



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, the rates in North Carolina for most measures have been at or below the national rates and for the following measures were among the ten *lowest*² in the country (Table 1).

Table 1: North Carolina is among those states with the lowest rates of the following:

Measure	Age Groups
Past Month Alcohol Use	12+, 12-20, 26+
Past Month Binge Alcohol Use	18-25, 12-20
Greatest Perception of Risk Associated with Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	12+, 26+

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 (DSM-IV)* (American Psychiatric Association, 1994).

On the global measure of any past year abuse of or dependence on illicit drugs or alcohol, rates in North Carolina have generally been below the national rates (Chart 1). When alcohol and illicit drugs are considered separately, however, some differences can be seen in that alcohol dependence rates are lower than the national rates and drug dependence rates are at or above the national rates (Chart 2).

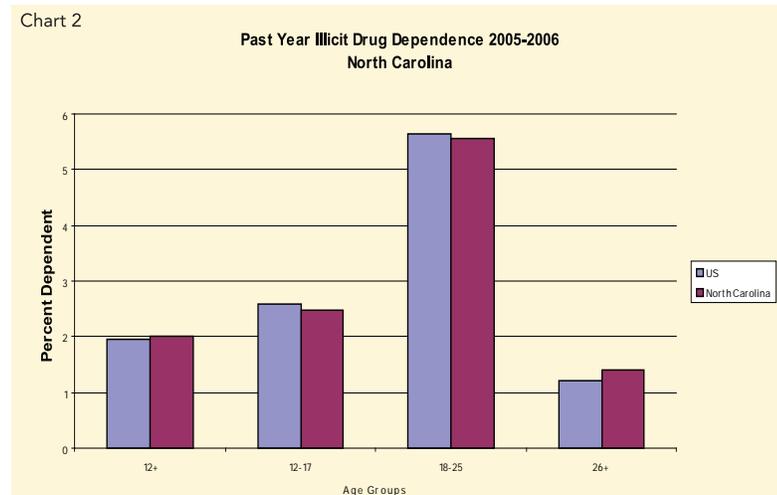
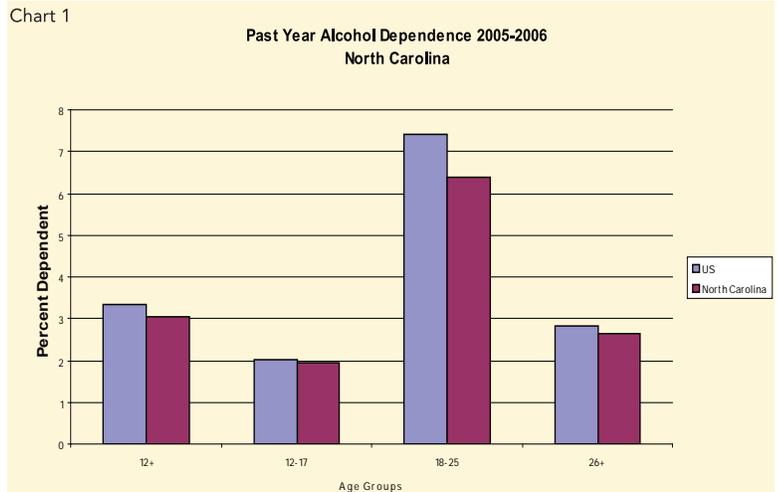
Substance Abuse Treatment Facilities

According to the 2006 National Survey of Substance Abuse Treatment Services (N SSATS),³ North Carolina had a total of 362 treatment facilities. Private non-profit and private for-profit organizations each had 147 facilities. One facility was owned/operated by a tribal government. The number of treatment facilities in North Carolina has increased by more than 80 since 2002. The change is primarily accounted for by increases in both private for-profit and private non-profit facilities (60 and 61 facilities respectively) and a decrease in those facilities owned or operated by Federal, State, or local government(s).

Although facilities may offer more than one modality of care, the majority of facilities in 2006 (300 of 362) offered some form of outpatient treatment. Sixty additional facilities offered some

form of residential care, and 34 facilities offered an opioid treatment program. In addition, 126 physicians and 48 treatment programs are certified to provide buprenorphine care.

In 2006, 42 percent of all facilities (153) received some form of Federal, State, county or local government funds, and 143 facilities (40%) had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

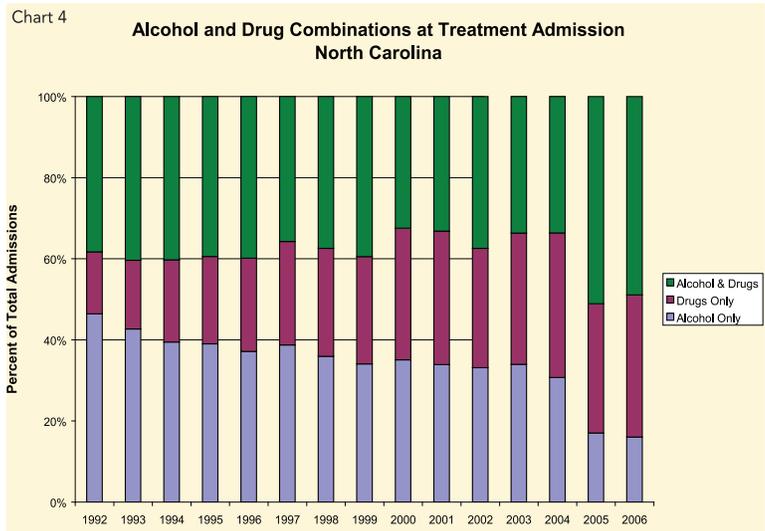
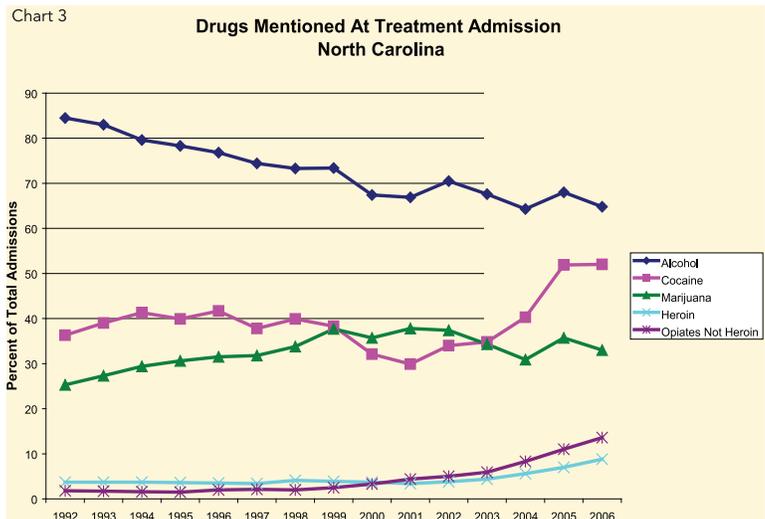


Treatment

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).⁴ In the 2006 N-SSATS survey, North Carolina showed a one-day total of 25,845 clients in treatment, the majority of whom (23,411 or 90%) were in outpatient treatment. Of the total number of clients in treatment on this date, 1,682 (6%) were under the age of 18.

Chart 3 shows the percentage of admissions mentioning particular drugs or alcohol at the time of admission.⁵ Across the last 15 years, there has been a steady decline in the number of admissions mentioning alcohol and concomitant increases in the mentions of cocaine and opiates other than heroin.

Across the years for which TEDS data are available, North Carolina has seen a substantial shift in the constellation of problems present at treatment admission. Alcohol-only admissions have declined from over 40 percent of all admissions in 1992 to less than 20 percent in 2006. Concomitantly, drug-only admissions have increased from 15 percent in 1992 to 35 percent in 2005 (Chart 4).





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.

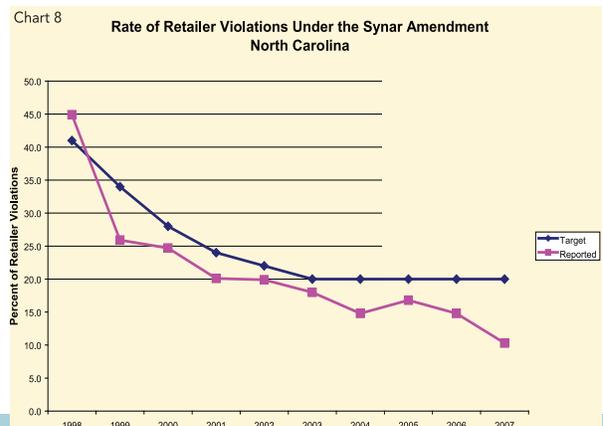
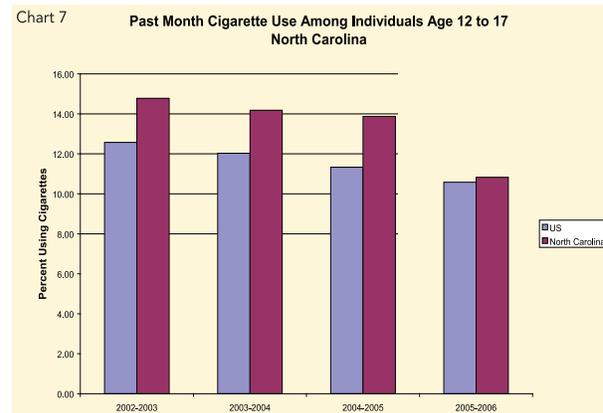
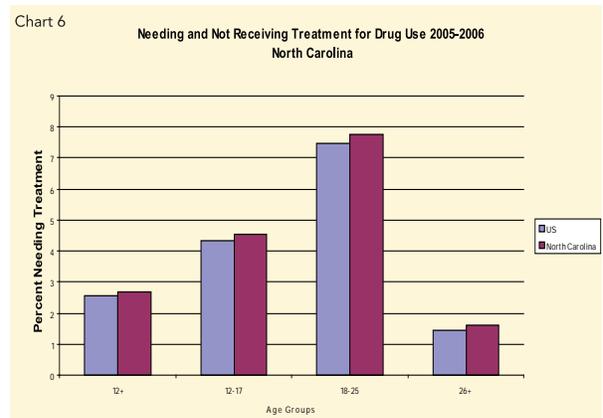
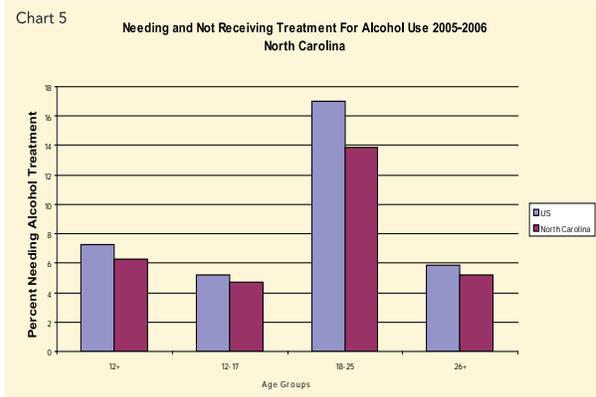
Unmet need for alcohol treatment in North Carolina has generally been below the national rates and in 2005-2006 was among the lowest in the country for all age groups except those 26 and older (Chart 5).

Rates of unmet need for drug treatment, however, have been more variable and in 2005-2006 were among the highest in the country for those age 26 and older (Chart 6).

Tobacco Use and Synar Compliance

Rates of past month cigarette use by underage smokers have generally been at or above the national rates (Chart 7).

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. North Carolina's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 1999 (Chart 8).

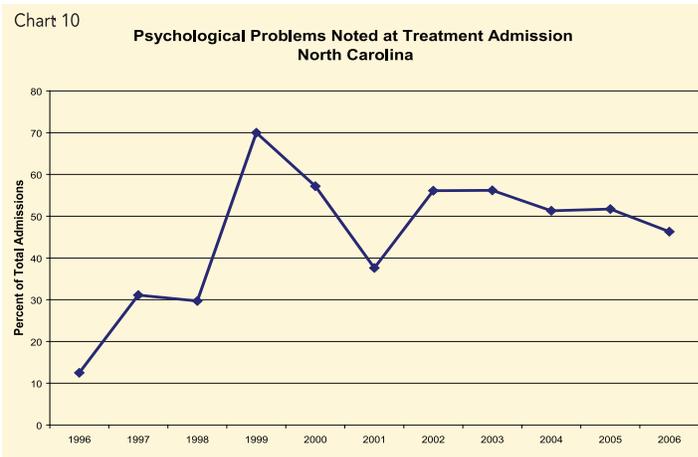
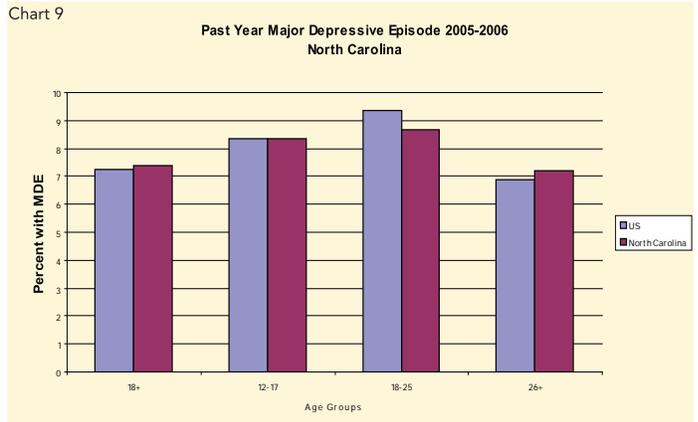


Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress, 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 for both of these measures have generally been at or below the national rates and for MDE were among the lowest in the country for individuals age 18 to 25 in 2005-2006 (Chart 9).

TEDS also collects information on whether or not psychological problems are noted at admission to substance abuse treatment. In North Carolina, the percentage of these admissions has more than tripled since 1992 (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:

\$38.9 million	Substance Abuse Prevention and Treatment Block Grant
\$12.2 million	Mental Health Block and Formula Grants
\$ 5.7 million	SAMHSA Discretionary Program Funds
\$56.8 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure; Emergency Response; Post-Traumatic Stress Disorder in Children; Children’s Services; Statewide Family Network.

CSAP: Drug-Free Communities (8 grants); SAMHSA Conference Grant; HIV/AIDS Services; Youth Transition to the Workplace.

CSAT: Recovery Community Service; Targeted Capacity Expansion—HIV/AIDS; Effective Adolescent Treatment; State Data Infrastructure; Strengthening Access and Retention; Recovery Community Services; and SAMHSA Dissertation Grant.

2005-2006

\$38.5 million	Substance Abuse Prevention and Treatment Block Grant
\$12.1 million	Mental Health Block and Formula Grants
\$ 7.3 million	SAMHSA Discretionary Program Funds
\$57.9 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure; Campus Suicide; Post-Traumatic Stress Disorder in Children; SAMHSA Conference Grant; Statewide Family Network; Child Mental Health Initiative.

CSAP: Drug-Free Communities (7 grants); HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant; HIV/AIDS Services; Youth Transition to the Workplace.

CSAT: Targeted Capacity Expansion—HIV/AIDS; State Adolescent Substance Abuse Treatment; Effective Adolescent Treatment; Strengthening Access and Retention; and Recovery Community Services.

2006-2007:

\$38.5 million	Substance Abuse Prevention and Treatment Block Grant
\$12.1 million	Mental Health Block and Formula Grants
\$ 6.8 million	SAMHSA Discretionary Program Funds
\$57.4 million	Total SAMHSA Funding

CMHS: State Mental Health Data Infrastructure; Campus Suicide; Post-Traumatic Stress Disorder in Children; Statewide Family Network; Child Mental Health Initiative.

CSAP: Drug-Free Communities (7 grants); HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant; HIV/AIDS Services.

CSAT: Targeted Capacity Expansion—HIV/AIDS; and State Adolescent Substance Abuse Treatment.

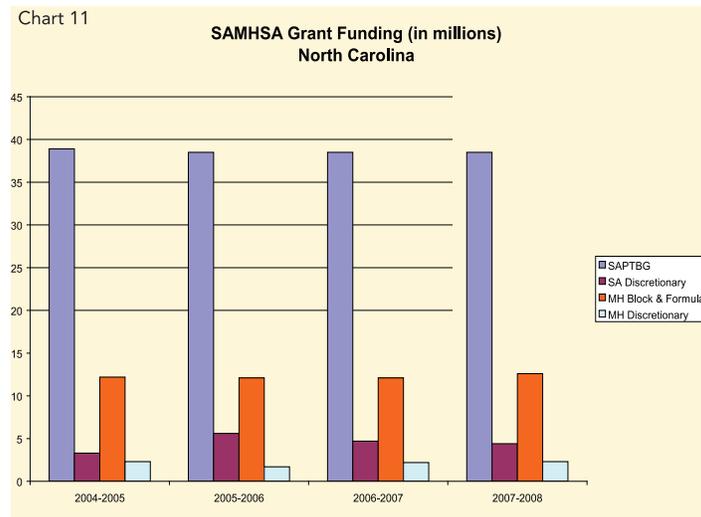
2007-2008:

\$38.5 million	Substance Abuse Prevention and Treatment Block Grant
\$12.6 million	Mental Health Block and Formula Grants
\$ 6.8 million	SAMHSA Discretionary Program Funds
\$57.9 million	Total SAMHSA Funding

CMHS: Campus Suicide; SAMHSA Conference Grant; State Mental Health Data Infrastructure; Statewide Family Network; Child Mental Health Initiative.

CSAP: Drug-Free Communities (6 grants); HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant; HIV/AIDS Services.

CSAT: State Adolescent Substance Abuse Treatment Coordination; 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 <http://www.samhsa.gov/statesummaries/index.aspx>.

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

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

¹ 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.

² 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.

³ 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: nontreatment halfway houses; jails, prisons or other organizations that treat incarcerated clients exclusively; and solo practitioners.

⁴ 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.

⁵ TEDS 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.

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.