

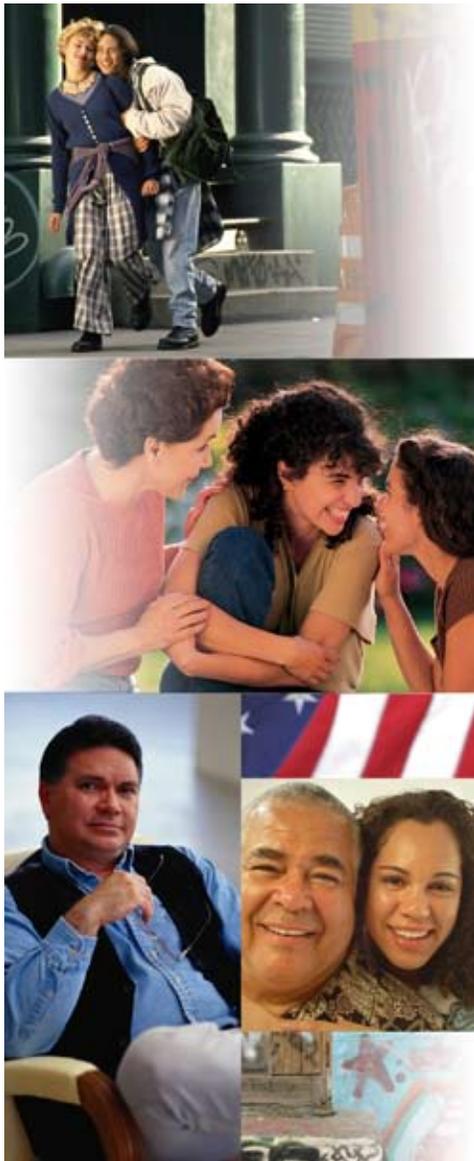
NEW YORK

# 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

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 of many measures of illicit drug and alcohol use in New York have been at or above the rates for the country as a whole. This is particularly seen in the rates of past month illicit drug use for the population age 26 and older, past year marijuana use, and past year cocaine use for the same age group

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.



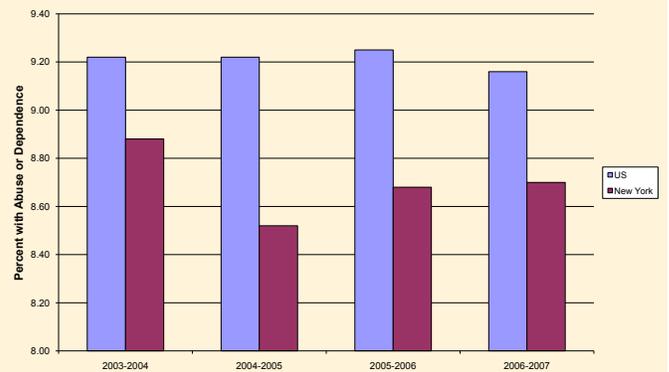
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
[www.samhsa.gov](http://www.samhsa.gov)



## Abuse and Dependence

Questions in NSDUH are used to classify persons as 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 dependence on or abuse of illicit drugs or alcohol, the rates for all population groups have consistently remained at or below the national rates (Chart 1).

Chart 1 Past Year Dependence on or Abuse of Alcohol or Illicit Drugs  
New York



## Substance Abuse Treatment Facilities

According to the 2006 National Survey of Substance Abuse Treatment Services (N SSATS),<sup>2</sup> in 2006 the majority of treatment facilities in New York—736 of 1,030 facilities (71%)—were private nonprofit. An additional 143 facilities were private for-profit, and 5 facilities were owned or operated by a Tribal government.

The number of treatment facilities in New York State has declined from a high of 1,260 in 2002 to 1,030 in 2006. The difference is primarily accounted for by a loss of 150 private nonprofit facilities, 58 private for-profit facilities, and 10 facilities operated/owned by the State government.

Although facilities may offer more than one modality of care, 707 of 1,030 facilities (68%) in New York in 2006 offered some form of outpatient care. There were 286 facilities that offered some form of residential care, and 209 that offered an opioid treatment program. In addition, 1,037 physicians and 282 programs were certified to provide buprenorphine treatment for opiate addiction.



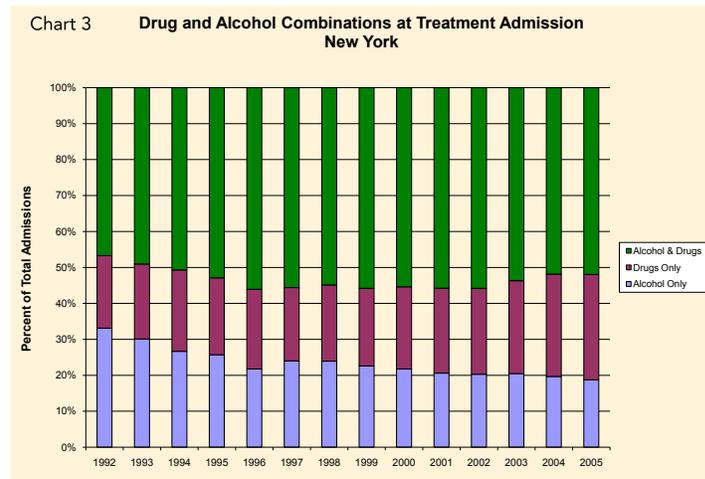
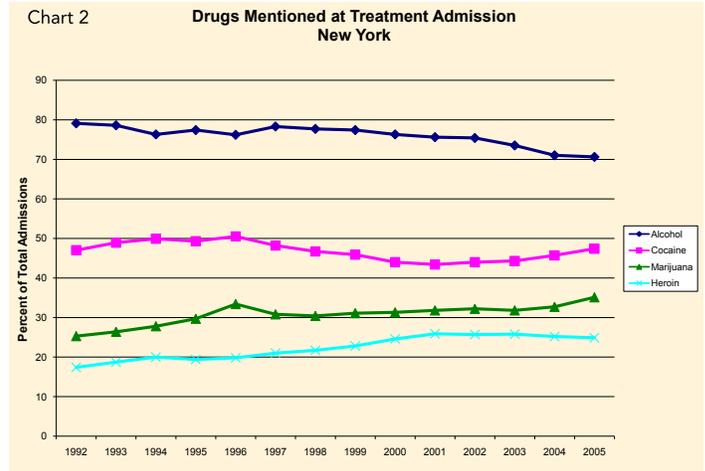
In 2006, 611 of all facilities (59%) received some form of Federal, State, county, or local government funds, and 585 facilities had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

## 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).<sup>3</sup> In the 2006 N-SSATS survey, New York showed a one-day census of 118,892 clients in treatment, 104,790 of whom (88%) were in outpatient treatment. Of the total number of clients in treatment on this date, 5,981 (5%) were under the age of 18.

Chart 2 shows the percentage of admissions mentioning particular drugs or alcohol at the time of admission.<sup>4</sup> Across the last 14 years, there has been a small decline in the number of admissions mentioning alcohol at treatment entry and modest increases in the number of admissions mentioning marijuana and heroin.

Across the years for which TEDS data are available, New York has seen a modest shift in the constellation of problems present at treatment admission (Chart 3). Alcohol-only admissions have declined from over 32 percent of all admissions in 1992 to just over 18 percent in 2005. Concomitantly, drug-only admissions have increased from 20 percent in 1992 to 29 percent in 2005.





## Unmet Need for Treatment

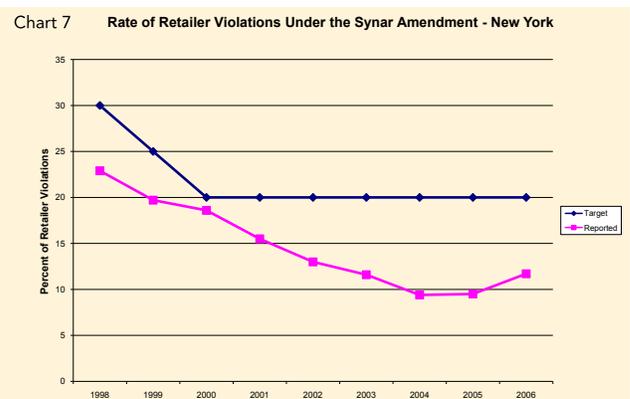
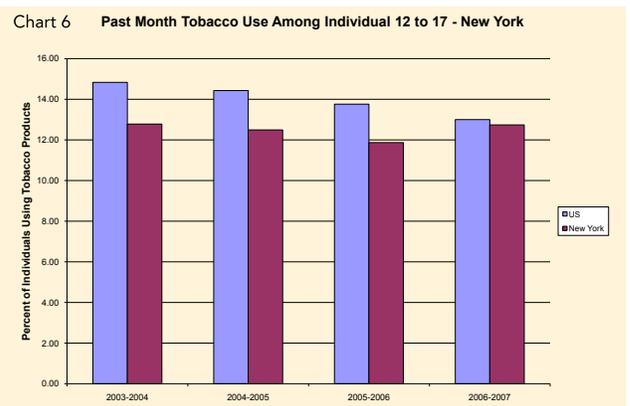
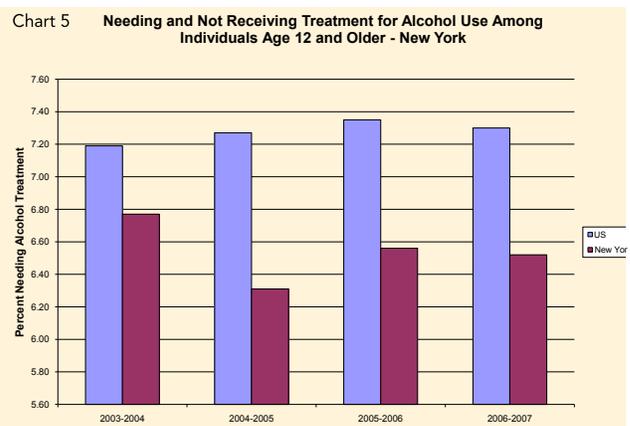
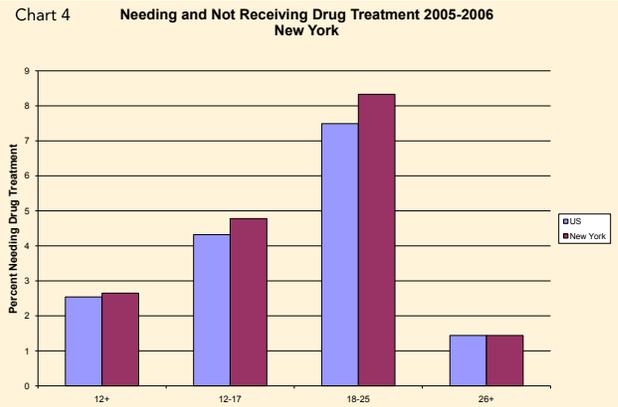
NSDUH defines unmet treatment need as an individual who meets the criteria for abuse of or dependence on illicit drugs or alcohol according to the *DSM-IV*, but who has not received specialty treatment for that problem in the past year. In New York, the unmet need for drug treatment has been quite variable and has been at or above the national rates (Chart 4); however, in the 2005-2006 survey, the rates were above the national rates for all age groups except for those individuals age 25+ for whom the rates were equal to the national rate.

Unmet need for alcohol treatment, however, has been at or below the national rate and, in the population of the State as a whole (those age 12 and older), has been consistently below the national rate (Chart 5).

## Tobacco Use and Synar Compliance

Rates of past month tobacco and cigarette use in New York have consistently been below the national rates. Further, rates for underage smokers (age 12 to 17) have consistently been among the lowest in the country (Chart 6).<sup>5</sup>

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 customers under the age of 18. New York's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 1998 (Chart 7).



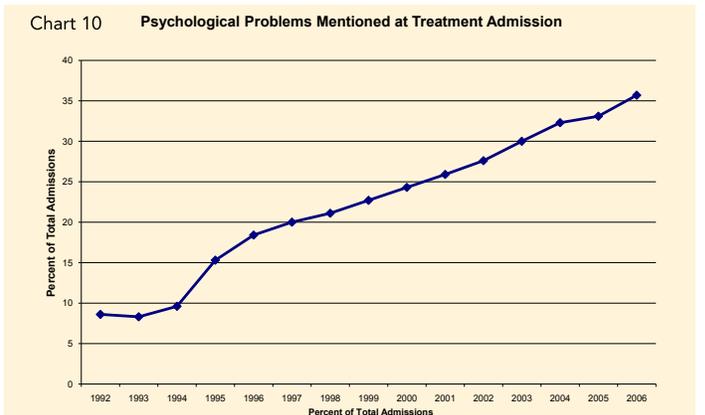
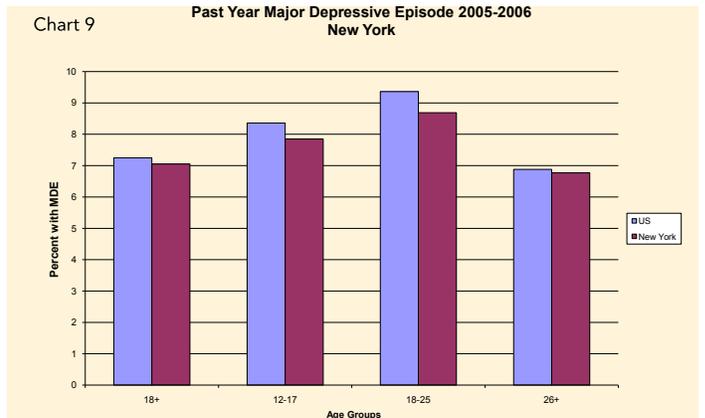
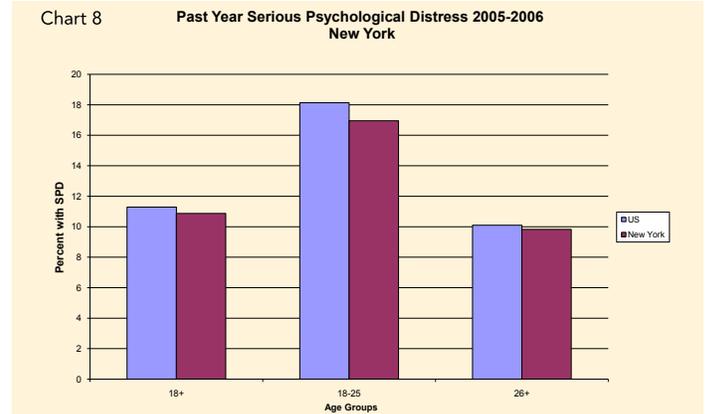
## Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress, 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.

The rates for both of these measures for all population groups and across all survey years have been at or lower than the rate for the Nation as a whole (Chart 8).

This is particularly true for past year MDE, which were among the lowest in the country for the population age 12 to 17 and 18 to 25; in the 2005-2006 analysis, they were among the lowest in the country (Chart 9).

The TEDS also collects information on psychological problems present at treatment admission. In New York, the percentage of admissions with these problems has increased from less than 10 percent in 1992 to over 35 percent in 2005 (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:

|                 |  |
|-----------------|--|
| \$116.2 million | Substance Abuse Prevention and Treatment Block Grant |
| \$ 33.6 million | Mental Health Block and Formula Grants               |
| \$ 66.4 million | SAMHSA Discretionary Program Funds                   |
| \$216.2 million | Total SAMHSA Funding                                 |

**CMHS:** Disaster Relief; Jail Diversion; Children’s Services; Public Safety Workers/First Response; Post-Traumatic Stress Disorder in Children; Suicide Hotline; Initiative to End Chronic Homelessness; Targeted Capacity Expansion—AIDS Service Capacity Building in Minority Communities; SAMHSA Conference Grant; Youth Violence Prevention; Statewide Consumer Network; State Mental Health Data Infrastructure Grant; Emergency Response; Evidence-Based Training and Education; Statewide Family Network; Targeted Capacity Expansion—Prevention and Early Intervention; Elderly Mental Health Outreach.

**CSAP:** Drug-Free Communities (44 grants); Drug-Free Communities—Mentoring; HIV/AIDS Services; State Incentive Cooperative Agreement.

**CSAT:** Targeted Capacity Expansion—HIV/AIDS; Adult, Juvenile, and Family Drug Courts; Targeted Capacity Expansion—General; Homeless Addiction Treatment; Young Offender Reentry Program; Residential Substance Abuse Treatment; Effective Adolescent Treatment; Recovery Community Support—Recovery; Grants for the Accreditation of OTPs; Strengthening Communities—Youth; Strengthening Access and Retention; Targeted Capacity Expansion—Minority Populations; State Data Infrastructure; Targeted Capacity Expansion—Innovative Treatment.

### 2005-2006

|                 |  |
|-----------------|--|
| \$115.1 million | Substance Abuse Prevention and Treatment Block Grant |
| \$ 33.2 million | Mental Health Block and Formula Grants               |
| \$ 42.0 million | SAMHSA Discretionary Program Funds                   |
| \$190.3 million | Total SAMHSA Funding                                 |

**CMHS:** Jail Diversion; Children’s Services; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; Suicide Hotline; Initiative to End Chronic Homelessness; Campus Suicide; Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Youth Suicide Prevention and Early Intervention; Youth Violence Prevention; Statewide Consumer Network; State Mental Health Data Infrastructure Grant; Statewide Family Network; Evidence-Based Training and Education; Child Mental Health Initiative; Linking Adolescent at Risk to Mental Health Services.

**CSAP:** Drug-Free Communities (50 grants); Drug-Free Communities—Mentoring; HIV/AIDS Services; HIV-Strategic Prevention Framework; Youth Transition to the Workplace; State Incentive Cooperative Agreement.

**CSAT:** Targeted Capacity Expansion—HIV/AIDS; Adult, Juvenile, and Family Drug Courts; Homeless Addiction Treatment; Young Offender Reentry Program; Effective Adolescent Treatment; Recovery Community Support—Recovery; Grants for the Accreditation of OTPs; Strengthening Communities—Youth; Strengthening Access and Retention; Targeted Capacity Expansion—Minority Populations; Targeted Capacity Expansion—Campus Screening—Colleges and Universities; Targeted Capacity Expansion—American Indians/Alaska Natives; Young Offender Reentry Program; Targeted Capacity Expansion—Innovative Treatment; SAMHSA Dissertation Grant.

## 2006-2007:

|                 |  |
|-----------------|--|
| \$115.1 million | Substance Abuse Prevention and Treatment Block Grant |
| \$ 33.2 million | Mental Health Block and Formula Grants               |
| \$ 43.9 million | SAMHSA Discretionary Program Funds                   |
| \$192.2 million | Total SAMHSA Funding                                 |

**CMHS:** Jail Diversion; Children’s Services; State Mental Health Data Infrastructure Grant; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; Campus Suicide; Suicide Hotline; Youth Suicide Prevention and Early Intervention; Statewide Family Network; Statewide Consumer Network; Linking Adolescents at Risk to Mental Health Services.

**CSAP:** Drug-Free Communities (51 grants); Drug-Free Communities—Mentoring; HIV—Strategic Prevention Framework; HIV/AIDS Services; Youth Transition to the Workplace.

**CSAT:** Targeted Capacity Expansion—Campus Screening—Colleges and Universities; Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—American Indians/Alaska Natives; Homeless Addiction Treatment; Young Offender Reentry Program; Recovery Community Support—Recovery; Grants for the Accreditation of OTPs; Strengthening Communities—Youth (substance abuse treatment); Targeted Capacity Expansion—Minority Populations; Young Offender Reentry Program.

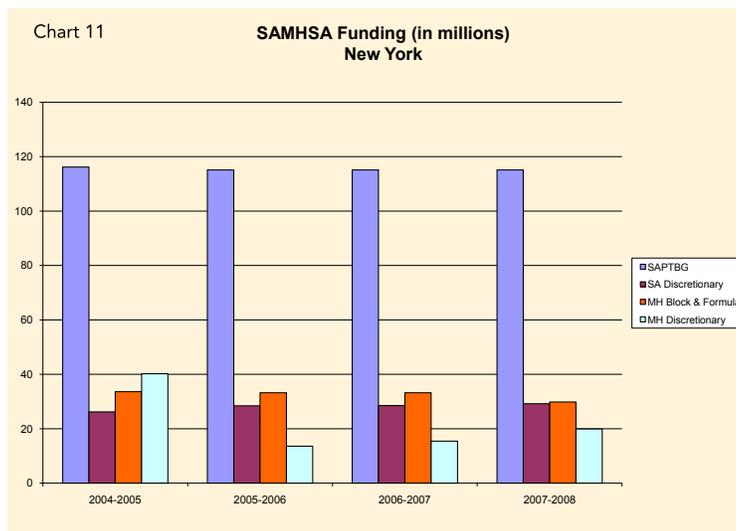
## 2007-2008:

|                 |  |
|-----------------|--|
| \$115.1 million | Substance Abuse Prevention and Treatment Block Grant |
| \$ 29.8 million | Mental Health Block and Formula Grants               |
| \$ 49.1 million | SAMHSA Discretionary Program Funds                   |
| \$194 million   | Total SAMHSA Funding                                 |

**CMHS:** Disaster Relief; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Campus Suicide; Children’s Services; Supportive Housing; Targeted Capacity Expansion—Meeting the Mental Health Needs of Older Adults; Suicide Hotline; Post-Traumatic Stress Disorder—Adaptation Centers; Youth Suicide Prevention and Early Intervention; Jail Diversion; Statewide Family Network; State Mental Health Data Infrastructure Grant; Seclusion and Restraint; Statewide Consumer Network; and Adolescents at Risk.

**CSAP:** Drug-Free Communities (48 grants); Drug-Free Communities—Mentoring; HIV—Strategic Prevention Framework; HIV/AIDS Services; Youth Transition to the Workplace; Youth Transition to the Workplace.

**CSAT:** Targeted Capacity Expansion—HIV/AIDS; Homeless Addiction Treatment; Grants for the Accreditation of OTPs; Recovery Community Support—Facilitating; Recovery Community Support—Recovery; Young Offender Reentry Program; Targeted Capacity Expansion—American Indians/Alaska Natives; Targeted Capacity Expansion—Campus Screening—Colleges and Universities; Targeted Capacity Expansion—Other Populations and Emerging Substance Abuse Issues.





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## For Further Information

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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>.

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## Data Sources

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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>.

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<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> 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.

<sup>3</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>4</sup> 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.

<sup>5</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.

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## Prevalence Data

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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.