1. Introduction

This report presents State estimates for 25 measures of substance use and mental disorders based on the 2009 and 2010 National Surveys on Drug Use and Health (NSDUHs). Changes (increases or decreases) that occurred between 2008-2009 and 2009-2010 for these measures also are presented. Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), NSDUH is an ongoing survey of the civilian, noninstitutionalized population of the United States aged 12 years or older. Interview data from 135,811 persons were collected in 2009-2010 (see Table A.9 in Appendix A). State estimates presented in this report have been developed using a small area estimation (SAE) procedure in which State-level NSDUH data are combined with county and census block group/tract-level data from the State. Aggregates of these State estimates are presented as regional and national estimates. Note that these estimates are benchmarked to the national design-based estimates (for details, see Section A.6 in Appendix A). This model-based methodology provides more precise estimates of substance use and mental disorders at the State level than those based solely on the sample, particularly for States with smaller samples.

Starting in 1999, the NSDUH sample was expanded to produce State-level estimates. The samples in each State were selected to represent proportionately the geography and demography of that State. The first report with State estimates was published in 2000 (Office of Applied Studies [OAS], 2000). It utilized the 1999 survey data and the SAE procedure. Because the SAE procedure requires significant preparatory steps for the modeling and extensive computation to generate results, the number of measures estimated has been limited to ones with high policy value. The first report included only seven measures. Subsequent State reports have been published annually, gradually extending the capabilities of the SAE procedure and increasing the number of measures estimated (Hughes, Muhuri, Sathe, & Spagnola, 2010, 2011; Hughes, Sathe, & Spagnola, 2008, 2009; Wright, 2002a, 2002b, 2003a, 2003b, 2004; Wright & Sathe, 2005, 2006; Wright, Sathe, & Spagnola, 2007). The current practice is to base annual estimates on a 2-year moving average of NSDUH data in order to enhance the precision for States with smaller samples.

State estimates also have been produced for additional measures by combining multiple years of NSDUH data and using sampling weights and direct estimation. The advantage of this approach is that it can be used on any variable in the NSDUH dataset; however, the estimates typically are not as accurate as the estimates based on the SAE methods. These estimates have been included in some reports and tables on the SAMHSA Web site.

1.1 Summary of NSDUH Methodology

NSDUH is the primary source of statistical information on the use of illicit drugs, alcohol, and tobacco by the U.S. civilian, noninstitutionalized population aged 12 or older. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The survey is planned and managed by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). The data are collected and processed by RTI

International[3] through a contract with CBHSQ. This section briefly describes the national survey methodology; for further details, see Appendix A.

The survey covers residents of households, noninstitutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Persons excluded from the survey include homeless people who do not use shelters, active military personnel, and residents of institutional group quarters, such as prisons and long-term hospitals.

The 1999 survey marked the first year in which the national sample was interviewed using a computer-assisted interviewing (CAI) method. The survey used a combination of computer-assisted personal interviewing (CAPI) conducted by an interviewer and audio computer-assisted self-interviewing (ACASI). Use of ACASI is designed to provide the respondent with a highly private and confidential means of responding to questions and increases the level of honest reporting of illicit drug use and other sensitive behaviors. For further details on the development of the CAI procedures for the 1999 National Household Survey on Drug Abuse (NHSDA, the former name of NSDUH), see OAS (2001).

The 1999 through 2001 NHSDAs and the 2002 through 2010 NSDUHs employed a 50-State design with an independent, multistage area probability sample for each of the 50 States and the District of Columbia. For the 50-State design, 8 States were designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) with target sample sizes of 3,600 per year or 7,200 over a 2-year period. In 2009-2010, sample sizes in these States ranged from 5,900 to 7,375 (see Table A.9). For the remaining 42 States and the District of Columbia, the target sample size was 900 per year or 1,800 over a 2-year period. Sample sizes in these States ranged from 1,719 to 1,934 in 2009-2010. This approach ensures there is sufficient sample in every State to support SAE while at the same time maintaining efficiency for national estimates. The design also oversampled youths and young adults, so that each State's sample was approximately equally distributed among three major age groups: 12 to 17 years, 18 to 25 years, and 26 years or older.

In 2002, several changes were introduced to the survey. Incentive payments of $30 were given to respondents for the first time in order to address concerns about the national and State response rates. Other changes included a change in the survey name, new data collection quality control procedures, and a shift from the 1990 decennial census to the 2000 census as a basis for population count totals and to calculate any census-related predictor variables that are used in the estimation.

An unanticipated result of these changes was that the prevalence rates for 2002 were in general substantially higher than those for 2001—higher than could be attributable to the usual year-to-year trend—and thus are not comparable with estimates for 2001 and prior years.[4] Therefore, the 2002 NSDUH was established as a new baseline for both the national and the State estimates. Given the varying effects of the incentive and other changes, not only are the estimates for 2002 and later years not comparable with prior years, but the relative rankings of States also may have been affected. Therefore, the rankings of States for 2002-2003 or later

[3] RTI International is a trade name of Research Triangle Institute, Research Triangle Park, North Carolina.
[4] For an overview of the impact of these changes, see Section C.2 of Appendix C in OAS (2005).

should not be compared with those for prior years. By combining data across 2 years, the precision of the small area estimates for the small sample States, and thus their rankings, have been improved significantly. In addition, by combining 2 years of data, the impact of the national model on those States has been reduced significantly relative to estimates based on a single year's data.[5]

Nationally in 2009-2010, 289,943 addresses were screened, and 135,811 persons responded within the screened addresses (see Table A.9 in Appendix A). The survey is conducted from January through December each year. The screening response rate (SRR) for 2009-2010 combined averaged 88.4 percent, and the interview response rate (IRR) averaged 75.1 percent, for an overall response rate (ORR) of 66.4 percent (Table A.9). The ORRs for 2009-2010 ranged from 52.2 percent in New York to 77.0 percent in South Dakota. Estimates in this report have been adjusted to reflect the probability of selection, unit nonresponse, poststratification to known census population estimates, item imputation, and other aspects of the estimation process. These procedures are described in the NSDUH methodological resource books (MRBs) (see http://www.samhsa.gov/data/Methodological_Reports.aspx).

The weighted SRR is defined as the weighted number of successfully screened households (or dwelling units)[6] divided by the weighted number of eligible households, or

$$SRR = \frac{\sum w_{hh} complete_{hh}}{\sum w_{hh} eligible_{hh}},$$

where w_{hh} is the inverse of the unconditional probability of selection for the household *(hh)* and excludes all adjustments for nonresponse and poststratification.

At the person level, the weighted IRR is defined as the weighted number of respondents divided by the weighted number of selected persons, or

$$IRR = \frac{\sum w_i complete_i}{\sum w_i selected_i},$$

where w_i is the inverse of the probability of selection for the ith person and includes household-level nonresponse and poststratification adjustments. To be considered a completed interview, a respondent must provide enough data to pass the usable case rule.[7]

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[5] Combining data across 2 years permits the estimation of change at the State level by expressing it as the difference of two consecutive 2-year SAE moving averages. Comparisons between the combined 2008-2009 data and the combined 2009-2010 data are presented in this report. This method is similar to the one used in the 2004-2005, 2005-2006, 2006-2007, 2007-2008, and 2008-2009 State reports (Hughes et al., 2008, 2009, 2010, 2011; Wright et al., 2007).

[6] A successfully screened household is one in which all screening questionnaire items were answered by an adult resident of the household and either zero, one, or two household members were selected for the NSDUH interview.

[7] The usable case rule requires that a respondent answer "yes" or "no" to the question on lifetime use of cigarettes and "yes" or "no" to at least nine additional lifetime use questions.

The weighted ORR is defined as the product of the weighted SRR and the weighted IRR or

$$ORR = SRR \times IRR.$$

1.2 Format of Report and Presentation of Data

This report has six chapters, including this introductory chapter. Chapters 2 through 6 discuss the findings of the 2009-2010 State small area estimates and comparisons between 2008-2009 and 2009-2010, along with U.S. maps of estimates for States at the end of each chapter. Tables showing comparisons between 2002-2003 and 2009-2010 State estimates will be available on the SAMHSA Web site at http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/Index.aspx. Appendix A presents the State estimation methodology. Data tables are presented in Appendices B and C. Appendix D includes a discussion on other sources of State-level data. Information on the contributors to this report is provided in Appendix E.

1.2.1 Mental Disorders

To address SAMHSA's need for estimates of serious mental illness, any mental illness, and suicidal thoughts (i.e., suicidal ideation), several important changes were made to the adult mental health items in the 2008 NSDUH questionnaire. These questionnaire changes caused discontinuities in trends for major depressive episode (i.e., depression) and serious psychological distress among adults aged 18 or older. As a result, adult depression and serious psychological distress estimates were excluded from the 2007-2008 State report. For youths aged 12 to 17, no questionnaire changes were made in 2008 that affected the estimation of youth depression items; so, estimates of youth depression have appeared in the 2004-2005 report and in all subsequent NSDUH State reports. An analysis was performed to better understand the nature of the changes in the reporting of adult depression associated with the questionnaire changes in 2008. This led to the development of statistical adjustments for the adult depression estimates for the years from 2005 to 2008; thus, comparable adult depression data are now available for the years 2005 and beyond. For more information about these changes, see Section A.11 in Appendix A of this report, Appendix B of the 2008 NSDUH national findings report (OAS, 2009), and Appendix B of the 2010 NSDUH mental health findings report (CBHSQ, 2012).

1.2.2 Chapter and Appendix Information

Chapter 2 presents State estimates for the prevalence of illicit drug use, marijuana use, the perceived risk of marijuana use, incidence of marijuana use, illicit drug use other than marijuana, cocaine use, and the nonmedical use of pain relievers. Chapter 3 discusses analogous estimates of alcohol use, binge alcohol use, and the perceived risk of binge alcohol use. Chapter 4 presents estimates of tobacco use, cigarette use, and the perceived risk of heavy cigarette use. Chapter 5 discusses the substance use disorder and treatment need-related measures (i.e., alcohol or illicit drug dependence or abuse and needing but not receiving treatment). Chapter 6 presents estimates of serious mental illness, any mental illness, and suicidal thoughts among adults aged 18 or older, as well as major depressive episode (i.e., depression) among youths aged 12 to 17

and adults aged 18 or older. In Chapters 2 through 6, trends between 2008-2009 and 2009-2010 are discussed.

At the ends of Chapters 2 through 6, State model-based estimates are portrayed in U.S. maps showing all 50 States and the District of Columbia. The maps reflect the ranking of States into fifths from lowest to highest for each measure to simplify the discussion in the chapters. Appendix A describes the SAE methodology for 2009-2010. For more details on the SAE methodology, see Appendix E of the 2001 State report (Wright, 2003b). Also included in Appendix A are the State sample sizes and response rates for 2008, 2009, 2010, 2008-2009 combined, and 2009-2010 combined (Tables A.1 to A.14). Tables of model-based estimates for each substance use or mental health measure are included in Appendix B. The quintile rankings can be determined from these tables that include all 50 States and the District of Columbia, listed in alphabetical order, by 4 age categories. Tables comparing the 2008-2009 and 2009-2010 estimates are presented in Appendix C. Note that because the layout is very similar for the tables in Appendix C and the tables that will be available on SAMHSA's Web site comparing the 2002-2003 and 2009-2010 estimates, a larger font size has been deliberately used for the years in the titles of these tables so that a reader can quickly distinguish between the two sets of tables. Tables comparing estimates over various time periods are presented for the four U.S. geographic regions in addition to State and age groups. These regions, defined by the U.S. Census Bureau, consist of the following groups of States:

Northeast Region - Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

Midwest Region - Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

South Region - Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

West Region - Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Tables for individual States (and for the Nation as a whole and its census regions) are available on the SAMHSA Web site and display all of the estimates discussed in this report by the appropriate age categories (see http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsaeStateTabs2010.htm). Also available on the SAMHSA Web site are tables of the total number of persons associated with each measure corresponding to the estimated percentages or rates for each substance use or mental health measure in Appendix B (see http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/Index.aspx). Estimates for all persons aged 18 or older for all 25 measures are also available on the Web site.

1.2.3 Figures

The color of each State on the U.S. maps indicates how the State ranks relative to other States for each measure. States could fall into one of five groups according to their ranking by

quintiles. Because there are 51 areas to be ranked for each measure, the middle quintile was assigned 11 areas and the remaining groups 10 each. In some cases, a "quintile" could have more or fewer States than desired because two (or more) States have the same estimate (to two decimal places). When such ties occurred at the "boundary" between two quintiles, all States with the same estimate were assigned to the lower quintile. Those States with the highest rates for a given measure are in red, with the exception of the perceptions of risk measures, for which the lowest perceptions of great risk are in red. Those States with the lowest estimates are in white, with the exception of the perceptions of risk measures, for which the highest perceptions of great risk are in white.

1.2.4 Confidence Intervals and Margins of Error

At the top of each table in Appendix B is the design-based national estimate along with a 95 percent design-based confidence interval, all of which are based on survey weights and the reported data. The State and regional estimates are model-based statistics (using SAE methodology) that have been adjusted such that the population-weighted mean of the estimates across the 50 States and the District of Columbia equals the design-based national estimate. For more details on this benchmarking, see Section A.6 in Appendix A. Associated with each State and regional estimate is a 95 percent Bayesian confidence interval. These intervals indicate the uncertainty in the estimate due to both sampling variability and model bias. For example, the State with the highest estimated rate of past month use of marijuana for young adults aged 18 to 25 was Vermont, with a rate of 32.0 percent and a 95 percent confidence interval that ranged from 28.4 to 35.9 percent (Table B.3). Therefore, the probability is 0.95 that the true prevalence of past month marijuana use in Vermont for persons aged 18 to 25 is between 28.4 and 35.9 percent. Note that in NSDUH State reports prior to the 2008-2009 report, the term "prediction interval" (PI) was used to represent uncertainty in the State and regional estimates. However, that term also is used in other applications to estimate future values of a parameter of interest. That interpretation does not apply to NSDUH State report estimates, so PI was replaced with "Bayesian confidence interval."

Margin of error is another term used to describe uncertainty in the estimates. For example, if (l, u) is a 95 percent symmetric confidence interval for the population proportion (p) and $\hat{p}$ is an estimate of p obtained from the survey data, then the margin of error of $\hat{p}$ is given by $(u - \hat{p})$ or $(\hat{p} - l)$. Because (l, u) is a symmetric confidence interval, $(u - \hat{p})$ will be the same as $(\hat{p} - l)$. In this case, the probability is 0.95 that the true population value (p) is within $\pm(u - \hat{p})$ or $(\hat{p} - l)$ of the survey estimate $(\hat{p})$. The margin of error defined above will vary for each estimate and will be affected not only by the sample size (e.g., the larger the sample, the smaller the margin of error), but also by the sample design (e.g., telephone surveys using random digit dialing and surveys employing a stratified multistage cluster design will, more than likely, produce a different margin of error) (Scheuren, 2004).

The confidence intervals shown in NSDUH reports are asymmetric, meaning that the distance between the estimate and the lower confidence limit will not be the same as the distance between the upper confidence limit and the estimate. For example, Utah's past month marijuana use rate of 7.7 percent for persons aged 18 to 25 years (see Table B.3) is 1.8 (i.e., 7.7 – 5.9) percentage points from the lower 95 percent confidence limit and 2.5 (i.e., 10.2 – 7.7) percentage

points from the upper limit. These asymmetric confidence intervals work well for small percentages often found in NSDUH reports while still being appropriate for larger percentages. Some surveys or polls provide only one margin of error for all reported percentages. This single number is usually calculated by setting the sample percentage estimate $(\hat{p})$ equal to 50 percent, which will produce an upper bound or maximum margin of error. Such an approach would not be feasible in this report because the estimates vary from less than 1 percent to over 75 percent; hence, applying a single margin of error to these estimates could significantly overstate or understate the actual precision levels. Therefore, given the differences mentioned above, it is more useful and informative to report the Bayesian confidence interval for each estimate instead of a margin of error.

In this report, State estimates are discussed in terms of their observed rankings because it provides a useful context. In Chapters 2 through 6, when it is indicated that a State has the highest or lowest rate, it does not imply that the State's rate is significantly higher or lower than the next highest or lowest State. When comparing two State prevalence rates, two overlapping 95 percent confidence intervals do not imply that their State prevalence rates are statistically equivalent at the 5 percent level of significance. For details on a more accurate test to compare State prevalence rates, see Section A.12 in Appendix A.

1.2.5 Comparisons of Estimates between Years

Comparisons between 2008-2009 and 2009-2010 are presented in Appendix C for 25 measures, by age group (see Tables C.1 to C.26). These tables show the estimates for 2008-2009 and 2009-2010 and a *p* value corresponding to a test of the hypothesis that there was "no change" over this period. The report discusses differences (i.e., increases or decreases) only if they are statistically significant at the 0.05 level of significance. These differences correspond to *p* values of 0.05 or less, which have been marked on the tables. In addition, *p* values greater than 0.05 but less than or equal to 0.10 have been marked on the tables to highlight other possible changes that may be of interest despite not quite reaching statistical significance. The methodology for testing for change involves fitting one model for 2008-2009 based on the predictor variables and the sample for those years and fitting a separate model for 2009-2010 based on the predictor variables and sample for those years. This methodology can lead to slightly different national models (i.e., models with slightly different model coefficients for the two sets of years). The change between 2008-2009 and 2009-2010 estimates the average yearly change between 2008 and 2010. "Average yearly change" indicates the change between 2008 and 2010 divided by 2. For more details on this topic, see Section A.13 in Appendix A on measuring change between years in State estimates.

1.2.6 Related Substance Use Measures

Throughout the report, there are a number of related drug use measures, such as marijuana use and illicit drug use. It might appear that one could draw conclusions by subtracting one from the other (e.g., subtracting the percentage who used illicit drugs other than marijuana in the past month from the percentage who used illicit drugs in the past month to find the percentage who only used marijuana in the past month). Because related measures have been estimated with different models, subtracting one measure from another related measure at the State or census region level in this report can give misleading results, perhaps even a "negative"

estimate, and should be avoided. However, these comparisons can be made at the national level because these estimates are design-based estimates. For example, at the national level, subtracting cigarette use rates from tobacco use rates will give the rate of persons who did not use cigarettes, but used other forms of tobacco (as shown in Chapter 4).

1.3 Measures Presented in This Report

Estimates for 2009-2010 were developed for 25 measures of substance use and mental disorders:

- past month use of illicit drugs,
- past year use of marijuana,
- past month use of marijuana,
- perception of great risk of smoking marijuana once a month,
- average annual rate of first use of marijuana,[8]
- past month use of illicit drugs other than marijuana,
- past year use of cocaine,
- past year nonmedical use of pain relievers,
- past month use of alcohol,
- past month binge alcohol use,
- perception of great risk of having five or more drinks of an alcoholic beverage once or twice a week,
- past month use of tobacco products,
- past month use of cigarettes,
- perception of great risk of smoking one or more packs of cigarettes per day,
- past year alcohol dependence or abuse,
- past year alcohol dependence,
- past year illicit drug dependence or abuse,
- past year illicit drug dependence,

[8] For details on how the average annual rate of first use of marijuana (incidence of marijuana) is calculated, see Section A.8 in Appendix A.

- past year dependence or abuse of illicit drugs or alcohol,
- needing but not receiving treatment for illicit drug use in the past year,
- needing but not receiving treatment for alcohol use in the past year,
- serious mental illness in the past year,
- any mental illness in the past year,
- serious thoughts of suicide in the past year, and
- past year major depressive episode (i.e., depression).

For all measures except serious mental illness, any mental illness, suicidal thoughts, and depression, there are separate estimates for three age groups (12 to 17, 18 to 25, and 26 or older) and a combined estimate for those aged 12 or older. For serious mental illness, any mental illness, suicidal thoughts, and depression, estimates are shown for two age groups (18 to 25 and 26 or older) and a combined estimate for those aged 18 or older. In addition, estimates of depression among youths aged 12 to 17 are presented. Estimates of past month alcohol use and binge alcohol use also are presented for those aged 12 to 20.

Statistical tests of differences between 2008-2009 and 2009-2010 were conducted for all 25 measures. Results of these statistical tests are available for the first time for three mental health measures, namely, serious mental illness, any mental illness, and suicidal thoughts.

1.4 Other NSDUH Reports and Products

The national results from the 2010 NSDUH were released in September 2011 (CBHSQ, 2011) and in January 2012 (CBHSQ, 2012). Similarly, the national results from the 2011 NSDUH will be released in September 2012.

Additional methodological information on the survey, including the questionnaire, is available on the CBHSQ Web site at http://www.samhsa.gov/data/Methodological_Reports.aspx. Brief descriptive reports and in-depth analytic reports focusing on specific issues or population groups also are produced by CBHSQ. Further information on accessing NSDUH publications, detailed tables, and public use files is contained in "Accessing Data from the National Survey on Drug Use and Health (NSDUH)" (OAS, 2004). A complete listing of previously published reports from NSDUH and other data sources is available from CBHSQ. Most of these reports are available through the Internet (http://www.samhsa.gov/data/NSDUH.htm). In addition, CBHSQ makes public use data files available to researchers through the Substance Abuse and Mental Health Data Archive (SAMHDA). Currently, data files are available for online analysis from the 1979 to 2010 NSDUHs at http://www.datafiles.samhsa.gov.

In the summer and fall of 2012, estimates for substate planning areas based on combined 2008-2010 NSDUH data will be available on the SAMHSA Web site at http://www.samhsa.gov/data/NSDUH/metro.htm. The substate planning area definitions for all 50 States and the District of Columbia are based on the areas for substate allocation of funds

under SAMHSA's Substance Abuse Prevention and Treatment (SAPT) block grant. Substate area estimates based on combined 2008-2010 data will be available for all measures listed in Section 1.3. Comparisons between 2006-2008 and 2008-2010 also will be available. For this comparison, the 2006-2008 substate small area estimates will be reproduced using the 2008-2010 substate region definitions. Along with the substate estimates, comparable State, regional, and national estimates will be summarized in tables along with maps that indicate the distribution of prevalence rates across the United States. The methodology used for producing substate estimates is similar to the SAE methodology used to produce the State estimates in this report.

1.5 Revised 2006-2010 Estimates

During regular data collection and processing checks for the 2011 NSDUH, data errors were identified. These errors affected the data for Pennsylvania (2006-2010) and Maryland (2008-2009). Cases with erroneous data were removed from the data files, and the remaining cases were reweighted to provide representative estimates. Therefore, some estimates using 2006-2010 NSDUH data in the 2011 national findings report and detailed tables, as well as other new reports (including this report), will contain estimates that differ from corresponding estimates found in some previous reports. All of the tables and maps in this report have a source note (i.e., "Revised March 2012") on them to indicate that they are based on updated NSDUH data (excluding the erroneous data for Pennsylvania and Maryland).

The errors had minimal impact on the national estimates and no effect on direct estimates for the other 48 States and the District of Columbia. The direct estimates for an area (e.g., a State or substate) are only based on its data. However, in reports such as the current one, where model-based SAE techniques are used, estimates for all States may be affected, even though the errors were concentrated in only two States. This is because the model-based estimate for a given State is a combination of the direct estimate for that State and the State estimate obtained from a national model. The national model, which has estimated parameter coefficients based on data from all States, changed when the erroneous Pennsylvania and Maryland data were removed and the remaining cases were reweighted. As a result, the model-based estimates in all States changed, although the most notable changes occurred in Pennsylvania and Maryland because the direct estimates in those States changed, as did their estimates based on the national model. In reports that do not use model-based estimates, the only estimates appreciably affected were estimates for Pennsylvania, Maryland, the mid-Atlantic division, and the Northeast region.

In this current report, the 2009-2010 and 2008-2009 model-based State estimates are based on the corrected data. Thus, the 2008-2009 estimates presented here in Appendices A and C may not match the 2008-2009 estimates shown in prior reports.