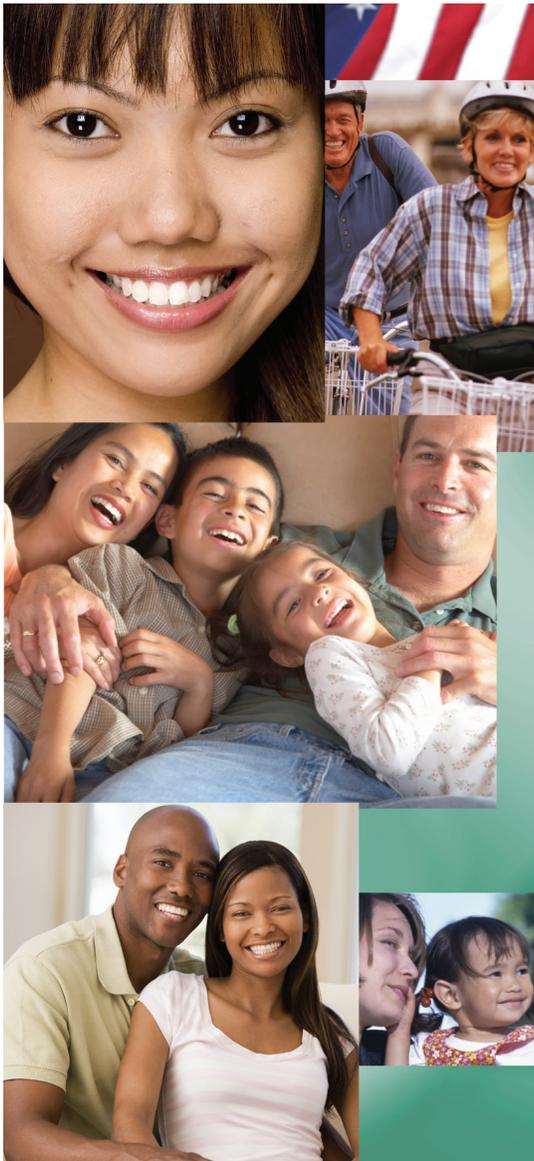




# States In Brief

Substance Abuse and Mental Health Issues At-A-Glance

A Short Report from the Office of Applied Studies



## Prevalence of Illicit Substance<sup>1</sup> and Alcohol Use and Abuse

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, rates of several measures of illicit drug use have remained at or above the national average for most age groups. This includes past month illicit drug use for the population age 12 and older; past month and past year marijuana use; and past month use of an illicit drug other than marijuana.

Rates of the nonmedical use of pain relievers, however, have remained at or below the national rates for all population groups, except those age 26 and older for whom the rates are higher than the national rates.

Rates of past month alcohol use and past month binge alcohol use have also consistently remained below the national average; in the 2005-2006 rate on the perception of risk associated with having five or more drinks of an alcoholic beverage once or twice a week, California ranked among the 10 *highest*<sup>2</sup> States in the country.

This is one in a series of brief state-based reports intended to give the reader a quick overview of substance abuse and mental health issues within a single state. The data derive principally from national surveys conducted by the Office of Applied Studies, a component of the Substance Abuse and Mental Health Services Administration. Sources for all data used in this report appear at the end.



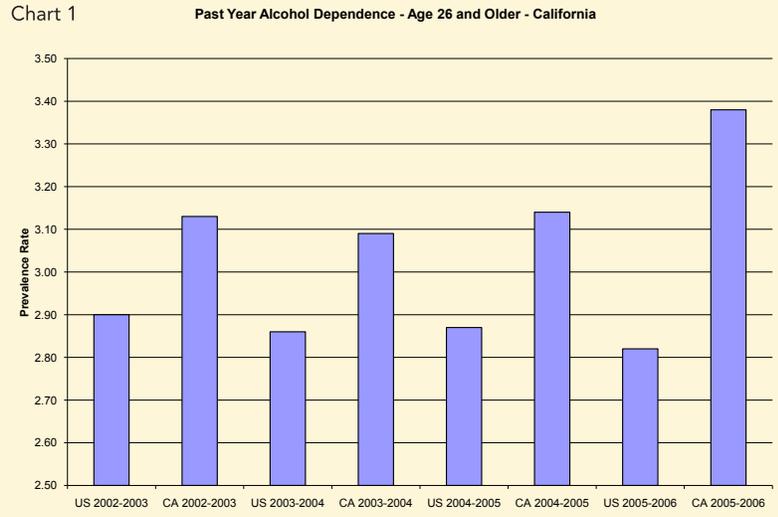


## Abuse and Dependence

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* (American Psychiatric Association, 1994).

Until the 2005-2006 surveys, rates of alcohol abuse or dependence in California were at or below the national average for all age groups. In 2005-2006, however, the rate for the population age 26 and older ranked among the 10 highest states in the country (Chart 1).

Since 2003-2004, rates of past year illicit drug dependence or abuse have remained higher than the national rates; however, these rates were not among the highest tier of states.



## Substance Abuse Treatment Facilities

According to the annual National Survey of Substance Abuse Treatment Services (N-SSATS)<sup>3</sup>, the number of treatment facilities in California recognized or certified by the Single State Agency has increased from 1,772 in 2002, to 1,820 in

2006. The major contribution for this increase was the addition of 43 private for-profit facilities (from 363 to 406 in 2002 and 2006, respectively), an increase of 7 federally operated facilities, and a decrease of 2 facilities operated or owned by Tribal Governments.

Although facilities may offer more than one modality of care, the majority of California facilities in 2006 (1,285 of 1,820, or 71%) offered some form of outpatient treatment; 41 percent of facilities offered some form of residential care; 132 facilities offered methadone treatment; and there were 921 physicians certified to provide buprenorphine therapy.

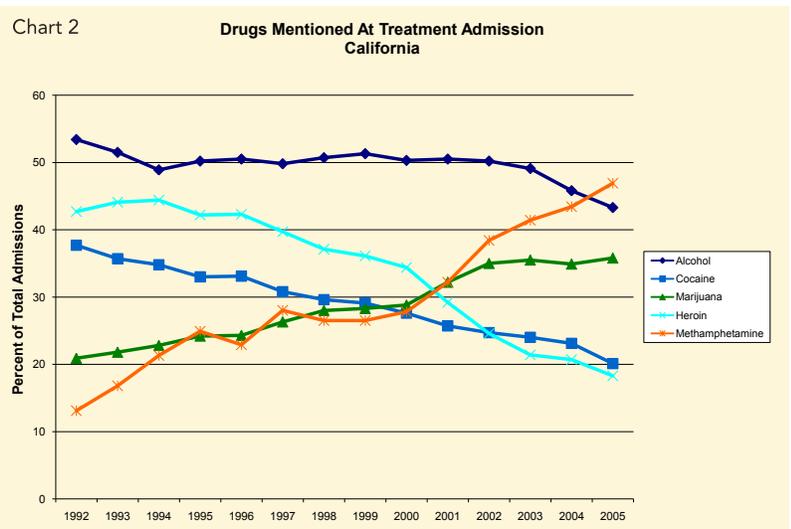
There were 1,140 facilities (63%) that received some form of Federal, state, county, or local government funds to provide treatment, and 476 facilities (26%) had agreements or contracts with managed care organizations for the provision of treatment services.



## 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)<sup>4</sup>. With 96 percent of all California facilities responding to the 2006 N-SSATS survey, California showed a one-day census total of 138,342 clients in treatment, the majority of whom (118,840 or 86%) were in outpatient treatment. Of the total number of clients in treatment on this date, 12,174 (9%) were under the age of 18.

Since 2002, there has been a steady increase in the annual number of admissions to treatment in California, from approximately 154,000 in 2002 to more than 183,000 in 2005 (the most recent year for which data are available). Chart 2 shows the percentage of admissions mentioning particular drugs or alcohol at the time of admission<sup>5</sup>. Across the last 13 years, there has been a decline in the number of admissions mentioning alcohol, cocaine, or heroin as a substance of abuse, and concomitant increases in the mentions of marijuana. The sharpest increase, however, has been the number of admissions attributable to methamphetamine abuse.





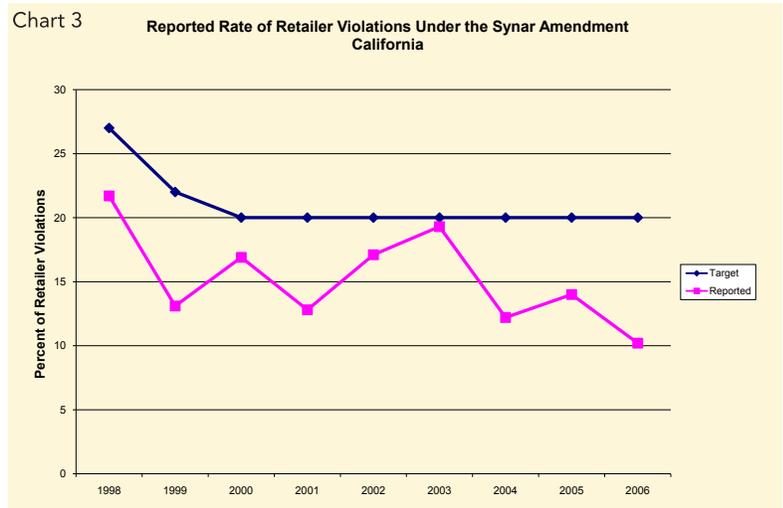
## Unmet Need for Treatment

California has consistently ranked at or above the national average in the rate of individuals needing and not receiving treatment for alcohol abuse for all age groups, as well as for individuals needing and not receiving treatment for drug use. Mirroring the rates of alcohol dependence for individuals 26 and older, as indicated above, the rate of individuals in this age group needing and not receiving treatment for alcohol abuse in 2005-2006 was among the highest in the country.

## Tobacco Use and Synar Compliance

California’s rate of underage smoking (individuals 12 to 17) and for smoking among all age groups has consistently remained among the 10 lowest states in the country since 2002 for all age groups. Similarly, the rates of the perception of risk associated with smoking one or two packs of cigarettes a day has consistently remained among the highest for all age groups.

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. California’s rates of Synar Amendment violations have been consistently within the target range since 1998 (Chart 3).



## Mental Health Indicators

The National Survey on Drug Use and Health measures past year serious psychological distress for individuals age 18 and older. Since 2004-2005, the survey has also measured past year major depressive episodes for the same age group and for individuals age 12 to 17.

Rates of serious psychological distress in California have been at or below the national rates for all survey years; in 2005-2006, rates for the 18 and older population, as well as rates for individuals 26 and older, were among the lowest in the country. Similarly, rates of past year major depressive episodes have remained among the lowest in the country for all population groups, except those age 12 to 17, for whom the rates have been at or slightly lower than those in the total U.S. population.

## SAMHSA Funding (Chart 4)

In 2004-2005, California received \$404 million in SAMHSA funding. Of this amount, \$252.4 million came from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), and \$65.4 million from the mental health block and formula grants. The remainder of California's funding came from the following SAMHSA discretionary programs: Children's Services (mental health); Evidence-Based Training and Evaluation (mental health); Emergency Response (mental health); Statewide Family Networks (mental health); State Mental Health Data Infrastructure Grants (mental health); Statewide Consumer Networks (mental health); Elderly Mental Health Outreach (mental health); Post-Traumatic Stress Disorder in Children (mental health); Disaster Relief (mental health); Initiative to End Chronic Homelessness; Youth Violence Prevention; Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Drug-Free Communities (42 grants); Ecstasy and Other Club Drug Prevention; HIV/AIDS Services; State Incentive Cooperative Agreement (substance abuse prevention); State Data Infrastructure (substance abuse treatment); Targeted Capacity Expansion—HIV/AIDS; SAMHSA Conference Grant; Access to Recovery; Methamphetamine Populations (substance abuse treatment); Homeless Addictions Treatment; Effective Adolescent Treatment; Targeted Capacity Expansion—General; Recovery Community Support—Facilitating; Pregnant and Post-Partum Women; Strengthening Communities—Youth; Young Offender Reentry Program; Adult, Juvenile and Family Drug Courts; Targeted Capacity Expansion—Rural Populations; Residential Substance Abuse Treatment; Strengthening Access and Retention; Addiction Technology Transfer Center; State Targeted Capacity Expansion—Screening, Brief Intervention and Referral to Treatment; and SAMHSA Dissertation Grant.



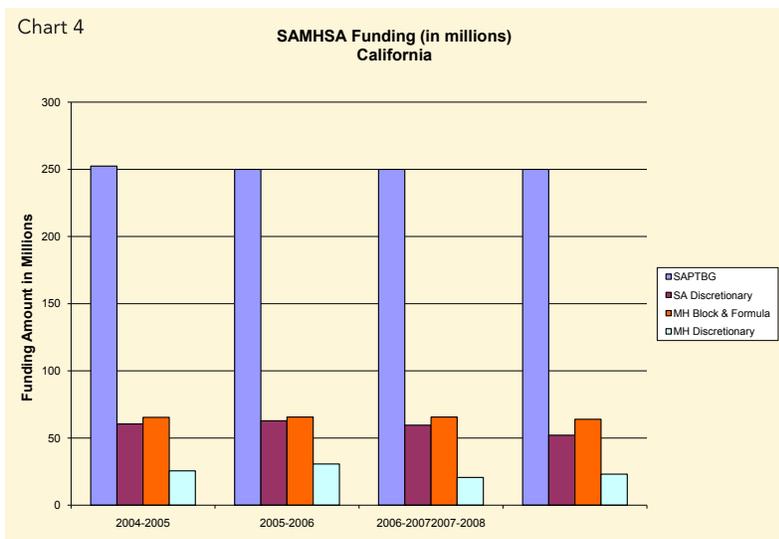
In 2005-2006, California received \$409.3 million in SAMHSA funding. Of this amount, \$250 million came from the SAPTBG, and \$65.6 million from the mental health block and formula grants. The remainder of California's funding came from the following SAMHSA discretionary programs: Evidence-Based Training and Evaluation (mental health); Children's Services (mental health); Targeted Capacity Expansion—Jail Diversion; Child Mental Health Initiative; Statewide Consumer Networks (mental health); State Mental Health Data Infrastructure Grants; Disaster Relief (mental health); Statewide Family Networks (mental health); Initiative to End Chronic Homelessness; Campus Suicide; Youth Violence Prevention; Targeted Capacity Expansion—Service Capacity Building in Minority Communities; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; Linking Adolescents at Risk to Mental

Health Services; Post-Traumatic Stress Disorder in Children; Community Treatment and Services Centers of the National Child Traumatic Stress Initiative; Initiative to End Chronic Homelessness; Drug-Free Communities (45 grants); Drug-Free Communities—Mentoring; Ecstasy and Other Club Drug Prevention; HIV—Strategic Prevention Framework; State Incentive Cooperative Agreement (substance abuse prevention); HIV/AIDS Services; SAMHSA Conference Grant; Effective Adolescent Treatment; Targeted Capacity Expansion—Rural Populations; Targeted Capacity Expansion—HIV/AIDS; Access to Recovery; Methamphetamine Populations (substance abuse treatment); Homeless Addictions Treatment; Targeted Capacity Expansion—American Indian/Alaska Natives; Targeted Capacity Expansion—General; Recovery Community Support—Facilitating; Pregnant and Post-Partum Women; Strengthening Communities—Youth; Young Offender Reentry Program; Juvenile Drug Courts; Adult, Juvenile and Family Drug Courts; Strengthening Access and Retention; Addiction Technology Transfer Center; Targeted Capacity Expansion—Campus Screening/Colleges and Universities; Family Drug Courts; State-Targeted Capacity Expansion—Screening, Brief Intervention and Referral to Treatment; and SAMHSA Dissertation Grant.

In 2006-2007, California received \$395.9 million in SAMHSA funding. Of this amount, \$250 million came from the SAPTBG, and \$65.6 million from the mental health block and formula grants. The remainder of California's funding came from the following SAMHSA discretionary programs: Children's Services (mental health); Targeted Capacity Expansion—Jail Diversion; Child Mental Health Initiative; Statewide Family Networks (mental health); State Mental Health Data Infrastructure Grants; Statewide Consumer Networks (mental health); Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Targeted Capacity Expansion—Jail Diversion; Children's Services (mental health); Campus Suicide; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; Linking Adolescents at Risk to Mental Health Services; Post-Traumatic Stress Disorder in Children; Community Treatment and Services Centers of the National Child Traumatic Stress Initiative; Youth Suicide Prevention and Early Intervention; SAMHSA Conference Grant; Drug-Free Communities (29 grants); HIV—Strategic Prevention Framework; HIV/AIDS Services; Strategic Prevention Framework State Incentive Grant; Homeless Addictions Treatment; Methamphetamine Populations (substance abuse treatment); Targeted Capacity Expansion—HIV/AIDS; Treatment for Homeless; Strengthening Communities—Youth; Young Offender Reentry Program; Juvenile Drug Courts; Targeted Capacity Expansion—Rural Populations; Targeted Capacity Expansion—American Indian/Alaska Natives; Effective Adolescent Treatment; Pregnant and Post-Partum Women; Juvenile Drug Courts;

Addiction Technology Transfer Center; Targeted Capacity Expansion—American Indian/Alaska Natives; Family Drug Courts; Access to Recovery; and State-Targeted Capacity Expansion—Screening, Brief Intervention and Referral to Treatment.

In 2007-2008, California received \$395.9 million in SAMHSA funding. Of this amount, \$250 million came from the SAPTBG, and \$65.6 million from the mental health block and formula grants. The remainder of California’s funding came from the following SAMHSA discretionary programs: Children’s Services (mental health); Child Mental Health Initiative; Targeted Capacity Expansion—Jail Diversion; Statewide Family Networks (mental health); Statewide Consumer Networks (mental health); Supportive Housing (mental health); Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Campus Suicide; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; Adolescents at Risk; Post-Traumatic Stress Disorder in Children; Post-Traumatic Stress Disorder—Treatment Centers; Community Treatment and Services Centers of the National Child Traumatic Stress Initiative; Youth Suicide Prevention and Early Intervention; SAMHSA Conference Grant; Drug-Free Communities (41 grants); HIV/AIDS Services; HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant; Prevention of Methamphetamine Abuse; Drug-Free Communities—Mentoring; Targeted Capacity Expansion—Rural Populations; Access to Recovery; Targeted Capacity Expansion—HIV/AIDS; State-Targeted Capacity Expansion—Screening, Brief Intervention and Referral to Treatment; Homeless Addictions Treatment; Effective Adolescent Treatment; Pregnant and Post-Partum Women; Recovery Community Support—Facilitating; Targeted Capacity Expansion—American Indian/Alaska Natives; Methamphetamine Populations (substance abuse treatment); Juvenile Drug Courts; Targeted Capacity Expansion—American Indian/Alaska Natives; Young Offender Reentry Program; Addiction Technology Transfer Center; Targeted Capacity Expansion—Campus Screening/Colleges and Universities; Family Drug Courts; and Recovery Community Support—Recovery.





## 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: U.S. Department of Health and Human Services, Substance Abuse & Mental Health Services Administration (SAMSHA). Grant awards by State: State summaries FY 2007/2008. From <http://www.samhsa.gov/statesummaries/index.aspx>.

Facility Data: U.S. Department of Health and Human Services, Substance Abuse & Mental Health Services Administration (SAMSHA). National survey of substance abuse treatment services (N-SSATS): 2006. From <http://www.dasis.samhsa.gov>.

Treatment Data: Interuniversity Consortium for Political and Social Research (ICPSR). Treatment episode data set—concatenated file. Substance abuse and mental health data archive. From <http://www.icpsr.umich.edu/SDA/SAMHD>.

<sup>1</sup> NSDUH 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.

<sup>2</sup> States 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.

<sup>3</sup> N-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: non-treatment halfway houses; jails, prisons, or other organizations that treat incarcerated clients exclusively; and solo practitioners.

## 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..

<sup>4</sup> TEDS 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.

<sup>5</sup> TEDS collects information on up to three substances of abuse which lead to the treatment episode. These are not necessarily a complete enumeration of all drugs used at the time of admission.

