



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 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, Oregon has consistently ranked among the *highest*² 10 States for several measures of use and abuse of alcohol and other substances in two age groupings—the population of the State age 12 and older and the population of the State age 26 and older (Table 1).

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

Measure	Age Groups
Past Month Illicit Drug Use	12+, 26+
Past Year Marijuana Use	12+, 26+
Past Month Marijuana Use	12+, 26+
Least Perception of Risk Associated with Monthly Marijuana Use	12+, 26+

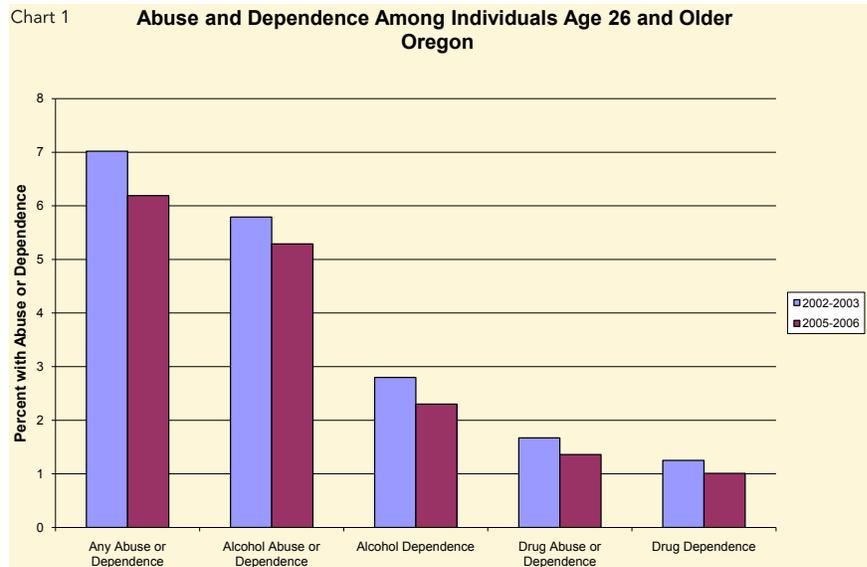
This is one in a series of brief state-based reports intended to give the reader a quick overview of substance abuse and mental health issues within a single state. The data derive principally from national surveys conducted by the Office of Applied Studies, a component of the Substance Abuse and Mental 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 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). Prevalence rates for alcohol and illicit drug abuse and/or dependence have fluctuated across the 4 years for which data are available. Prevalence rates for all four age groups (12+, 12-17, 18-25, and 26+) have remained at or near the national average. Comparing prevalence rates for the population age 26 and older, however, shows a marked decline between 2002–2003 and 2005–2006 where the rates are among the lowest in the country (Chart 1).



Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS),³ the number of treatment facilities has declined slightly between 2002 and 2006, from a high of 232 facilities to the current 224 facilities. In 2006, 124 facilities (55%) were private nonprofit. Another 55 facilities (25%) were private for-profit, and 35 facilities (16%) were operated by local governments. Notably, Oregon has nine facilities (4% of all facilities) that are owned/operated by tribal government(s), and two facilities that offer treatment programs in American Indian/Alaska Native languages.

Although facilities may offer more than one modality of care, 200 out of 232 facilities offer some form of outpatient treatment; 50 facilities offer some form of residential care; 12 facilities statewide offer opioid treatment programs; and 68 physicians are certified to provide buprenorphine care.

In 2006, 132 of 232 facilities received some form of Federal, State, county, or local government funds, and 167 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).⁴ In the N-SSATS: 2006 survey, Oregon showed a one-day census on March 31, 2006, of 22,353 clients in treatment. Of these, 2,273 (approximately 10%) were under the age of 18. The majority of clients (89%) were in outpatient treatment.

Chart 2 shows that the percentage of admissions mentioning two or more drugs at admission⁵ has risen substantially over time.

TEDS also collects information on the mention of particular drugs or alcohol at the time of admission. Across the last 13 years, there has been a steady decline in the number of admissions mentioning alcohol or cocaine as an abused substance and concomitant increases in the mentions of marijuana and heroin (Chart 3).

The decline in alcohol mentions at admissions is mirrored by the change in admissions composition where alcohol-only admissions declined from 54 percent in 1992 to 30 percent in 2005 and drug-only admissions increased from 8 percent to 26 percent across the same time period (Chart 4).

Chart 2
Number of Substances Mentioned at Admission
Oregon

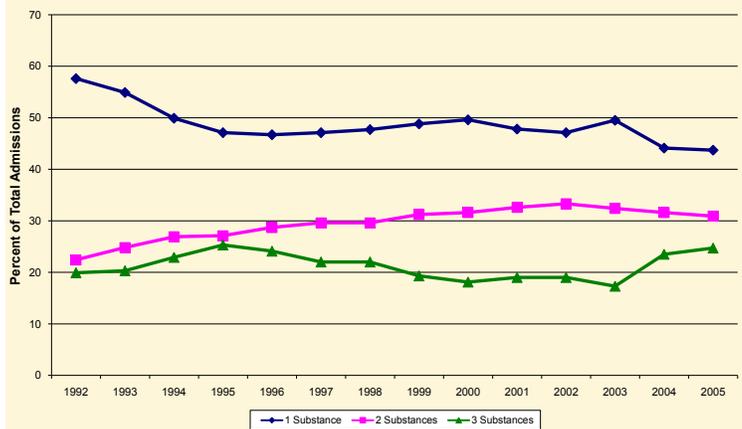


Chart 3
Oregon Alcohol and Drug Mentions At Treatment Admission
Oregon

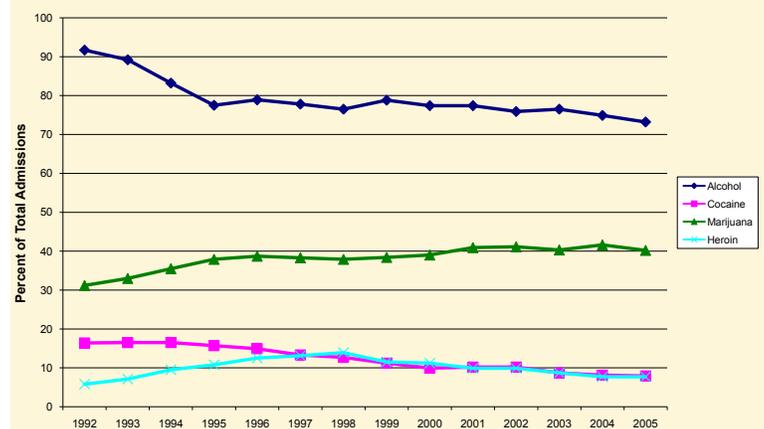
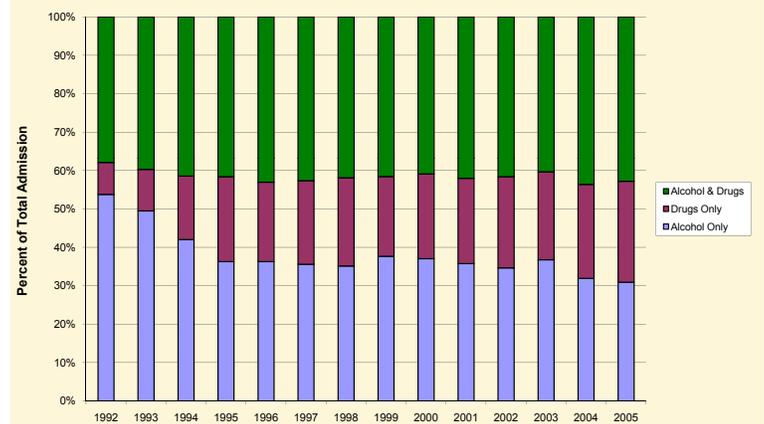


Chart 4
Alcohol and Drug Combinations at Treatment Admission
Oregon





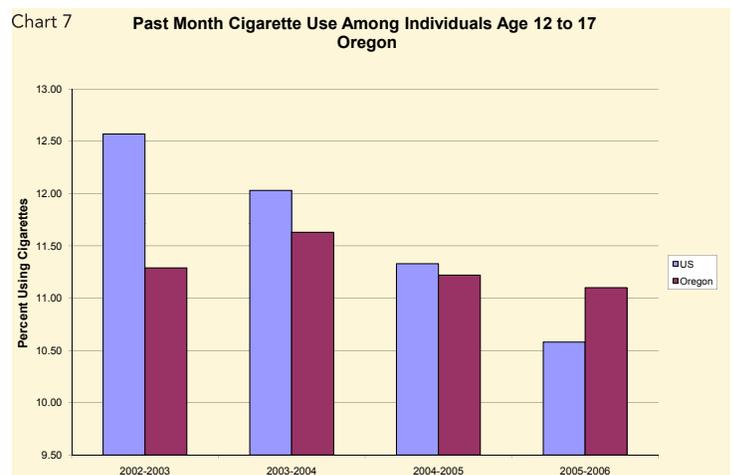
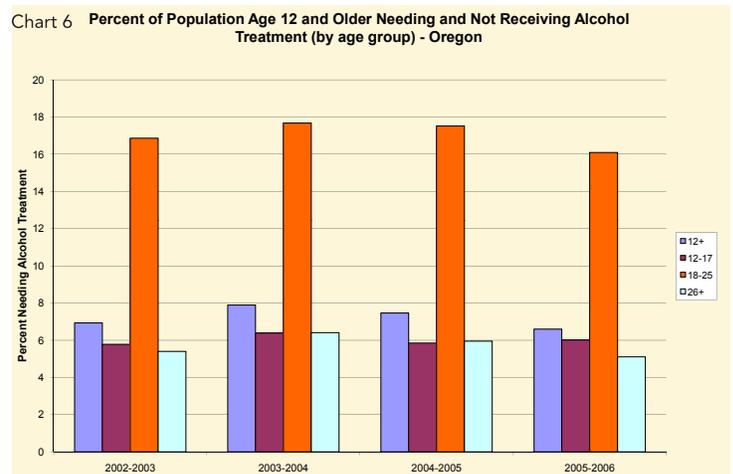
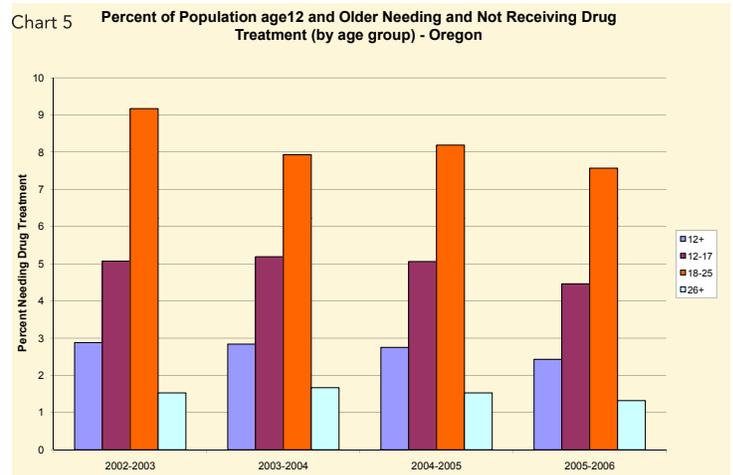
Unmet Need for Treatment

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 the rates of unmet need for treatment for alcohol and illicit drug abuse in Oregon are at or below the national rates, the individuals in the age group 18 to 25 show the largest gaps in treatment need (Charts 5 and 6).

Tobacco Use and Synar Compliance

Past month tobacco use in Oregon has remained at or below the national rate for all age groups from 2002–2003 through 2005–2006. For the population as a whole (those age 12 and older) and for the population age 26 and older, the rates of past month tobacco use, as well as the rate of past month cigarette use, were among the lowest in the country in 2005–2006. (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 customers under the age of 18. Oregon’s rate of retailer violations has been under the target rate since 2000 (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 (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.

In 2005–2006, the rates of past year SPD and past year MDE were at or below national rates for the population age 12 and older; however, the population 18 to 25 years old demonstrated rates in 2005–2006 which placed them among the highest in the country, with more than 20 percent of this age group experiencing serious psychological distress in the past year and more than 10 percent experiencing a major depressive episode (Chart 9).

Chart 8
Reported Rate of Retailer Violations Under the Synar Amendment
Oregon

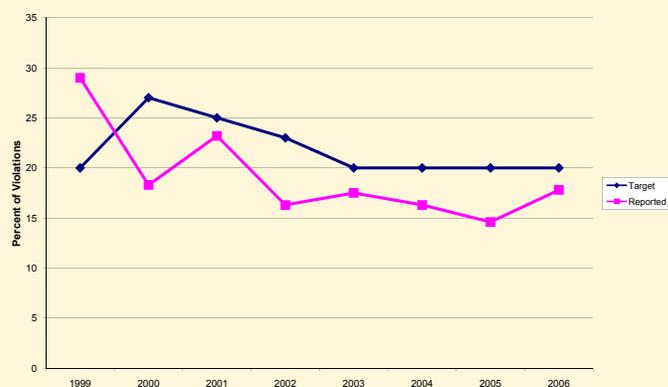
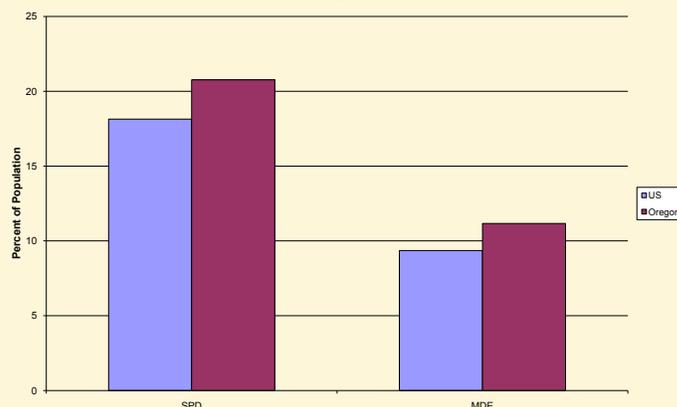


Chart 9
SPD and MDE Among Individuals Age 18 to 25 - 2005-2006
Oregon





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 10). 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:

\$16.8 million	Substance Abuse Prevention and Treatment Block Grant
\$5.1 million	Mental Health Block and Formula Grants
\$14.6 million	SAMHSA Discretionary Program Funds
\$36.5 million	Total SAMHSA Funding

CMHS: Post-Traumatic Stress Disorder in Children; Mental Health Statewide Consumer Network program; Initiative to End Chronic Homelessness; Targeted Capacity Expansion—Prevention and Early Intervention; State Mental Health Data Infrastructure Grant; Emergency Response; Statewide Family Network; Children’s Services; Youth Violence Prevention.

CSAP: Drug-Free Communities (31 grants); SAMHSA Conference Grants; American Indian/Alaska Native Resource Center; Youth Transition to the Workplace; Prevention of Methamphetamine and Inhalant Use; State Incentive Cooperative Agreement; Ecstasy and Other Club Drugs Prevention; Drug-Free Communities Mentoring; Methamphetamine Populations.

CSAT: Targeted Capacity—HIV/AIDS; Recovery Community Service; Homeless Addictions Treatment; Addiction Technology Transfer Center; Effective Adolescent Treatment; State Data Infrastructure; Recovery Community Support—Facilitating; Residential Substance Abuse Treatment; Adult, Juvenile, and Family Drug Courts; Targeted Capacity Expansion—Minority Populations; Strengthening Access and Retention; and, Pregnant and Post-Partum Women.

2005–2006:

\$16.2 million	Substance Abuse Prevention and Treatment Block Grant
\$5.1 million	Mental Health Block and Formula Grants
\$17.2 million	SAMHSA Discretionary Program Funds
\$38.5 million	Total SAMHSA Funding

CMHS: Circles of Care—American Indian and Alaska Native Children; State Mental Health Data Infrastructure Grant; Statewide Family Network (mental health); Campus Suicide; Children’s Services; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; Child Mental Health Initiative; Campus Suicide; Youth Violence Prevention.

CSAP: Drug-Free Communities (25 grants); Youth Transition to the Workplace; Prevention of Methamphetamine and Inhalant Use; AI/AN National Resource Center; State Incentive Cooperative Agreement; Ecstasy and Other Club Drugs Prevention; Methamphetamine Populations.

CSAT: Targeted Capacity Expansion—AI/AN; Targeted Capacity Expansion—HIV/AIDS; Homeless Addictions Treatment; Addiction Technology Transfer Center; Effective Adolescent Treatment; Recovery Community Support—Facilitating; Targeted Capacity Expansion—Rural Populations; Family Drug Courts; Targeted Capacity Expansion—Minority Populations; Strengthening Access and Retention; Pregnant & Post-Partum Women; and Adult, Juvenile and Family Drug Courts.

2006–2007:

\$16.2 million	Substance Abuse Prevention and Treatment Block Grant
\$5.1 million	Mental Health Block and Formula Grants
\$15.5 million	SAMHSA Discretionary Program Funds
\$36.8 million	Total SAMHSA Funding

CMHS: Youth Suicide Prevention and Early Intervention; Mental Health Statewide Consumer Network Program; State Mental Health Data Infrastructure Grant; Statewide Family Network; Campus Suicide; Children’s Services; Child Mental Health Initiative; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; Circles of Care—American Indian and Alaska Native Children; Youth Suicide Prevention and Early Intervention; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; Campus Suicide.

CSAP: Drug-Free Communities (29 grants); Youth Transition to the Workplace; Prevention of Methamphetamine and Inhalant Use; SAMHSA Conference Grant.

CSAT: Targeted Capacity Expansion—Rural Populations; Methamphetamine Populations; Targeted Capacity Expansion—AI/AN; Homeless Addictions Treatment; Addiction Technology Transfer Center; Recovery Community Support—Facilitating Family Drug Courts; Targeted Capacity Expansion—Minority Populations; Young Offender’s Reentry Program; Recovery Community Support; and Pregnant and Post-Partum Women.

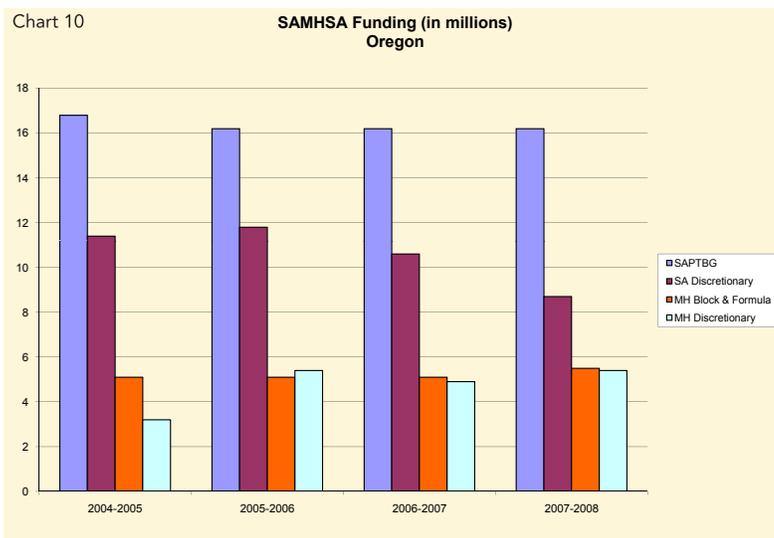
2007–2008:

\$16.2 million	Substance Abuse Prevention and Treatment Block Grant
\$5.1 million	Mental Health Block and Formula Grants
\$14.1 million	SAMHSA Discretionary Program Funds
\$35.8 million	Total SAMHSA Funding

CMHS: Supportive Housing—Mental Health; Statewide Consumer Network program; Campus Suicide; Children’s Services; Child Mental Health Initiative; Circles of Care—American Indian and Alaska Native Children; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; Youth Suicide Prevention and Early Intervention; State Data Infrastructure.

CSAP: Drug-Free Communities (27 grants); Youth Transition to the Workplace; Drug-Free Communities—Mentoring; Prevention of Methamphetamine Abuse.

CSAT: Addiction Technology Transfer Center; Homeless Addictions Treatment; Pregnant and Post-Partum Women; Targeted Capacity Expansion—Rural Populations; Family Drug Courts; E-Therapy Category; Targeted Capacity Expansion—AI/AN; and, Young Offender’s Reentry Program.





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: <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>.

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: non-treatment 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.