

States In Brief



Substance Abuse and Mental Health Issues At-A-Glance

A Short Report from the Office of Applied Studies



Prevalence of Illicit Substance¹ and Alcohol Use

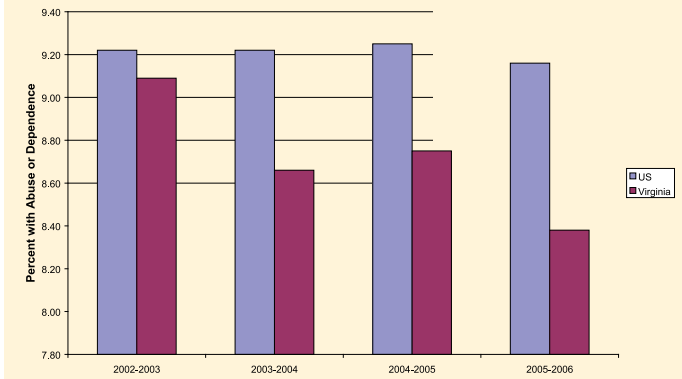
The National Survey on Drug Use and Health (NSDUH) generates state-level estimates for 23 measures of substance use and mental health problems for four age groups: the entire state population over age 12 (12+); individuals age 12 to 17; individuals age 18 to 25; and individuals age 26 and older (26+). Since State estimates of substance use and abuse were first generated using the combined 2002-2003 NSDUHs and continuing until the most recent state estimates based on the combined 2005-2006 surveys, Virginia's rates² on all major prevalence measures have remained at or below the rates for the country as a whole.



Abuse and Dependence

Questions in NSDUH are used to classify persons as being dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* (American Psychiatric Association, 1994). As with the prevalence rates above, rates of past year abuse or dependence on illicit drugs or alcohol have remained consistently at or below the rates for the country as a whole for all population groups (Chart 1).

Chart 1 Past Year Abuse of or Dependence on Illicit Drugs or Alcohol Among Individuals Age 12 and Older - Virginia



Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS),² in 2006, there were 196 treatment facilities in Virginia. Of these, 55 (28%) were private nonprofit and 43 (22%) were private for-profit. The State government operated an additional 70 facilities.

The number of treatment facilities in Virginia has declined from 228 in 2002 to 196 in 2006. The decrease is primarily attributable to a loss of 13 private for-profit facilities and 26 facilities owned/operated by the State government.

Although facilities may offer more than one modality of care, in 2006 the majority of Virginia facilities (167 of 196, or 85%) offered some form of outpatient care. Another 42 facilities offered residential care, and 20 facilities had opioid treatment programs. In addition, 133 physicians and 35 treatment programs were certified to provide buprenorphine treatment.

In 2006, 123 facilities (63%) received some form of Federal, State, county, or local government funds, and 97 facilities (50%) had agreements or contracts with managed care organizations for the provision of substance abuse treatment services



Treatment

State treatment data for substance use disorders are derived from two primary sources—an annual one-day census in N-SSATS and annual treatment admissions from the Treatment Episode Data Set (TEDS).³ In the 2006 N-SSATS survey, Virginia showed a total of 22,847 clients in treatment, the majority of whom (21,311 or 93%) were in outpatient treatment. Of the total number of clients in treatment on this date, 2,879 (12%) were under the age of 18.

Chart 2 shows the percentage of admissions mentioning particular drugs or alcohol at the time of admission.⁴ Across the last 14 years, there has been a modest decline in the number of admissions mentioning alcohol as a substance of abuse and modest increases in admissions mentioning marijuana and heroin.

Across the years for which TEDS data are available, Virginia has seen a modest shift in the constellation of problems present at treatment admission. Alcohol-only admissions have declined from over 26 percent of all admissions in 1992 to just over 14 percent in 2005. Concomitantly, drug-only admissions have increased from 15 percent in 1992 to 23 percent in 2005 (Chart 3).

Chart 2
Drug Mentions at Treatment Admission
Virginia

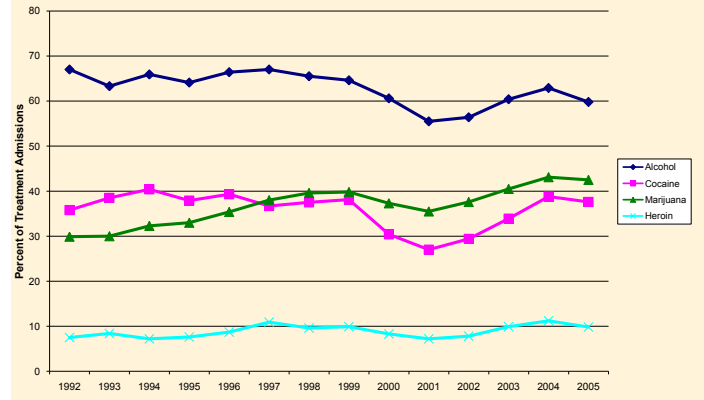
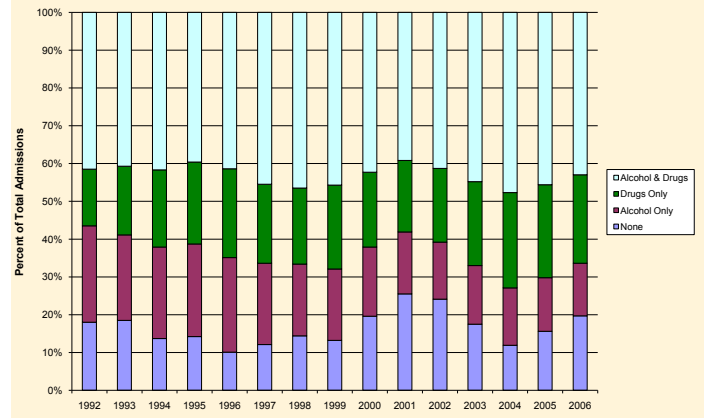


Chart 3
Drug Combinations at Treatment Admission
Virginia





Unmet Need for Treatment

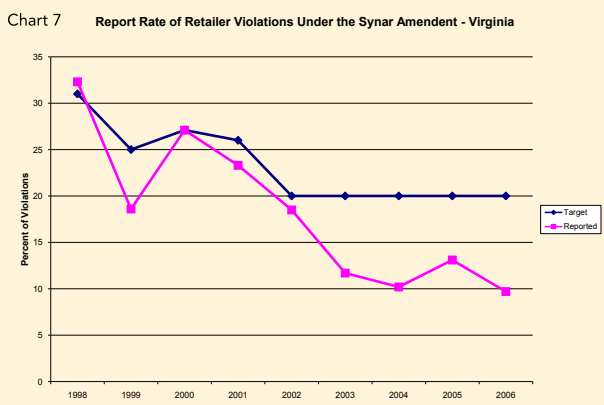
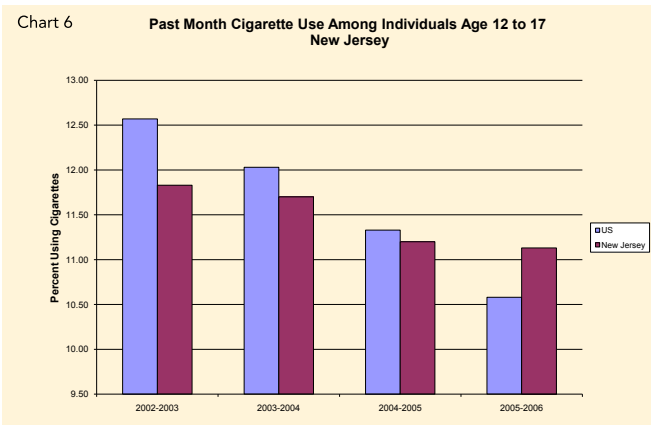
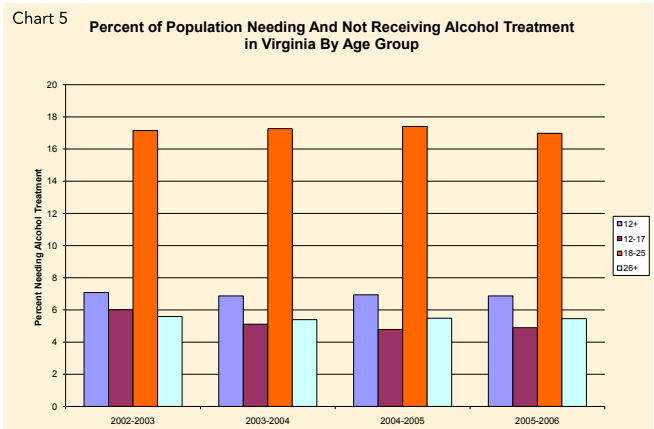
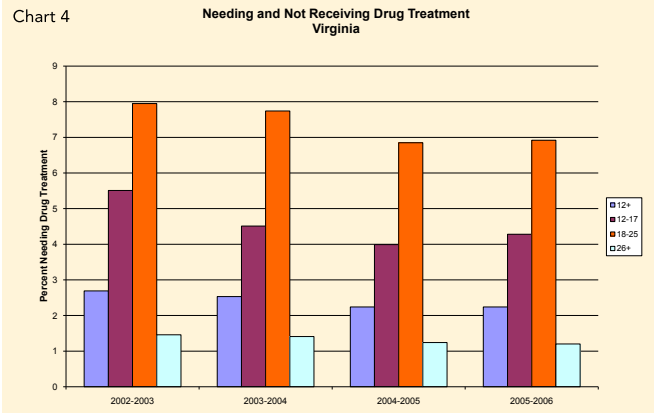
NSDUH defines unmet treatment need as an individual who meets the criteria for abuse of or dependence on illicit drugs or alcohol according to the *DSM-IV*, but who has not received specialty treatment for that problem in the past year.

While rates of individuals needing and not receiving drug or alcohol treatment have generally remained at or below the national rates, those age 18 to 25 exhibit unmet treatment need higher than other population groups both in Virginia and in the country as a whole (Charts 4 and 5).

Tobacco Use and Synar Compliance

Rates of the use of tobacco products and cigarettes by underage smokers have typically been at or below the national rates (Chart 6).

SAMHSA monitors the rate of retailer violation of tobacco sales through the Agency's responsibilities under the Synar Amendment. Retailer violation rates represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. Virginia's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 2001 (Chart 7).



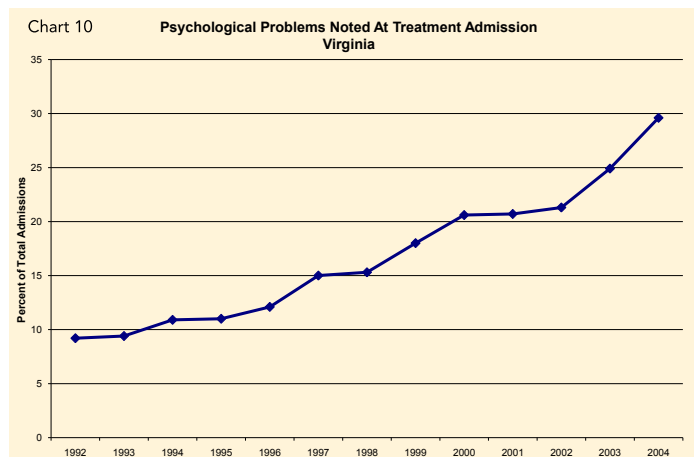
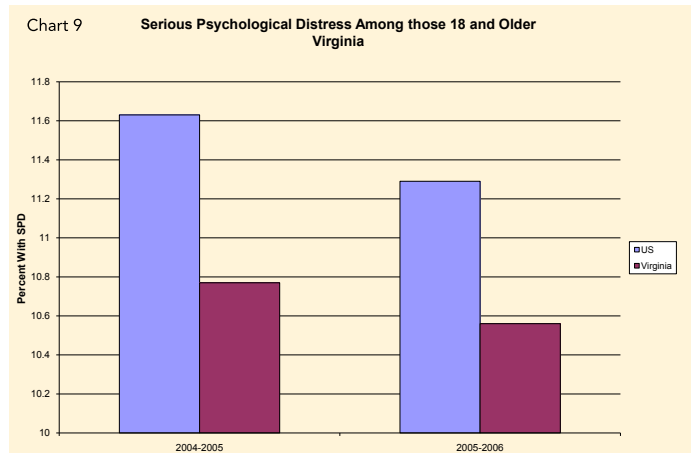
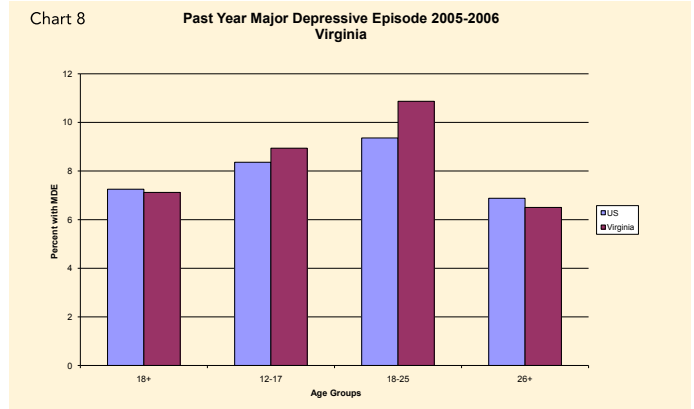
Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress (SPD), an overall indicator of nonspecific psychological distress. Since 2004-2005, the survey also measures past year major depressive episodes (MDE) for the same age group and for individuals age 12 to 17. MDE is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.

Rates of past year MDE for those age 12 to 17 and those age 18 to 25 have generally been above the rates for the country as a whole (Chart 8).

On the other hand, rates of past year SPD have generally been among the lowest in the country since 2004 (Chart 9).

TEDS also collects information on psychological problems present at treatment admission. In Virginia, the percentage of admissions with such problems has tripled since 1992⁵ (Chart 10).





SAMHSA Funding

SAMHSA funds two basic types of grants—block and formula grants allocated to states and territories by formula and discretionary grants which are awarded competitively (Chart 11). Each of the three SAMHSA Centers (the Center for Substance Abuse Treatment [CSAT], the Center for Substance Abuse Prevention [CSAP], and the Center for Mental Health Services [CMHS]) has a unique discretionary portfolio.

2004-2005:

\$43.3 million	Substance Abuse Prevention and Treatment Block Grant
\$12.6 million	Mental Health Block and Formula Grants
\$13.0 million	SAMHSA Discretionary Program Funds
\$68.9 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure Grant; Co-Occurring State Incentive Grant; Emergency Response; Disaster Relief; Jail Diversion; Statewide Consumer Networks; Minority Fellowship Program; National Technical Assistance Center on Consumer/Peer-Run Programs; Public Safety Workers—First Response; Post-Traumatic Stress Disorder in Children.

CSAP: Drug-Free Communities (19 grants); HIV/AIDS Services; Youth Transition to the Workplace; Anti-Drug Coalition; SAMHSA Conference Grant.

CSAT: State Data Infrastructure; Residential Substance Abuse Treatment; Addiction Technology Transfer Center; Adult, Juvenile, and Family Drug Courts; Targeted Capacity Expansion—Rural Populations; Targeted Capacity Expansion—HIV/AIDS; and Strengthening Access and Retention.

2005-2006

\$42.9 million	Substance Abuse Prevention and Treatment Block Grant
\$12.5 million	Mental Health Block and Formula Grants
\$12.5 million	SAMHSA Discretionary Program Funds
\$67.9 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure Grant; Co-Occurring State Incentive Grant; Youth Suicide Prevention and Early Intervention; Statewide Consumer Networks; Minority Fellowship Program; National Technical Assistance Center on Consumer/Peer-Run Programs; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; Targeted Capacity Expansion—Jail Diversion.

CSAP: Drug-Free Communities (20 grants); SAMHSA Conference Grant; HIV/AIDS Services; HIV—Strategic Prevention Framework; Anti-Drug Coalition; Youth Transition to the Workplace.

CSAT: State Adolescent Substance Abuse Treatment Coordination; Addiction Technology Transfer Center; Young Offender Reentry Program; Targeted Capacity Expansion—Rural Populations; Targeted Capacity Expansion—HIV/AIDS; and Strengthening Access and Retention.

2006-2007:

\$42.9 million	Substance Abuse Prevention and Treatment Block Grant
\$12.5million	Mental Health Block and Formula Grants
\$13.3 million	SAMHSA Discretionary Program Funds
\$68.7 million	Total SAMHSA Funding

CMHS: Mental Health Data Infrastructure Grant; Seclusion and Restraint; Emergency Response; Co-Occurring State Incentive Grant; Youth Suicide Prevention and Early Intervention; Consumer/Consumer Supporter Technical Assistance Center; Minority Fellowship Program; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; Targeted Capacity Expansion—Jail Diversion.

CSAP: HIV—Strategic Prevention Framework; Drug-Free Communities (19 grants); HIV—Strategic Prevention Framework; Youth Transition to the Workplace.

CSAT: State Adolescent Substance Abuse Treatment Coordination; Addiction Technology Transfer Center; Young Offender Reentry Program; Targeted Capacity Expansion—Rural Populations; and Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Other Populations and Emerging Substance Abuse Issues; and Recovery Community Services Recovery.

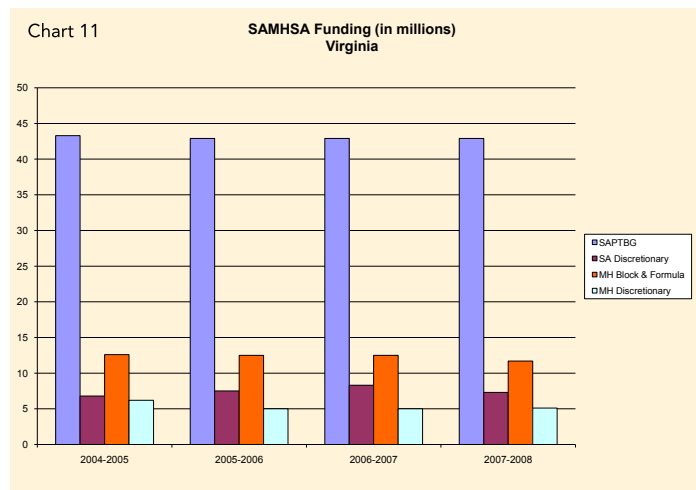
2007-2008:

\$42.9 million	Substance Abuse Prevention and Treatment Block Grant
\$11.7 million	Mental Health Block and Formula Grants
\$12.4 million	SAMHSA Discretionary Program Funds
\$67 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure Grant; Co-Occurring State Incentive Grant; Youth Suicide Prevention and Early Intervention; Statewide Consumer Networks; Minority Fellowship Program; National Technical Assistance Center on Consumer/Peer-Run Programs; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; SAMHSA Conference Grant; Targeted Capacity Expansion—Jail Diversion.

CSAP: HIV—Strategic Prevention Framework; Drug-Free Communities (17 grants); Youth Transition to the Workplace; Anti-Drug Coalition; HIV/AIDS Services.

CSAT: State Adolescent Substance Abuse Treatment Coordination; Addiction Technology Transfer Center; Young Offender Reentry Program; Targeted Capacity Expansion—Rural Populations; and Targeted Capacity Expansion—HIV/AIDS.





For Further Information

A comprehensive listing of all NSDUH measures for every state is available at: <http://oas.samhsa.gov/statesList.cfm>.

Also, information about variations in incidence and prevalence of the NSDUH substance abuse and mental health measures within each state is available at: <http://oas.samhsa.gov/metro.htm>.

Data Sources

Grant Awards: Available at www.samhsa.gov/statesummaries/index.aspx.

Facility Data: National Survey of Substance Abuse Treatment Services (N-SSATS): 2006, available at www.dasis.samhsa.gov.

Treatment Data: Treatment Episode Data Set—Concatenated File—available from the Substance Abuse and Mental Health Data Archive at www.icpsr.umich.edu/SDA/SAMHDA.

¹NSDUH defines illicit drugs to include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. Nonmedical use is defined as use not prescribed for the respondent by a physician or used only for the experience or feeling the drug(s) caused. Nonmedical use of any prescription-type pain reliever, sedative, stimulant, or tranquilizer does not include over-the-counter drugs. Nonmedical use of stimulants includes methamphetamine use.

²N-SSATS is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS does not collect information from the following three types of facilities: nontreatment halfway houses; jails, prisons or other organizations that treat incarcerated clients exclusively; and solo practitioners.

³TEDS is an admissions-based system, and TEDS admissions do not represent individuals. For example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

⁴TEDS collects information on up to three substances of abuse that lead to the treatment episode. These are not necessarily a complete enumeration of all drugs used at the time of admission.

⁵States are assigned to one of five groups according to their ranking (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. Throughout this document “highest” refers to the 10 States in the first quintile and “lowest” to those in the fifth quintile.

Prevalence Data

Wright, D. & Sathe, N. (2005) *State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D. & Sathe, N. (2006) *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-06-4142, NSDUH Series H-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., Sathe, N. & Spagnola, K. (2007) *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-07-4235, NSDUH Series H-31). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Hughes, A. & Sathe, N. (2008) *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-08-4311, NSDUH Series H-33). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.