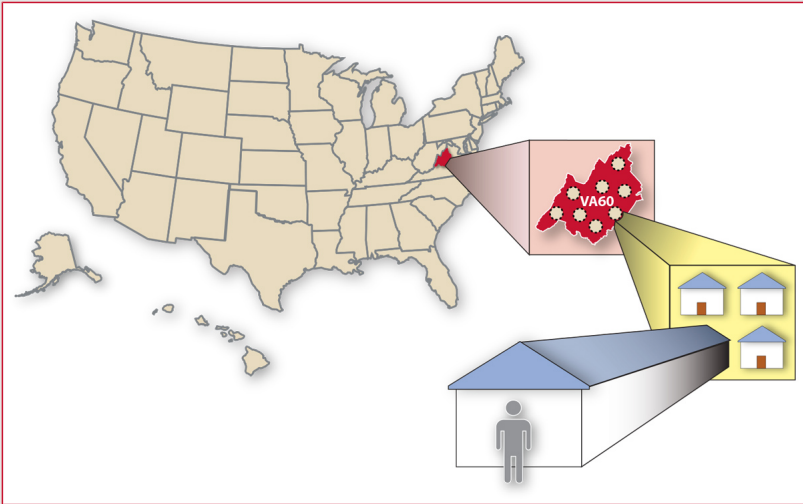
Increases in cocaine use may be most notable among young adults. For example, a longitudinal study of students currently aged 19 to 28 found that past year cocaine use has increased from 3.9 percent in 2013 to 5.0 percent in 2014 and 5.7 percent in 2015. Based on those findings, the study investigators indicated that cocaine may be making a comeback.⁴ The 2015 NSDUH data also indicate that cocaine use among young adults aged 18 to 25 is of particular concern because in 2015, 663,000 young adults used cocaine for the first time in the past year; this accounted for nearly 7 out of every 10 new cocaine users aged 12 or older despite representing just 13 percent of the total population aged 12 or older.^{5,6}



In Brief

- Based on data from the combined 2014–2015 National Surveys on Drug Use and Health, 1.7 million young adults aged 18 to 25 in the United States used cocaine in the past year (4.98 percent of the young adult population). This equates to about 1 out of every 20 young adults across the nation using cocaine in the past year.
- Among census regions, past year cocaine use among young adults ranged from 4.22 percent in the Midwest to 6.06 percent in the Northeast. At the state level, past year cocaine use varied from 1.83 percent in Mississippi to 10.54 percent in New Hampshire.
- Cocaine use among young adults increased in 16 states (when comparing combined 2014–2015 estimates with combined 2013–2014 estimates) and 3 regions. Use remained unchanged for the remaining 34 states and the District of Columbia and for the West. No decreases occurred in any census region or state.

Figure 0. NSDUH Sampling Design for the Nation



NSDUH measures cocaine (including crack) use for the U.S. civilian, noninstitutionalized population aged 12 years or older. NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. NSDUH collects information from individuals residing in households, noninstitutionalized group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. One of NSDUH's strengths is the stability of the survey design, which allows for multiple years of survey data to be combined to examine state-level estimates on cocaine use and several other substance use or mental health outcomes. Policymakers and prevention practitioners can use current state-level data on cocaine use among young adults aged 18 to 25 to improve their understanding of the scope of the issue in this population, to identify changing trends, and to inform educational and prevention efforts in the communities they serve.

This issue of *The CBHSQ Report* uses data from the 2013, 2014, and 2015 NSDUHs to present state (including the District of Columbia) estimates of past year cocaine use among young adults aged 18 to 25. All estimates in this report are based on a small area estimation (SAE) methodology in which state-level NSDUH data are combined with county and census block group/tract-level data from the state to provide more precise estimates.⁷ Findings in this report are annual averages based on combined 2014–2015 NSDUH data from 33,500 young adults aged 18 to 25. The combined 2013–2014 estimates are based on data obtained from 38,700 young adults.⁸ For each individual year, the data used in this report are based on information obtained from young adults aged 18 to 25 (22,000 in 2013, and 16,000 in 2014, and 17,000 in 2015).

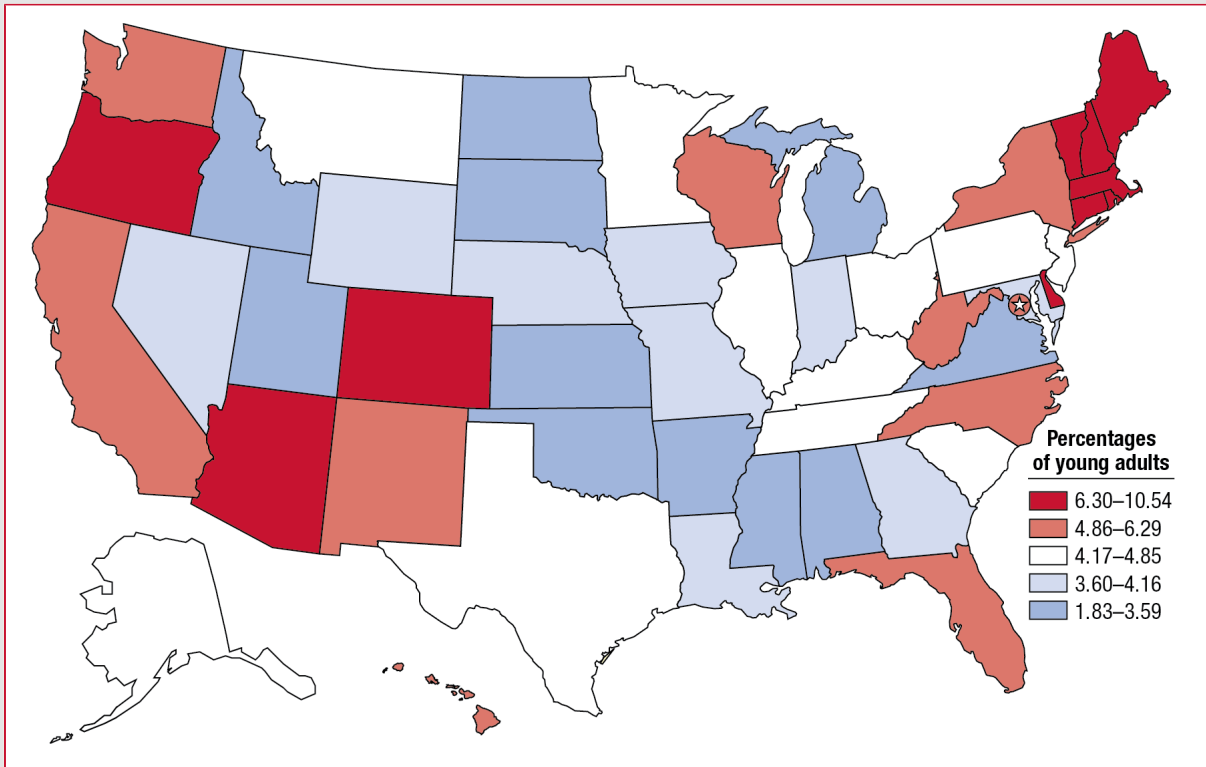
Estimates in this report are displayed in tables and on a U.S. map. To produce the map showing the estimates of past year cocaine use among young adults, state estimates were first rank-ordered from lowest to highest and then divided into quintiles (fifths). States with the lowest estimates (i.e., the lowest fifth) are assigned to the bottom quintile and are shown in dark blue. States with the highest estimates are assigned to the top quintile and are shown in dark red. All other states are assigned to one of three quintiles between the lowest and highest quintiles. In some cases, a "quintile" could have more or fewer states than desired because two (or more) states had the same estimate (to two decimal places). When such ties occurred at the "boundary" between two quintiles, all of the states with the same estimate were conservatively assigned to the lower quintile.

Table 1 shows the estimates associated with the map rank-ordered from highest to lowest and divided into quintiles.⁹ For the estimates in Table 2, states are listed alphabetically. Ninety-five percent confidence intervals are included as a measure of precision for each estimate. Additionally, the combined 2014–2015 estimates are compared with combined 2013–2014 estimates to examine changes over time. The inclusion of a common year (i.e., 2014) in these comparisons increases the precision of the difference and the ability to detect statistically significant differences. Any statistically significant difference between the 2014–2015 and 2013–2014 estimates is to be interpreted as the average annual change between 2013 and 2015. All changes discussed in this report are statistically significant at the .05 level.

STATE ESTIMATES

Based on combined 2014–2015 NSDUH data, an estimated 1.7 million young adults aged 18 to 25 across the nation used cocaine in the past year. This translates to about 1 in 20 young adults (4.98 percent of the young adult population) using cocaine in the past year, which was an increase from 4.51 percent (about 1.6 million) in 2013–2014. Among the four census regions,¹⁰ cocaine use ranged from 4.22 percent in the Midwest to 6.06 percent in the Northeast. However, there were notable differences across states where cocaine use varied from 1.83 percent in Mississippi to 10.54 percent in New Hampshire (Figure 1; and Table 1). Of the 10 states with the highest rates of cocaine use among young adults, 6 were in the Northeast (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont), 3 were in the West (Arizona, Colorado, and Oregon), and 1 was in the South (Delaware). States with the lowest rates of cocaine use were mainly in the South (Alabama, Arkansas, Mississippi, Oklahoma, and Virginia) and Midwest (Kansas, Michigan, North Dakota, and South Dakota). The remaining 2 states in the lowest quintile group were in the West (Idaho and Utah).¹¹

Figure 1. Past year cocaine use among young adults aged 18 to 25, by state: percentages, annual averages based on 2014-2015 NSDUHs



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2014 and 2015.

Table 1. Cocaine use in the past year among young adults aged 18 to 25, by quintile group and size of state estimate: percentages, annual averages based on 2014-2015 NSDUHs

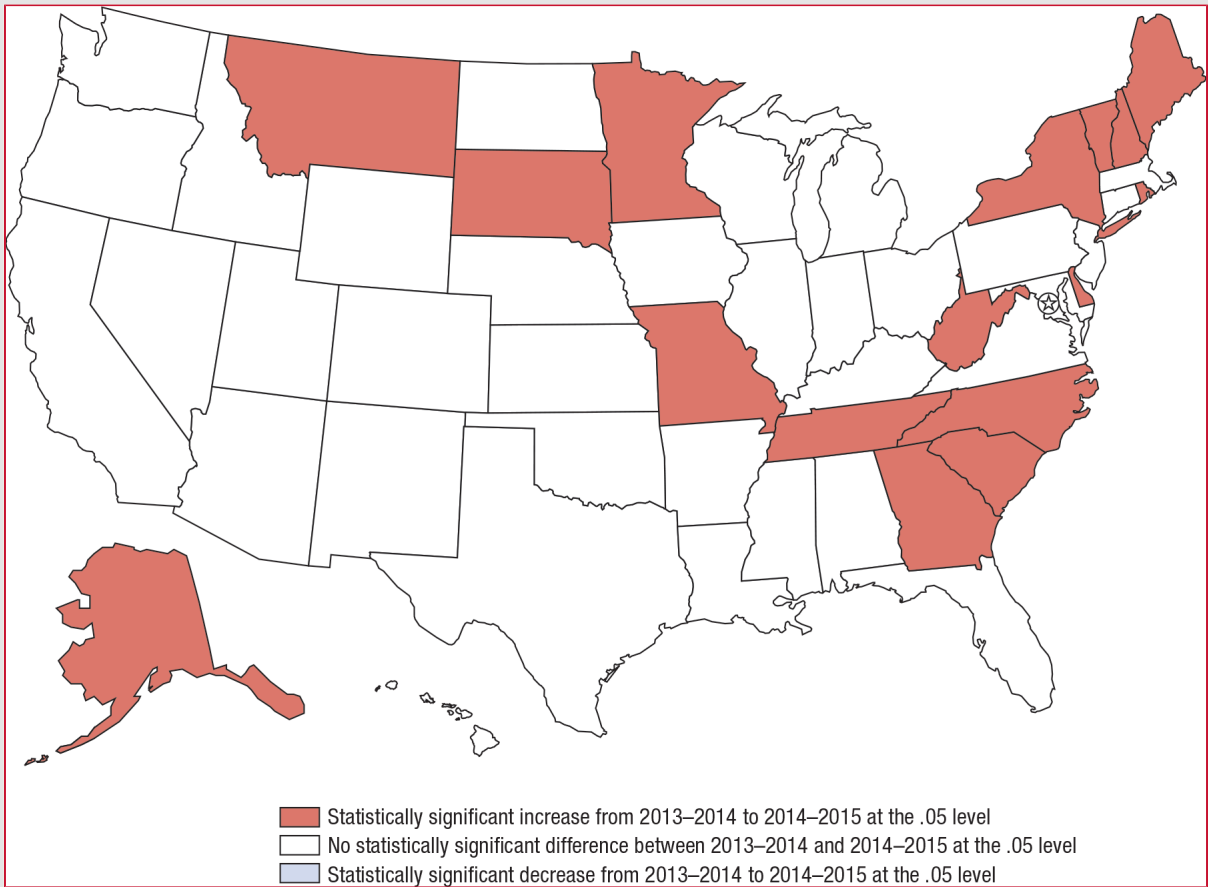
State	Census region	Percentage	Quintile group
New Hampshire	Northeast	10.54%	5
Vermont	Northeast	9.33%	5
Colorado	West	8.62%	5
Rhode Island	Northeast	7.64%	5
Connecticut	Northeast	7.60%	5
Massachusetts	Northeast	7.28%	5
Arizona	West	6.92%	5
Oregon	West	6.81%	5
Maine	Northeast	6.41%	5
Delaware	South	6.36%	5
New York	Northeast	6.29%	4
New Mexico	West	5.93%	4
Florida	South	5.91%	4
California	West	5.91%	4
District of Columbia	South	5.60%	4
Washington	West	5.39%	4
West Virginia	South	5.32%	4
Hawaii	West	5.21%	4
North Carolina	South	5.12%	4
Wisconsin	Midwest	4.96%	4
Minnesota	Midwest	4.85%	3
Illinois	Midwest	4.81%	3
Alaska	West	4.79%	3
Kentucky	South	4.74%	3
Pennsylvania	Northeast	4.71%	3
Montana	West	4.65%	3
New Jersey	Northeast	4.55%	3
South Carolina	South	4.42%	3
Ohio	Midwest	4.24%	3
Tennessee	South	4.22%	3
Texas	South	4.19%	3
Nevada	West	4.16%	2
Missouri	Midwest	4.12%	2
Nebraska	Midwest	3.99%	2
Indiana	Midwest	3.91%	2
Georgia	South	3.85%	2
Wyoming	West	3.74%	2
Maryland	South	3.66%	2
Iowa	Midwest	3.63%	2
Louisiana	South	3.61%	2
Idaho	West	3.59%	1
Kansas	Midwest	3.59%	1
Oklahoma	South	3.58%	1
Michigan	Midwest	3.56%	1
Virginia	South	3.50%	1
North Dakota	Midwest	3.45%	1
Alabama	South	3.20%	1
South Dakota	Midwest	3.15%	1
Arkansas	South	2.89%	1
Utah	West	2.73%	1
Mississippi	South	1.83%	1

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 to 2015.

CHANGES OVER TIME

Nationally, past year cocaine use among young adults aged 18 to 25 increased from 4.51 percent in 2013–2014 to 4.98 percent in 2014–2015. Increases also occurred in 3 out of 4 census regions (Northeast, Midwest, and South) (Figure 2; and Table 2). At the state level, 16 states experienced an increase in cocaine use between 2013–2014 and 2014–2015. The majority of the increases occurred in the South (6 states) and Northeast (5 states) (Figure 2). Other increases occurred in the Midwest (3 states) and West (2 states). The remaining 34 states and the District of Columbia experienced no change in past year cocaine use among young adults. No decreases were observed in any census region or state.

Figure 2. Statistically significant differences in percentages of past year cocaine use among young adults aged 18 to 25, by state: 2013–2014 versus 2014–2015 NSDUHs



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 to 2015.

Table 2. Cocaine use in the past year among young adults aged 18 to 25, by state: percentages, annual averages: 2013-2014 NSDUHs versus 2014-2015 NSDUHs

Area	Census region	Combined 2013-2014			Combined 2014-2015		
		Estimate	95% CI (lower)	95% CI (upper)	Estimate	95% CI (lower)	95% CI (upper)
National*		4.51%	4.22%	4.83%	4.98%	4.65%	5.34%
Northeast*		5.19%	4.65%	5.78%	6.06%	5.44%	6.75%
Midwest*		3.81%	3.45%	4.22%	4.22%	3.78%	4.70%
South*		3.77%	3.44%	4.13%	4.32%	3.95%	4.73%
West		5.78%	5.16%	6.47%	5.88%	5.25%	6.58%
Alabama	South	3.09%	2.18%	4.37%	3.20%	2.20%	4.63%
Alaska*	West	3.84%	2.73%	5.38%	4.79%	3.44%	6.64%
Arizona	West	6.23%	4.61%	8.37%	6.92%	5.16%	9.23%
Arkansas	South	2.54%	1.73%	3.71%	2.89%	1.99%	4.18%
California	West	6.11%	5.17%	7.20%	5.91%	4.97%	7.01%
Colorado	West	7.25%	5.55%	9.42%	8.62%	6.69%	11.06%
Connecticut	Northeast	6.66%	4.89%	9.01%	7.60%	5.60%	10.24%
Delaware*	South	5.21%	3.89%	6.94%	6.36%	4.71%	8.52%
District of Columbia	South	5.44%	4.03%	7.31%	5.60%	4.04%	7.70%
Florida	South	5.53%	4.69%	6.52%	5.91%	4.92%	7.08%
Georgia*	South	2.96%	2.13%	4.08%	3.85%	2.90%	5.11%
Hawaii	West	4.24%	3.02%	5.94%	5.21%	3.73%	7.23%
Idaho	West	3.11%	2.17%	4.45%	3.59%	2.52%	5.09%
Illinois	Midwest	4.51%	3.67%	5.53%	4.81%	3.81%	6.04%
Indiana	Midwest	3.81%	2.74%	5.27%	3.91%	2.77%	5.51%
Iowa	Midwest	3.86%	2.74%	5.43%	3.63%	2.54%	5.15%
Kansas	Midwest	3.80%	2.74%	5.24%	3.59%	2.51%	5.11%
Kentucky	South	4.23%	3.08%	5.77%	4.74%	3.38%	6.60%
Louisiana	South	3.03%	2.14%	4.26%	3.61%	2.48%	5.22%
Maine*	Northeast	4.79%	3.50%	6.53%	6.41%	4.77%	8.58%
Maryland	South	3.60%	2.54%	5.09%	3.66%	2.56%	5.21%
Massachusetts	Northeast	6.27%	4.72%	8.27%	7.28%	5.51%	9.57%
Michigan	Midwest	3.16%	2.49%	4.01%	3.56%	2.77%	4.56%
Minnesota*	Midwest	3.60%	2.56%	5.03%	4.85%	3.46%	6.77%
Mississippi	South	1.90%	1.26%	2.86%	1.83%	1.18%	2.84%
Missouri*	Midwest	3.35%	2.37%	4.71%	4.12%	2.90%	5.81%
Montana*	West	3.53%	2.52%	4.91%	4.65%	3.37%	6.38%
Nebraska	Midwest	3.45%	2.43%	4.88%	3.99%	2.81%	5.64%
Nevada	West	4.18%	2.97%	5.85%	4.16%	2.97%	5.79%
New Hampshire*	Northeast	8.49%	6.55%	10.94%	10.54%	8.16%	13.53%
New Jersey	Northeast	4.03%	2.99%	5.42%	4.55%	3.44%	6.00%
New Mexico	West	5.97%	4.43%	8.00%	5.93%	4.33%	8.08%
New York*	Northeast	5.35%	4.44%	6.43%	6.29%	5.22%	7.55%
North Carolina*	South	4.03%	2.96%	5.45%	5.12%	3.94%	6.63%
North Dakota	Midwest	3.18%	2.24%	4.50%	3.45%	2.42%	4.90%
Ohio	Midwest	3.79%	3.05%	4.69%	4.24%	3.31%	5.41%
Oklahoma	South	3.00%	2.10%	4.27%	3.58%	2.46%	5.18%
Oregon	West	6.13%	4.59%	8.15%	6.81%	5.22%	8.85%
Pennsylvania	Northeast	4.16%	3.40%	5.09%	4.71%	3.78%	5.86%
Rhode Island*	Northeast	5.85%	4.29%	7.93%	7.64%	5.71%	10.16%
South Carolina*	South	2.82%	1.95%	4.06%	4.42%	3.20%	6.08%
South Dakota*	Midwest	2.44%	1.68%	3.53%	3.15%	2.17%	4.56%
Tennessee*	South	3.25%	2.30%	4.57%	4.22%	2.99%	5.92%
Texas	South	3.67%	2.96%	4.55%	4.19%	3.38%	5.18%
Utah	West	3.24%	2.18%	4.79%	2.73%	1.70%	4.36%
Vermont*	Northeast	7.37%	5.69%	9.50%	9.33%	7.10%	12.16%
Virginia	South	3.74%	2.77%	5.03%	3.50%	2.60%	4.70%
Washington	West	5.54%	4.12%	7.41%	5.39%	3.96%	7.29%
West Virginia*	South	3.62%	2.49%	5.24%	5.32%	3.82%	7.38%
Wisconsin	Midwest	4.60%	3.35%	6.28%	4.96%	3.55%	6.90%
Wyoming	West	3.88%	2.75%	5.46%	3.74%	2.51%	5.52%

CI = confidence interval.

* The difference between the estimates for 2013-2014 and the estimates for 2014-2015 is significant at the level .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 to 2015.

DISCUSSION

In 2014–2015, state-level rates of past year cocaine use among young adults reached as high as 1 in 10 (10.54 percent in New Hampshire) and were as low as 1 in 50 (1.83 percent in Mississippi). In addition, increases in use among young adults are occurring in all regions of the country but mainly in the South and Northeast (Table 2). Given the severe health consequences associated with cocaine use and empirical evidence that points to a possible emerging trend that affects all regions and states, state-level data may be particularly useful. This report highlights the prevalence of cocaine use among young adults at the state level, which may help policymakers plan for and allocate resources to provide effective preventive interventions and increase access to substance use treatment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides resources for people with substance use issues, including issues related to cocaine use. For information on substance use and mental health treatment facilities and programs around the country, see <https://findtreatment.samhsa.gov/>. SAMHSA also has a free and confidential 24-hour-a-day, 365-day-a-year information service, in English and Spanish, for individuals and family members facing substance use issues. For more information, go to www.samhsa.gov/find-help/national-helpline.

Other Available NSDUH State Measures

The combined 2014–2015 NSDUH state estimates of past year cocaine use and 13 additional behavioral health measures are available online at www.samhsa.gov/data/. The 13 additional measures are substance use and mental health outcomes, including marijuana initiation and use, heroin use, alcohol and tobacco use, alcohol use disorder, serious thoughts of suicide, serious mental illness, any mental illness, and depression. Maps are provided for all outcomes and tables including percentages and counts for each state, census region, and the nation by age group, as well as the methodology that generated the state estimates.

A Note about the 2015 NSDUH Questionnaire Redesign

In 2015, several changes were made to the NSDUH questionnaire and data collection procedures, resulting in the establishment of a new baseline for several measures.¹² As a result, estimates for several measures included in prior state reports are not available. For details, see Section A of the *2014-2015 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology* report at <http://www.samhsa.gov/data/>.

ENDNOTES

1. National Institute on Drug Abuse. (2016). *DrugFacts—Cocaine*. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/cocaine>
2. The White House Office of National Drug Control Policy. (2016). *Coca in the Andes*. Retrieved from <https://www.whitehouse.gov/ondcp/targeting-cocaine-at-the-Source>
3. Drug related death information is available from multiple sources. See the National Institute on Drug Abuse. (2016). *Overdose death rates*. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates> and the Centers for Diseases Control and Prevention, National Center for Health Statistics. (2016). *Multiple Cause of Death 1999-2015*. Retrieved from <https://wonder.cdc.gov/mcd.html>.
4. Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Miech, R. A. (2016). *Monitoring the Future national survey results on drug use, 1975-2015: Volume II, college students and adults ages 19-55* (pp. 142, 177). Ann Arbor, MI: Institute for Social Research, The University of Michigan. Retrieved from http://www.monitoringthefuture.org/pubs/monographs/mtf-vol2_2015.pdf
5. Center for Behavioral Health Statistics and Quality. (2016). *Risk and protective factors and estimates of substance use initiation: Results from the 2015 National Survey on Drug Use and Health*. Retrieved from <http://www.samhsa.gov/data/>
6. In 2015, approximately 68 percent of all 968,000 new past year cocaine users aged 12 or older were 18- to 25-year-olds (663,000), followed by adults aged 26 or older (20 percent or 193,000) and adolescents aged 12 to 17 (about 12 percent or 112,000). In terms of population representation, 18- to 25-year-olds account for 13.0 percent of the total U.S. civilian, noninstitutionalized population of 267,694,000 people aged 12 or older. For people aged 26 or older and 12 to 17, it is 77.7 and 9.3 percent, respectively. See Table 12.2A in *Results from the National Survey on Drug Use and Health: Detailed Tables* at <http://www.samhsa.gov/data/>.
7. Small area estimation (SAE) is a model-based methodology that provides more precise estimates of substance use at the state level than those based solely on the sample, particularly for smaller states. The precision of the SAE estimates, particularly for states with smaller sample sizes, can be improved significantly by combining data across 2 years (e.g., 2013 and 2014, 2014 and 2015).
8. The difference in sample sizes for each of the states between 2013–2014 and 2014–2015 is due to a sample redesign in 2014. These sample sizes are based on age reported during the interview phase of the survey and are slightly different from the sample sizes based on age reported during the screening phase of the survey as provided in the *2014-2015 NSDUH Guide to State Tables and Summary of Small Area Estimation Methodology* report. For additional information, go to <http://www.samhsa.gov/data/>.
9. In this report, state estimates are discussed in terms of their observed rankings because they provide useful context. However, a state having a highest or lowest rate does not imply that the state's rate is significantly higher or lower than the rate of the next highest or lowest state. Similarly, the quintiles were not selected to represent statistical differences across quintiles or to correspond to proximity to a target public health threshold for a particular measure. For example, the division of states into quintiles does not indicate that states in the same quintile are statistically similar to each other. Although nearly equal number of states are contained in each quintile, the size of the intervals (i.e., the difference between the upper and lower limits of each quintile) that define the map boundaries is not necessarily uniform across each quintile. When comparing two state prevalence rates, the method of overlapping confidence intervals is more conservative (i.e., it rejects the null hypothesis of no difference less often) than the standard method based on Z statistics when the null hypothesis is true. Even if confidence intervals for two states overlap, the two estimates may be declared significantly different by the test based on Z statistics. Hence, the method of overlapping confidence intervals is not recommended to test the difference of two state estimates. A detailed description of the method of overlapping confidence intervals and its comparison with the standard methods for testing of a hypothesis is given in the following articles: (a) Schenker, N., & Gentleman, J. F. (2001). On judging the significance of differences by examining the overlap between confidence intervals. *American Statistician*, 55(3), 182–186. (b) Payton, M. E., Greenstone, M. H., & Schenker, N. (2003). Overlapping confidence intervals or standard error intervals: What do they mean in terms of statistical significance? *Journal of Insect Science*, 3, 34.
10. The West has 13 states: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, and WY. The South has 16 states plus the District of Columbia: AL, AR, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV. The Northeast has 9 states: CT, MA, ME, NH, NJ, NY, PA, RI, and VT. The Midwest has 12 states: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, and WI.
11. As discussed in the introduction, when ties (i.e., state estimates with the same value—to two decimal places) occur at the "boundary" between two quintiles, all of the states with the same value were conservatively assigned to the lower quintile. This occurred for Idaho and Kansas, each with estimates equal to 3.59 percent. Thus, both states were assigned to the lowest quintile, which increased the number of states from 10 to 11 (Table 1).
12. 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 <http://www.samhsa.gov/data/>

SUGGESTED CITATION

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SUMMARY

Background: Cocaine is a powerfully addictive stimulant. Recent findings suggest that cocaine use may be reemerging as a public health concern in the United States. This report highlights State estimates of cocaine use. **Methods:** This report presents 2014 to 2015 National Survey on Drug Use and Health (NSDUH) estimates of past year cocaine use among persons aged 18 to 25 in each of the 50 States and the District of Columbia. **Results:** Based on data from the combined 2014–2015 National Surveys on Drug Use and Health, 1.7 million young adults aged 18 to 25 in the United States used cocaine in the past year (4.98 percent of the young adult population). This equates to about 1 out of every 20 young adults across the nation using cocaine in the past year. At the state level, past year cocaine use varied from 1.83 percent in Mississippi to 10.54 percent in New Hampshire. Cocaine use among young adults increased in 16 states (when comparing combined 2014–2015 estimates with combined 2013–2014 estimates) and 3 regions. Use remained unchanged for the remaining 34 states and the District of Columbia and for the West. No decreases occurred in any census region or state. **Conclusion:** These findings suggest that cocaine is emerging as an issue among young adults, although the prevalence of the issue is not uniform across all States.

Key words: cocaine, young adults, state estimates, National Survey on Drug Use and Health, NSDUH

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KEYWORDS

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Short Report, Population Data, 2014, Policymakers, Substance Abuse, Young Adults as Population Group, Cocaine, Multi-Year Trend, All US States Only, 2015

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

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by SAMHSA. The data used in this report are based on information obtained from young adults aged 18 to 25 (22,000 in 2013, and 16,000 in 2014, and 17,000 in 2015). NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

The CBHSQ Report is prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, and by RTI International in Research Triangle Park, North Carolina. (RTI International is a registered trademark and a trade name of Research Triangle Institute.)

Information on the most recent NSDUH is available in the following publication:

Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from <http://samhsa.gov/data/>.

Also available online at <http://www.samhsa.gov/data/population-data-nsduh>.



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