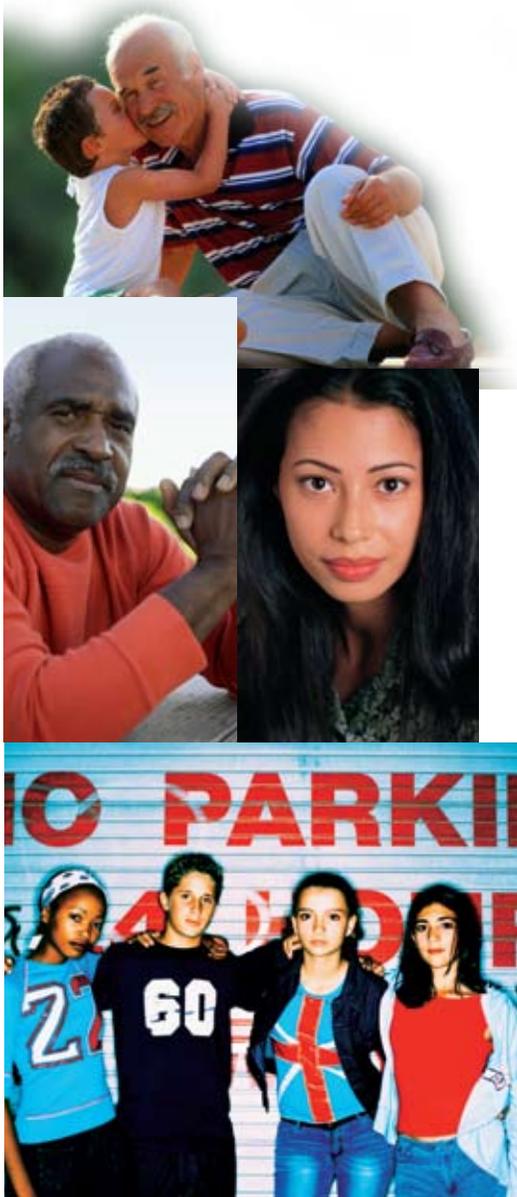


# States In Brief

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 age 12 and older (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 District of Columbia has ranked among those States with the highest<sup>2</sup> rates (Table 1):

**Table 1: The District of Columbia is among those States with the highest rates of the following:**

Measure	Age Groups
Past Month Illicit Drug Use	12+, 26+
Past Month Marijuana Use	26+
Past Year Marijuana Use	12+, 26+
Least Perception of Risk Associated with Smoking Marijuana Once a Month	12-17
Past Month Use of an Illicit Drug Other than Marijuana	26+
Past Year Cocaine Use	12+, 26+
Past Month Binge Alcohol Use	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 (SAMHSA). Sources for all data used in this report appear at the end.



Over the same time period, the District of Columbia has also been among the 10 States with the *lowest* rates of the following:

**Table 2: The District of Columbia is among those States with the lowest rates of the following:**

Measure	Age Groups
Past Year Cocaine Use	12-17
Past Year Nonmedical Use of Pain Relievers	12+, 12-17, 18-25
Past Month Alcohol Use	12-17
Past Month Binge Alcohol Use	12-17
Greatest Perception of Risk Associated with Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	12-17

## Abuse and Dependence

Questions in NSDUH are used to classify persons 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).

In the District of Columbia, there are distinct differences among age groups on the measures of past year alcohol dependence and past year drug dependence. Across all survey years for both measures, the 12 to 17 year old age groups has ranked among the lowest in the country, while the population age 26 and older has ranked among the highest in the country



## Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS)<sup>3</sup> annual surveys, the number of treatment facilities in the District of Columbia has decreased slightly from 51 in 2002, to 46 in 2006. Of the 46 facilities, 60 percent (28) were private non-profit, and nearly one-quarter (11) were private for-profit.

Although facilities may offer more than one modality of care, the majority of facilities in the District of Columbia in 2006 offered some form of outpatient treatment (37 or 80%). An additional 16 facilities offered some form of residential care, and 10 programs offered an opioid treatment program. In addition, 38 physicians and 9 treatment programs were certified to provide buprenorphine care.

In 2006, 72 percent of all facilities (33) received some form of Federal, State, county, or local government funds, and three facilities had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

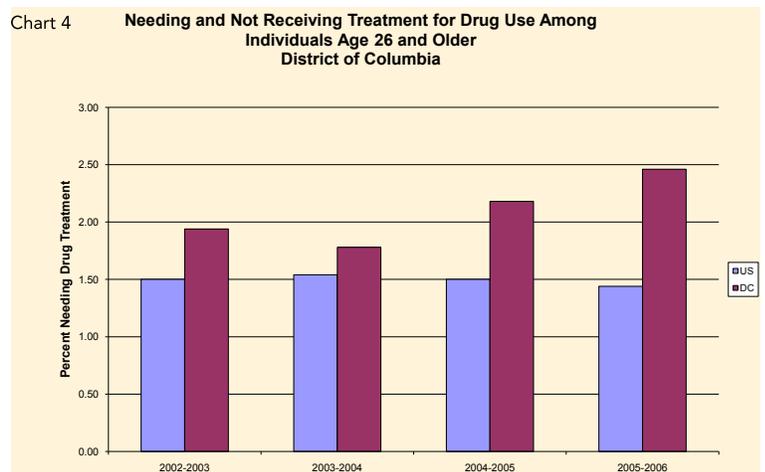
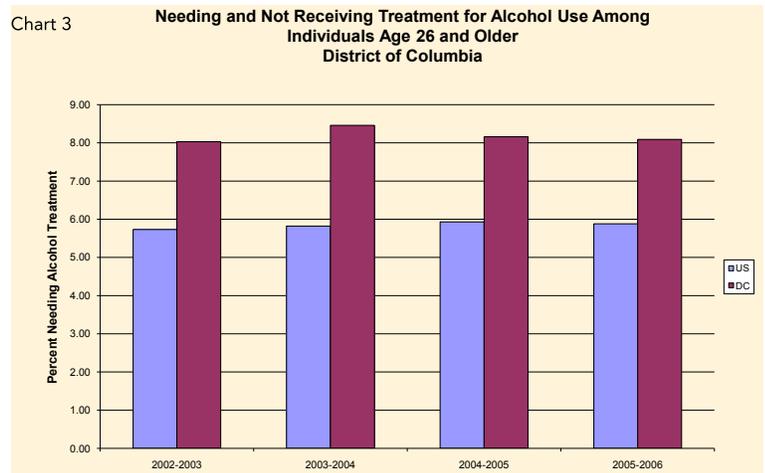
## Treatment

State treatment data for substance use disorders are derived from two primary sources—an annual 1-day census in N-SSATS, and annual treatment admissions from the Treatment Episode Data Set (TEDS).<sup>4</sup> In the 2006 N-SSATS survey, the District of Columbia showed a total of 4,310 clients in treatment, the majority of whom (3,682 or 85%) were in outpatient treatment. Of the total number of clients in treatment on this date, 206 (5%) were under the age of 18.

## 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.

Similar to the information presented above on the rates of alcohol and illicit dependence, rates of unmet need for alcohol and drug treatment for individuals age 26 and older in the District of Columbia have been among the highest in the country across all survey years (Charts 3 and 4).

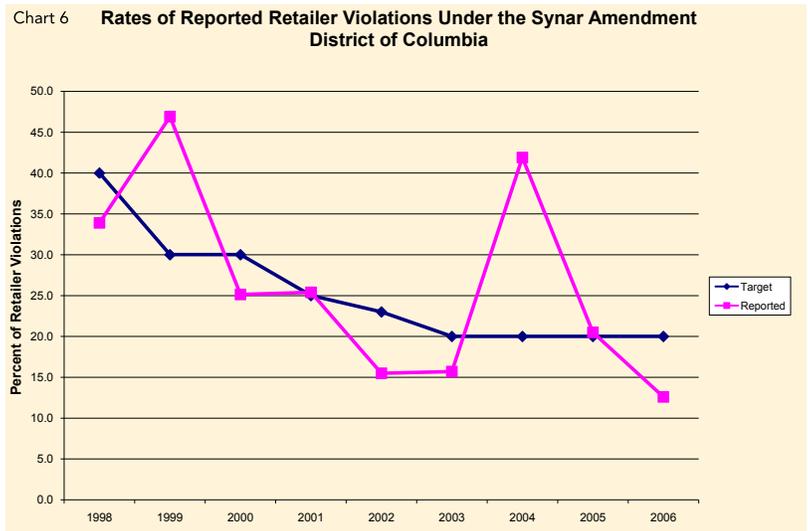
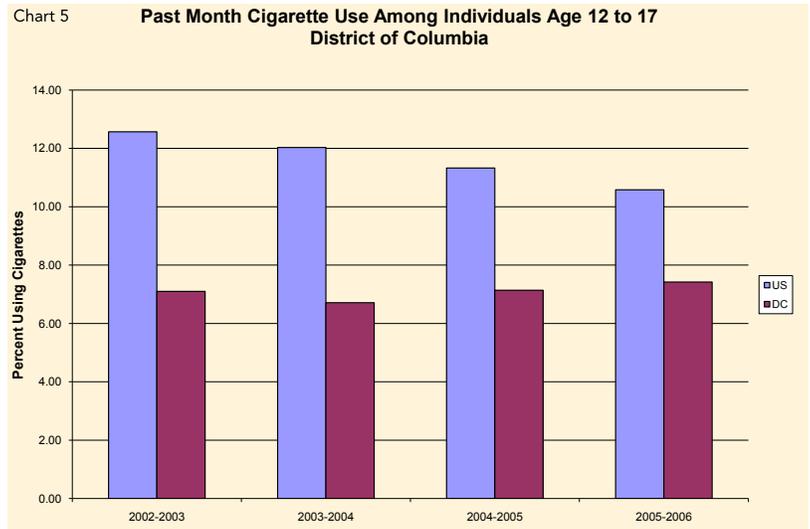




## Tobacco Use and Synar Compliance

Rates of underage use of cigarettes or other tobacco products in the District of Columbia have consistently been among the lowest in the country (Chart 5).

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. Rates of noncompliance with the Synar Amendment in the District of Columbia have been quite variable since the program began in 1998 (Chart 6).

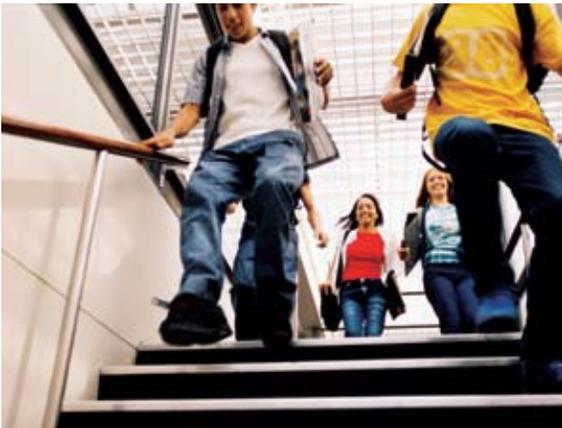
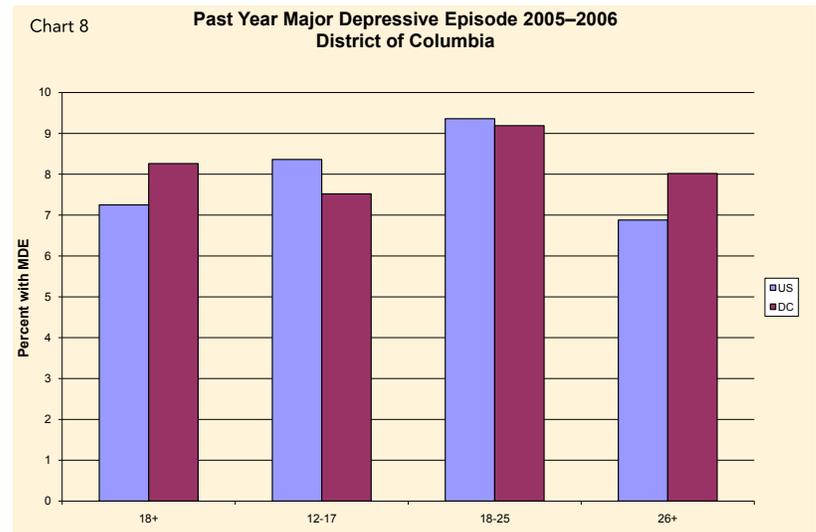
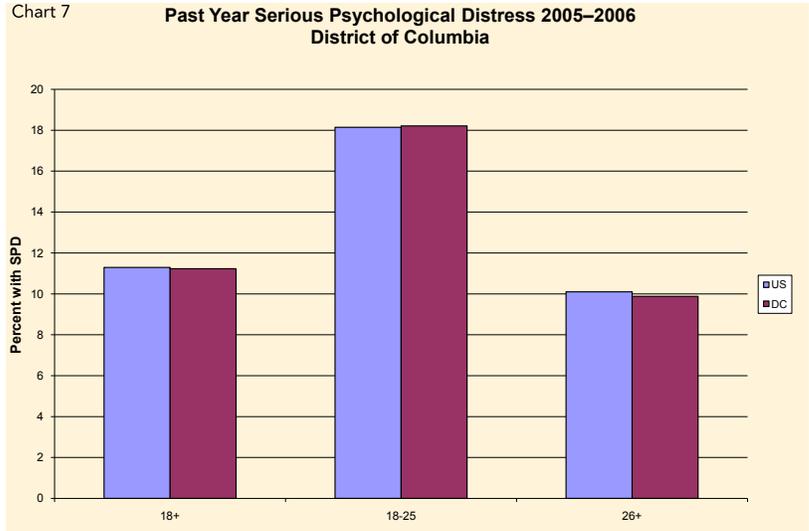


## Mental Health Indicators

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 serious psychological distress in the District of Columbia have generally been at or below the national average (Chart 7).

Similarly, rates of past year major depressive episode have also been below the national average for the population age 12 to 17, and at or above the national average for other age groups (Chart 8).






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## SAMHSA Funding

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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 9). 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:

\$6.6 million	Substance Abuse Prevention and Treatment Block Grant
\$1.6 million	Mental Health Block and Formula Grants
\$12.9 million	SAMHSA Discretionary Program Funds
\$21.1 million	Total SAMHSA Funding

**CMHS:** Emergency Response; Minority Fellowship Program; Elderly Mental Health Outreach; Youth Violence Prevention; National Training and Technical Assistance Center for Child and Adolescent Mental Health; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Children’s Services; National Technical Assistance Center; State Mental Health Data Infrastructure.

**CSAP:** Drug-Free Communities; HIV/AIDS Youth Services; State Incentive Cooperative Agreement; HIV/AIDS Services.

**CSAT:** Targeted Capacity Expansion—HIV/AIDS; State Data Infrastructure; NASADAD State Collaborative Activity; Homeless Addictions Treatment; Effective Adolescent Treatment.

### 2005–2006:

\$6.6 million	Substance Abuse Prevention and Treatment Block Grant
\$1.5 million	Mental Health Block and Formula Grants
\$11.5 million	SAMHSA Discretionary Program Funds
\$19.6 million	Total SAMHSA Funding

**CMHS:** Campus Suicide; Minority Fellowship Program; National Training and Technical Assistance Center for Child and Adolescent Mental Health; Linking Adolescents at Risk to Mental Health Services; State Mental Health Data Infrastructure; Children’s Services; Co-Occurring State Incentive Grant; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Youth Violence Prevention.

**CSAP:** HIV/Strategic Prevention Framework; Drug-Free Communities; HIV/AIDS Services; SAMHSA Conference Grant.

**CSAT:** Young Offender Re-entry Program; Targeted Capacity Expansion—HIV/AIDS; NASADAD State Collaborative Activity; State Adolescent Substance Abuse Treatment; Effective Adolescent Treatment.

**Office of Applied Studies:** SAMHSA Dissertation Grant.

**2006–2007:**

\$6.6 million	Substance Abuse Prevention and Treatment Block Grant
\$1.5 million	Mental Health Block and Formula Grants
\$9.9 million	SAMHSA Discretionary Program Funds
\$18.0 million	Total SAMHSA Funding

**CMHS:** State Mental Health Data Infrastructure; Minority Fellowship Program; Campus Suicide; National Training and Technical Assistance Center for Child and Adolescent Mental Health; Co-Occurring State Incentive Grant; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Linking Adolescents at Risk to Mental Health Services.

**CSAP:** HIV/AIDS Services; HIV/Strategic Prevention Framework; SAMHSA Conference Grant.

**CSAT:** NASADAD State Collaborative Activity; State Adolescent Substance Abuse Treatment; Young Offender Re-entry Program; Targeted Capacity Expansion—HIV/AIDS.

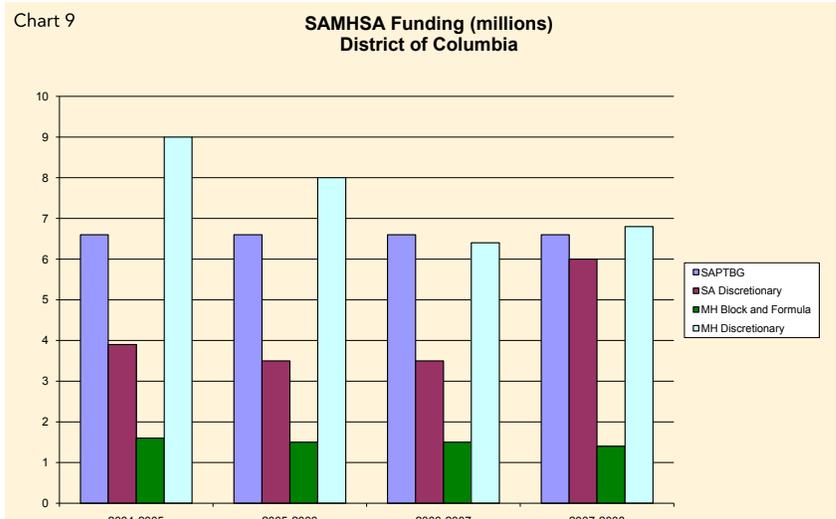
**2007–2008:**

\$6.6 million	Substance Abuse Prevention and Treatment Block Grant
\$1.4 million	Mental Health Block and Formula Grants
\$12.8 million	SAMHSA Discretionary Program Funds
\$20.8 million	Total SAMHSA Funding

**CMHS:** AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Campus Suicide; State Data Infrastructure; Supportive Housing; Minority Fellowship Program; National Training and Technical Assistance Center for Child and Adolescent Mental Health; Adolescents at Risk; Co-Occurring State Incentive Grant.

**CSAP:** SAMHSA Conference Grant; Drug-Free Communities; HIV/Strategic Prevention Framework; HIV/AIDS Services.

**CSAT:** State Adolescent Substance Abuse Treatment; Young Offender Re-entry Program; Access to Recovery; Treatment for Homeless; Targeted Capacity Expansion—HIV/AIDS.



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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: <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: <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> 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.

<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.

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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.