Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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# Initiative Blends Research & Practice

**Seventeen years.** According to the Institute of Medicine, that's the average gap between the time a researcher publishes a new research finding and practitioners out in the field actually put that finding to use.

Now that gap is closing. A joint initiative by SAMHSA's Center for Substance Abuse Treatment (CSAT) and the National Institute on Drug Abuse (NIDA) is ensuring that professionals treating people with substance use disorders have almost immediate access to research results. Working together in "blending teams," researchers supported by NIDA and trainers from SAMHSA's Addiction Technology Transfer Centers (ATTCs) are translating research into easy-to-use products.

"This is a landmark initiative," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. "For the first time in history, tools describing research-based practices are being made available at nearly the same

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Initiative Blends Research & Practice

*continued from cover page*

time that the research results are published in peer-reviewed journals."

## Blending Research and Practice

Launched in 2001, the NIDA/SAMHSA Blending Initiative takes place at a time when scientific advances are producing a broad range of promising options for treating addiction, said NIDA Deputy Director Timothy P. Condon, Ph.D.

But just because researchers discover what works in treating addiction doesn't mean that practitioners know about their findings.

"If research is done and only published in peer-reviewed journals that remain on the shelves," asked Dr. Condon, "does it have an impact on individuals' lives?"

The answer is "no," said Lewis E. Gallant, Ph.D., Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). In fact, he added, that's a major obstacle that keeps practitioners from adopting evidence-based practices.

"Reading the big monographs that many researchers produce is good if you're a researcher, but not if you're trying to tease out things you can use in your practice," he explained. "It doesn't translate very well."

Past efforts have tried to make it easy for service providers to use evidence-based practices, but few have succeeded, said Catherine D. Nugent, M.S., L.G.P.C., a senior public health adviser in CSAT's Division of Services Improvement.

"Ineffective methods, such as written practice guidelines, are sometimes used to get findings from researchers into the hands of practitioners," she explained. "What's really needed is a more sophisticated, comprehensive approach toward helping service providers use these evidence-based practices."

## Translating Research

The Blending Initiative answers that need, said Ms. Nugent. Each year, the initiative tackles two or three topics.

The process begins with a group of experts—both scientists and practitioners—who come together to discuss NIDA-funded research and how those findings might help fill gaps in addiction treatment.

"What we look for is something that has a solid base of research evidence showing that it is effective," said Cindy L. Miner, Ph.D., Deputy Director of NIDA's Office of Science Policy and Communications. The group also looks for innovations that will have a realistic expectation of being adopted and that will have a big impact once they are.

Most of the topics grow out of research from NIDA's Clinical Trials Network, an innovative partnership in which academic researchers and community-based treatment providers develop and refine new treatment options for patients in community-level clinical practice.

"Since the Clinical Trials Network is the foremost undertaking of community-oriented research, it's natural that results coming out of that network would be the most likely type of findings to be applicable in the treatment world," said Jack B. Stein, M.S.W., Ph.D., formerly Deputy Director of NIDA's Division of Epidemiology, Services, and Prevention Research. Dr. Stein recently became Director of CSAT's Division of Services Improvement.

Once a topic is selected, the next step is a "hand-off" meeting where the researchers hand off their research results to those whose specialty is implementation. "We bring together the researchers and the ATTC experts

**"For the first time in history, tools describing research-based practices are being made available at nearly the same time that the research results are published . . . "**

**—H. Westley Clark, M.D., J.D., M.P.H., Director, SAMHSA's Center for Substance Abuse Treatment**

to discuss the science and the field's needs," said Dr. Miner. "Then they decide what needs to be developed to fill those needs." Out of that group comes a blending team that devotes the next 6 months to developing products and activities designed for clinicians.

The final step in the blending team process is to alert the field to the newly available products. Blending Initiative products often debut at NASADAD meetings, explained Dr. Miner, where they are introduced or focus-tested depending on their stage of development. And then the ATTCs start using the products to train the addiction treatment workforce, so that clinicians can reap the benefits of research.

For additional information on the Blending Initiative, go to **www.nattc.org,** click on "About Us," and click on "NIDA/SAMHSA-ATTC Blending Initiative." Email no@nattc.org or call 1 (816) 235-6888. In addition, visit **www.nida.nih.gov/blending.**

***—By Rebecca A. Clay***

**Blending Initiative Resources: See pages 4 and 5.**

## *From Dr. Broderick*

# Bringing Science to Services

In 2001, the Institute of Medicine released a report stating that "Between the health care we have and the health care we could have lies not just a gap, but a chasm." Among the myriad causes, according to the report, *Crossing the Quality Chasm,* is a lag of 17 years between the publication of health care research results and their impact on treatment delivery.

To narrow this chasm, SAMHSA launched the Science-to-Services agenda. A systematic, Agency-wide effort, Science to Services brings effective, evidence-based mental health and substance abuse interventions into routine clinical practice. It also strengthens feedback from clinicians to fine-tune and frame investigations by services research programs.

This issue of *SAMHSA News* highlights the Blending Initiative, a key effort to enhance communication between the scientific and clinical communities.

Launched in 2001 as a joint effort by SAMHSA and the National Institute on Drug Abuse (NIDA), the Blending Initiative seeks to bring important scientific findings into mainstream addiction treatment practice more quickly than in the past.

Underlying the Initiative is the idea that effective practices based on scientifically tested evidence can be described and packaged into readily accessible tools and provided to treatment professionals. By supporting these activities, the Blending Initiative has enabled SAMHSA, for the first time, to bring research-based practices to clinicians at almost the same time the research is published in the field.

Research constantly expands the boundaries of our understanding and our options for helping people with mental and addictive disorders. But we cannot effect change unless we translate our knowledge into action. The Blending Initiative provides a bridge to achieving our ultimate goal, which is to improve the quality of services that people receive to enhance their recovery.

***Eric B. Broderick, D.D.S., M.P.H.***
***Assistant Surgeon General***
***SAMHSA Acting Deputy Administrator***

## Dr. Broderick Tapped for Interim Post

Eric B. Broderick, D.D.S., M.P.H., will guide SAMHSA in the interim period until President Bush nominates and the Senate confirms a new Administrator for the Agency.

Dr. Broderick's career spans 33 years at the U.S. Department of Health and Human Services. He is an Assistant Surgeon General, and a Rear Admiral, in the United States Public Health Service. His extensive experience includes managing public health programs focusing on mental health, substance abuse, and oral health for the Indian Health Service. In addition, he has expertise in health policy development and program assessment.

Dr. Broderick has served as SAMHSA's Acting Deputy Administrator since March 2006. Between 2002 and 2005, he served as Senior Advisor for Tribal Health Policy in the Immediate Office of the Secretary, Office of Governmental Affairs.

Dr. Broderick obtained both his undergraduate and dental degrees from Indiana University. He was awarded a Master in Public Health degree from the University of Oklahoma in 1988.

# Tools

Several Blending Initiative products are already available:

- *S.M.A.R.T. Treatment Planning: Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful,* is a curriculum for a 6-hour classroom training program to help treatment providers make the most of this widely used screening instrument (see right).
- Another curriculum is *Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals*, the basis of a 6-hour classroom training program that provides an overview of buprenorphine treatment.
- A third curriculum, *Short-Term Opioid Withdrawal Using Buprenorphine: Findings and Strategies from a NIDA Clinical Trials Network Study*, provides 4 hours of classroom training on using buprenorphine with opioid-dependent patients.

Several other products under development include *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency* and also *Promoting Awareness of Motivational Incentives.*

For a complete list of Blending Initiative products, visit the Addiction Technology Transfer Center's National Office Web site at **www.nattc.org/aboutUs/blendingInitiative/products2.htm.** Questions can be emailed to the National Office at no@nattc.org. Details of the Blending Initiative are also available on NIDA's Web site at **www.nida.nih.gov/blending.**

## S.M.A.R.T. Treatment Planning

A look at how the S.M.A.R.T. Treatment Planning products were created illustrates the close cooperation required by the Blending Initiative. The initiative brings together researchers supported by the National Institute on Drug Abuse (NIDA) and trainers from SAMHSA's Addiction Technology Transfer Centers (ATTCs) to get research findings into the hands of practitioners.

With NIDA support, researcher A. Thomas McLellan, Ph.D., founder and Chief Executive Officer of the Treatment Research Institute (TRI) in Philadelphia, PA, and his colleagues developed the Addiction Severity Index (ASI) in 1980. The ASI helps addiction counselors systematically collect information about seven areas of patients' lives, including alcohol and drug use, medical and psychiatric problems, employment, legal issues, and family and social relationships.

In addition to giving clinicians a framework for gathering information about all aspects of a client's life, the ASI also provides objective data that both clinicians and researchers can readily understand.

"The substance abuse field has never had something like a blood pressure rating, where you could say, 'This client is 130 over 80,' " explained Deni Carise, Ph.D., TRI's Director of Treatment Systems

### S.M.A.R.T.

**S**pecific
**M**easurable
**A**ttainable
**R**ealistic
**T**ime-limited objectives and interventions for treatment planning.

## S.M.A.R.T. Companion Products

The Blending Team members have produced various spin-off products from the S.M.A.R.T. Treatment Planning Curriculum.

Related products include the following:

- **Online courses.** Blending team member Nancy A. Roget, M.S., Principal Investigator of the Mountain West Addiction Technology Transfer Center (ATTC) in Reno, NV, has developed an online version of this curriculum. Originally designed to meet the needs of clinicians spread out across

# BLENDING INITIATIVE RESOURCES

Research. "We basically had descriptive things like, 'This person drinks far too much,' or 'This person drinks a lot,' or 'This person's a heavy drinker.' You can't tell which person drinks more than the others."

By now, most clinicians use the ASI to assess substance use disorders. Yet these professionals don't always make the most of the data generated by the tool, viewing it merely as required paperwork. "People often do the assessment, throw it in the chart, and close the file," said Dr. Carise.

The ASI Blending Team hopes to make the assessment tool more broadly accessible and understandable, so that it can be used to maximum advantage. The team consists of Dr. McLellan, Dr. Carise, and Meghan Love on the science side and three ATTC representatives on the technology-transfer side.

Aimed at addiction counselors and their supervisors, the S.M.A.R.T. Treatment Planning curriculum explains how to use the ASI for clinical purposes, and in particular, treatment planning. "The curriculum walks people through the process of collecting information about patients' problems and then using that information as the building blocks of a treatment plan," explained ASI Blending Team Chair Richard T. Spence, Ph.D., Director of the Gulf Coast ATTC in Austin, TX.

After developing and piloting the curriculum, the blending team conducted a "training of trainers" session. The ATTCs are now developing a cadre of trainers who can offer the training, said Dr. Spence, noting that the ATTC national office maintains a list of available trainers around the country.

The curriculum for *S.M.A.R.T. Treatment Planning: Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful* can be accessed at **www.nattc.org/aboutUs/blendingInitiative/blendingteams.htm#asi.** ◗

vast rural areas, the course is now open to participants across the Nation.

Offered periodically, the 4-week course doesn't require participants to sign on at particular times but does require them to read material and post responses to questions on an electronic bulletin board. "Participants have a whole week's time to do the homework," said Ms. Roget. "That way it doesn't interrupt their lives or their ability to provide services to their clients."

The Mid-America ATTC, in Kansas City, MO, has adapted the 4-week online course to include more application-to-practice assignments. These assignments provide additional opportunities to apply the information to professional settings. The 6-week course is currently in pilot phase and will be released in the Blackboard Academic Suite (Release 7.1) learning system, said Mid-America ATTC Director Pat Stilen, LCSW, CADAC. The Mountain West ATTC online curriculum is available at **www.mwattc.org.** The Mid-America ATTC's online course will be distributed through the National ATTC Network this fall.

- **Checklists.** The Mid-America ATTC has also put together several checklists to accompany the S.M.A.R.T. Treatment Planning curriculum, including the S.M.A.R.T. Treatment Plan Checklist and Progress Note Checklists. The Treatment Plan Checklist reviews the seven problems addressed in the ASI, offers guidelines for S.M.A.R.T. treatment planning, and provides a model of comprehensive, individualized treatment planning.

  The Progress Note Checklists provide guidelines for writing progress notes and producing other documentation. "These checklists serve as a reminder and reinforcement of S.M.A.R.T. Treatment Planning principles," explained Ms. Stilen, urging counselors to download the checklists and laminate them for repeated use. The checklists are available at the Mid-America ATTC Web site at **www.mattc.org/information/smart/checklist.html.**

- **Curriculum Infusion Package.** The Mountain West ATTC has created a package that condenses the material the ASI Blending Team has produced. The ATTC distributes the CD-ROM to addiction educators. The goal is to not only get information out to current treatment providers but to influence the next generation of counselors, too. To download the files, go to **http://casat.unr.edu/mwattc/ASISMART_Products.php** and click on S.M.A.R.T. Treatment Planning Curriculum Infusion Package. ◗

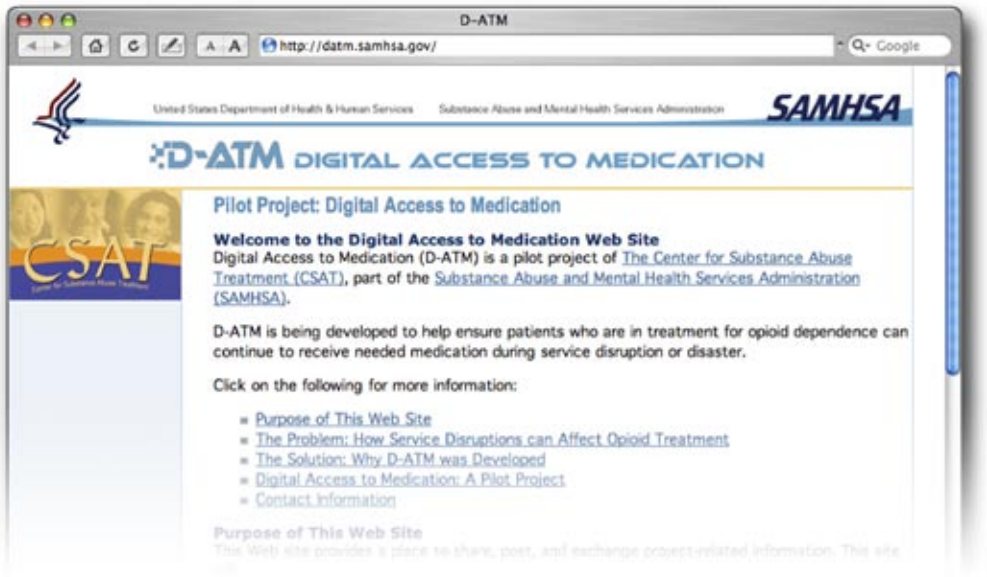
***—By Rebecca A. Clay***

# Disaster Response: Digital Access to Medication

Disasters—both natural and human-made—present a special challenge for service providers and recipients in treatment for opioid addiction: how to ensure the continuous availability of critical services for patients in a highly regulated environment.

To help, SAMHSA's Center for Substance Abuse Treatment (CSAT) recently launched the next phase of a multi-year project. The goal is to develop a system to help patients in treatment for opioid dependence obtain their medication in the midst of an emergency or other serious service disruption.

The project, Digital Access to Medication (D-ATM), focuses on the retrieval of patient dosage information during or following emergencies—such as snowstorms, power failures, hurricanes, tornadoes, or terrorist attacks—that may cause a treatment program to close or make it difficult for patients to access care at their "home" programs.




## The Need

Service continuity is critical for patients in treatment for opioid dependence. This type of treatment is highly regulated, because medication (usually methadone) cannot be obtained from a pharmacy. For this reason, most patients must go daily to a SAMHSA-regulated treatment center for their medication.

Providers at each center know that the accuracy of a patient's dose is critical. Too high a dose could cause an adverse reaction; too low a dose could be ineffective and potentially disrupt a patient's recovery. In an emergency situation, it is even more critical that patients know their medication will be readily available and dispensed in the correct dosage.

Following the September 11, 2001, terrorist attacks, one Opioid Treatment Program (OTP) located near the World Trade Center was destroyed. Several other OTPs in the New York metropolitan area remained closed for days or weeks. Approximately 1,000 patients were displaced.

Despite the chaos, patients continued to seek treatment, and staff and administrators in the area kept other OTPs open to serve their own patients and assist others without access to the OTPs where they were normally enrolled.

In August 2005, OTP patients had a similar experience when Hurricane Katrina devastated areas of Louisiana, Mississippi, and Alabama. New Orleans residents, including OTP patients, fled to temporary shelters across the United States. The seven New Orleans-area OTPs shut down for an extended period of time. A year later, three remain closed.

To provide medication, staff members at OTPs often had to make critical dosing decisions with little information other than a patient's recall.

"After these catastrophes, patients showed us just how much maintaining their recovery mattered to them," said Arlene Stanton, Ph.D., SAMHSA project officer for D-ATM in CSAT's Division of Pharmacologic Therapies. "The D-ATM program will support their efforts."

But even in non-disaster situations, patients encounter challenges to their recovery. "For instance, a patient who is traveling might find it impossible to reach a specific destination in time—maybe a plane flight was cancelled or delayed. With a system like D-ATM, this patient would be assured that another program could provide needed medication," said Dr. Stanton.

## The Solution

Immediately after September 11, 2001, CSAT began working with key stakeholders from New York, Connecticut, and New Jersey. In 2002, CSAT funded a feasibility/planning study to explore how a Web-based, centralized database could help ensure that OTP patients received their appropriate medications safely and effectively. Other developmental work followed.

CSAT funded the current D-ATM pilot project in fall 2005. D-ATM's purpose is to develop the infrastructure for the system and then pilot test it on a limited basis. Guided by four principles—simplicity, affordability, acceptability, and confidentiality—the project will use a Web-based system to ensure patients can access medication as easily as accessing a neighborhood automatic-teller machine to obtain cash.

Starting in the metropolitan New York area, the D-ATM pilot project may ultimately involve up to 50 programs. A steering committee will continue to provide critical guidance for the project.

Completion of D-ATM is expected in late 2007. At that time, a review of the pilot system will be conducted to determine its effectiveness and to identify any modifications needed to expand the program nationwide.

### How D-ATM Would Work

In the event of a disaster, patients may need to seek treatment somewhere other than their home programs. Therefore, the D-ATM project uses a biometric device—such as a fingerprint scanner—to store patients' recent dosage information to a centralized database.

Simply by scanning a patient's fingerprint, service providers at a "guest" OTP will be able to verify the visitor-patient's medication information and retrieve a report on current prescriptions and dosages. To ensure confidentiality, the system will hold limited information on any patients—in other words, only the defined set of data needed to ensure safe and accurate dosing.

A patient's information will be accessible only if the patient initiates the transaction by allowing a fingerscan or by presenting another type of information that will identify that person to the system.

To maintain privacy, the system will not include patients' names or other identifying information such as a Social Security number. Even in non-emergency settings, this type of patient information is limited due to stringent privacy regulations such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other restrictions.

SAMHSA recently created a D-ATM Web site that provides a place to share, post, and exchange project-related information. As the project develops, the Web site will post progress notes, current project status, upcoming milestones, technical information, frequently asked questions, and outstanding issues. Planned pilot test locations and information about patient protections will also be included.

For more information about the Digital Access to Medication project, visit the D-ATM Web site at **www.datm.samhsa.gov.** Or send an email to Dr. Stanton at arlene.stanton@samhsa.hhs.gov.

***—By Meredith Hogan Pond***

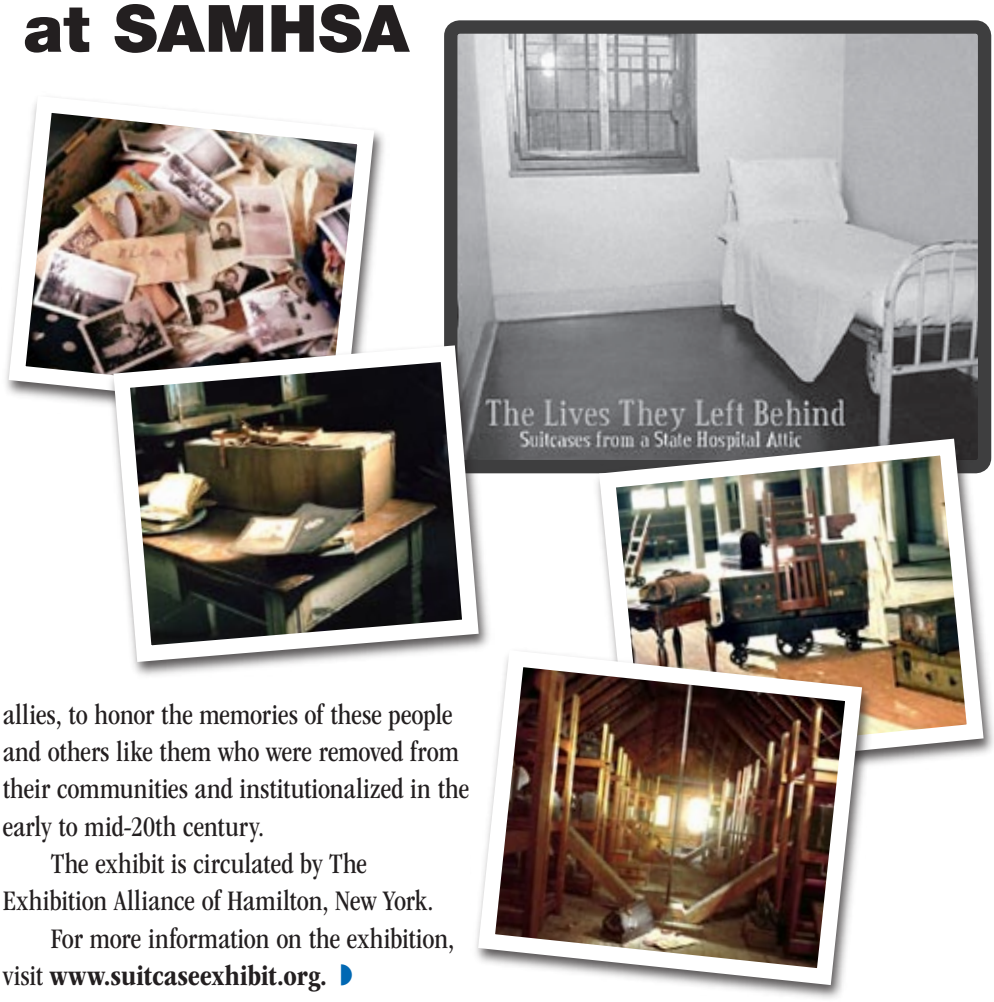
# Exhibit Debuts at SAMHSA

SAMHSA recently hosted the debut of a traveling exhibition, *The Lives They Left Behind: Suitcases from a State Hospital Attic.*

In 1995, during the closure of the Willard Psychiatric Center in New York's Finger Lakes region, several hundred suitcases filled with the personal belongings of former patients were discovered in the hospital attic. The suitcases and their contents bear witness to the rich, complex lives these people led before they were hospitalized at Willard.

"We bring you this exhibit as a part of SAMHSA's designating 2006 as the 'Year of the Consumer,' " said A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services. "Our intent is to raise awareness of the critical importance of consumers and families being at the center of their own personal mental health care. Unfortunately, as this new exhibit shows, that has not always been the case."

The exhibit was created by the Community Consortium, an organization of people with psychiatric histories and their allies, to honor the memories of these people and others like them who were removed from their communities and institutionalized in the early to mid-20th century.




The exhibit is circulated by The Exhibition Alliance of Hamilton, New York.

For more information on the exhibition, visit **www.suitcaseexhibit.org.**

# SAMHSA Honors Television, Film, Radio

SAMHSA recently honored television, film, and radio writers and producers at the second annual Voice Awards, hosted by Mariel Hemingway, at the Skirball Cultural Center in Los Angeles, CA. Winners were recognized for creating dignified, respectful, and accurate portrayals of people with mental health problems.

"Because the entertainment field has the capacity to influence how the public views important social issues, it is critical that we acknowledge those who portray issues related to mental health and mental illness accurately," said Assistant Surgeon General Eric B. Broderick, D.D.S., M.P.H., SAMHSA Acting Deputy Administrator.

Winners in the television category were the crime dramas "Law & Order: SVU" (NBC) for the episode "Ripped," and "Sue Thomas: F.B.Eye" (PAX) for the episode "Mind Games."

*Proof* and *Jellysmoke* won in the film category. In *Proof,* the daughter of a brilliant mathematician affected by mental illness comes face to face with her fears about her possible predisposition toward mental illness. *Jellysmoke* explores the adjustment to life outside a psychiatric hospital by a young man with bipolar disorder.

In the radio category, winners included "Morning Edition" (National Public Radio) for "Katrina and Recovery."

David Hoberman, co-creator and executive producer of "Monk" (USA), received a Career Achievement Award for his years of mental health advocacy. The TV series stars Tony Shaloub as Adrian Monk, a former police detective who is recovering from obsessive-compulsive disorder.

In addition, SAMHSA presented Special Recognition Awards to both Ruta Lee and Patty Duke for their long-standing commitment to mental health advocacy.

Five mental health advocates received Consumer Leadership Awards for raising awareness of mental health and expanding understanding that mental health problems exist in every community and affect almost every family in the Nation. A Lifetime Achievement Award was presented to Carmen Lee, a mental health advocate, and founder and executive director of Stamp Out Stigma, a non-profit organization dedicated to changing public perceptions of people living with mental illnesses.

The Voice Awards are part of the National Anti-Stigma Campaign, a program sponsored by SAMHSA with the Ad Council.

For more information about the Voice Awards, visit SAMHSA's Web site at **www.allmentalhealth.samhsa.gov/voiceawards.**

Ruta Lee (center), recipient of a Special Recognition Award, Dr. Eric Broderick SAMHSA's Acting Deputy Administrator (left), and Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services (right).


David Hoberman, executive producer of "Monk," accepts his Voice Award for Career Achievement.


Sandra McQueen-Baker, a consumer leader from Miami, FL, accepts her Voice Award.

Mariel Hemingway, host of this year's Voice Awards, presents Carmen Lee, founder of Stamp Out Stigma, with a Lifetime Achievement Award.

# Ads Encourage Hurricane Survivors To Seek Help

Although the floodwaters receded more than a year ago, tears are still falling for many survivors of the devastating Gulf Coast hurricanes of 2005.

That's the story told by one of the new national print and billboard advertisements recently launched by SAMHSA and the Ad Council to encourage hurricane survivors to seek mental health services as the Nation marks the 1-year anniversary of Hurricane Katrina.

The anniversary of the disaster may trigger the reappearance of the same emotions that survivors experienced immediately following the hurricanes.

"The new public service ads, from SAMHSA's Hurricane Mental Health Awareness Campaign, offer a doorway to help for survivors who are still struggling with the emotional toll of last year's hurricanes," said Assistant Surgeon General Eric B. Broderick, D.D.S., M.P.H., SAMHSA's Acting Deputy Administrator.

Launched last fall, the campaign is designed to help the adults, children, and first responders who may be in need of mental health services.

Research on the mental health consequences of disasters shows that the psychological effects of the 2005 hurricanes can be long lasting. (See *SAMHSA News,* November/December 2005 and July/August 2006.) Individuals displaced by the storms lost their homes, schools, communities, places of worship, daily routines, social support, personal possessions, and more.

In some cases, these losses were amplified by the loss of loved ones. Even now, some survivors still remain separated from families and friends.

"Mental health experts and recent studies have revealed that hurricane victims continue to suffer from the devastating losses they experienced last year," said Peggy Conlon, President and Chief Executive Officer of The Advertising Council, SAMHSA's partner in this nationwide mental health effort.

These public service announcements are part of a larger effort by SAMHSA and the Federal Emergency Management Agency (FEMA) to provide mental health recovery services to persons affected by the hurricanes. To date, nearly $110 million in mental health services grants have been awarded through this effort (see *SAMHSA News,* January /February 2006).

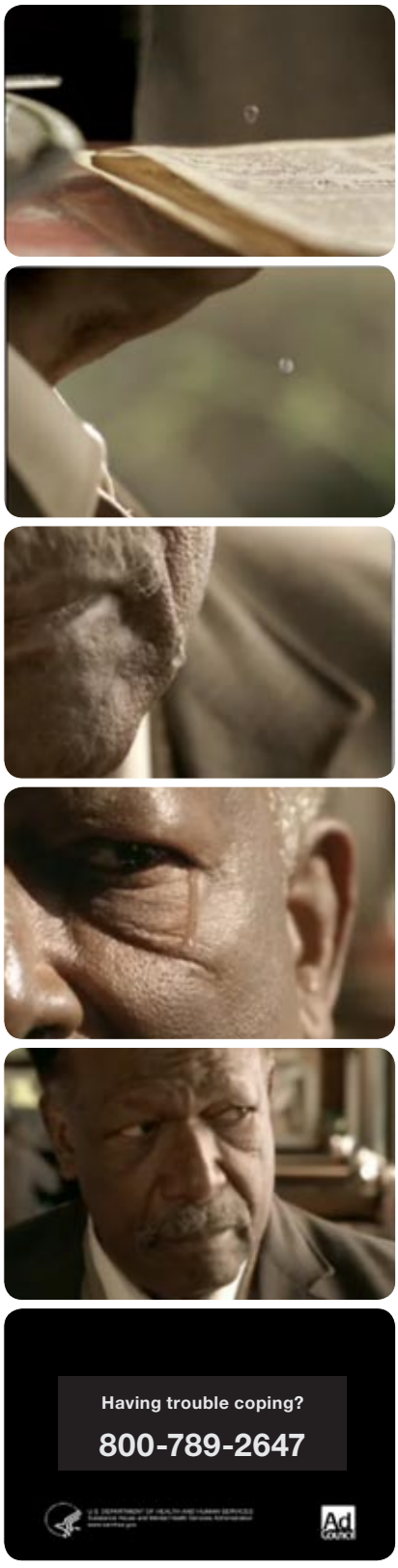
The print, television, and radio ads—distributed to media outlets nationwide during the last week of August—encourage survivors to take time to check on how they and their families are doing.

Confidential toll-free numbers are available:

- 1 (800) 789-2647 for adults and parents,
- 1 (800) 273-TALK (8255) for first responders.

Trained professionals are on the line to assist with information and referrals to local mental health services.

For more information on SAMHSA's campaign, or to view the public service ads, visit **www.samhsa.gov.**


Print ads from SAMHSA and the Ad Council on the 1-year anniversary of Hurricane Katrina feature a closeup photograph of a survivor's face.

The headline reads, "A year after the hurricane, all the water still hasn't receded." SAMHSA is encouraging survivors to seek mental health services.

# Decline Continues in Youth Drug Use

SAMHSA recently announced that current illicit drug use among youth age 12 to 17 continues to decline. The rate has been moving downward from 11.6 percent using drugs in the past month in 2002 to 11.2 percent in 2003, 10.6 percent in 2004, and 9.9 percent in 2005.

This initial report from the 2005 National Survey on Drug Use and Health (NSDUH) was released at the annual *National Alcohol and Drug Addiction Recovery Month* observance (see *SAMHSA News,* page 11).

The report, *Results from the 2005 National Survey on Drug Use and Health: National Findings,* focuses on significant trends since 2002 in substance abuse and mental health problems.

Similarly, the rate of current marijuana use among youth age 12 to 17 declined significantly from 8.2 percent in 2002 to 6.8 percent in 2005, and the average age of first use of marijuana increased from under 17 years of age in 2003 to 17.4 years in 2005.

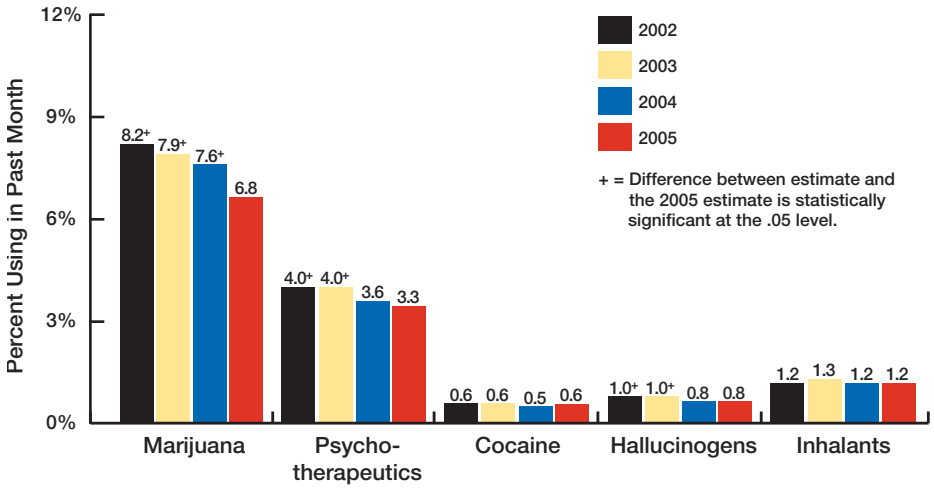
Furthermore, drinking among teens declined, with 16.5 percent of youth age 12 to 17 reporting current alcohol use and 9.9 percent reporting binge drinking. This compares with 17.6 percent of this age group reporting drinking in 2004 and 11.1 percent reporting binge drinking in the past month in 2004.

These declines in alcohol use by youth age 12 to 17 follow years of relatively unchanged rates.

For young adults age 18 to 25, the picture is mixed. While there were no significant changes in overall past-month use of any illicit drugs in this age group between 2002 and 2005, cocaine use increased from 2.0 percent in 2002 to 2.6 percent in 2005. Past-month non-medical use of prescription drugs among young adults increased from 5.4 percent in 2002 to 6.3 percent in 2005, due largely to an increase in non-medical use of narcotic pain relievers.

The baby boomer generation presents a different story. Among adults age 50 to 59, the rate of current illicit drug use increased from 2.7 percent to 4.4 percent between 2002 and 2005.

**Past-Month Use of Selected Illicit Drugs Among Youth Age 12 to 17: 2002-2005**




Source: SAMHSA Office of Applied Studies. *Results from the 2005 National Survey on Drug Use and Health: National Findings,* 2006, page 18.

## More Survey Findings

**Marijuana.** There were 14.6 million past-month users of marijuana in 2005. Among those age 12 and older, the rate of past-month marijuana use was about the same in 2005 (6.0 percent) as in 2004 (6.1 percent), 2003 (6.2 percent), and 2002 (6.2 percent).

**Prescription Drugs.** There were 6.4 million persons age 12 and older (2.6 percent) who used prescription drugs non-medically in the past month. Of these, 4.7 million used narcotic pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants (including 512,000 who used methamphetamine), and 272,000 used sedatives. Each of these estimates is similar to the estimates for 2004.

Those who used prescription drugs non-medically were asked how they obtained the drugs they used most recently. In 2005, the prevalent source for drugs used non-medically was "from a friend or relative for free" (59.8 percent). Another 16.8 percent reported obtaining the drug from one doctor, while 4.3 percent reported getting narcotic pain relievers from a drug dealer or other stranger, and 0.8 percent reported buying the drug on the Internet.

**Methamphetamine.** From 2002 to 2005, decreases were seen in lifetime (5.3 to 4.3 percent) and past-year (0.7 to 0.5 percent) methamphetamine use, but not past-month use (0.3 percent in 2002 vs. 0.2 percent in 2005) for those age 12 and older.

**Alcohol.** More than one-fifth (22.7 percent) of persons age 12 and older participated in binge drinking in 2005, which is comparable to the 2004 estimate. Binge drinking was defined as having five or

more drinks on the same occasion on at least 1 day in the 30 days prior to being surveyed.

**Prevention Measures.** Current marijuana use was much less prevalent among youth who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.6 percent vs. 27.0 percent).

**Substance Dependence or Abuse.** In 2005, an estimated 22.2 million persons (9.1 percent of the population age 12 and older) were classified with substance dependence or abuse in the past year, based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV). Of these, 3.3 million were dependent on or abused both alcohol and illicit drugs; 3.6 million were dependent on or abused illicit drugs but not alcohol; and 15.4 million were dependent on or abused alcohol, but not illicit drugs. These numbers are basically unchanged since 2002.

Adults age 21 and older who had first used alcohol before age 21 were almost five times more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (9.6 percent compared to 2.1 percent).

**Co-Occurring Substance Use and Serious Psychological Distress.** Serious psychological distress among adults age 18 and older was associated with past-year substance dependence or abuse in 2005. Among the 24.6 million adults with serious psychological distress in 2005, 21.3 percent (5.2 million) were dependent on or abused illicit drugs or alcohol. The rate of substance dependence or abuse among adults without serious psychological distress was 7.7 percent (14.9 million people).

**Depression.** In 2005, 15.8 million adults (7.3 percent of persons age 18 and older) reported a major depressive episode in the past year, a statistically significant decline from the 17.1 million adults (8 percent) reporting past-year major depressive episodes in 2004.


Photo by A. Martin Castillo

At the National Press Club launch of *National Alcohol and Drug Addiction Recovery Month,* Dr. H. Westley Clark (at podium), Director of SAMHSA's Center for Substance Abuse Treatment, talks about new findings from the Agency's 2005 National Survey on Drug Use and Health. Seated (l to r) are John P. Walters, Director of National Drug Control Policy, and Dr. Eric Broderick, SAMHSA's Acting Deputy Administrator.

**National Alcohol and Drug Addiction Recovery Month,** sponsored by SAMHSA's Center for Substance Abuse Treatment, celebrated its 17th year with poetry slams, banquets, walks, and many other community events.

Thousands of people across the Nation participated to honor the successes of people and families in recovery and those who serve them.

The annual event, celebrated each year in September, serves to educate the public that substance abuse is a national health crisis. *Recovery Month* encourages Government, businesses, and individuals to work toward increasing access to alcohol and drug treatment programs.

The message is treatment is effective and recovery is possible!

*Recovery Month* highlights the benefits of treatment not only for affected individuals, but also for their friends and workplace.

In 2006, SAMHSA sponsored 39 community events including the Second Annual California *Recovery Month* "Ride, Rally, and Celebration." This event, hosted in collaboration with United for Recovery, included motorcycle vendors and their recovery-related exhibit spaces, entertainment, and prizes.

In Hartford, CT, SAMHSA sponsored the 7th Annual Walk for Recovery from Alcohol and Other Drug Addiction. Participants enjoyed music by performers in recovery, short speeches, testimonials, and activities for children.

To mark *Recovery Month,* many people submitted personal stories to the *Recovery Month* Web site. To date, more than 50 personal recovery stories have been posted there.

For more information, visit **www.recoverymonth.gov.**

There were 2.2 million youth (8.8 percent) who experienced a major depressive episode during the past year. Among youth age 12 to 17, the occurrence of a major depressive episode in the past year was associated with a higher prevalence of illicit drug or alcohol dependence or abuse (19.8 percent), compared with the prevalence among youth who did not report past-year major depressive episodes (6.9 percent).

The 2005 survey is available on the SAMHSA Web site at **www.oas.samhsa.gov.**

# Teen Treatment Programs Need Improvement

Adolescents with substance abuse problems require specially designed treatment programs because they are at vulnerable stages of developmental change. However, a recent SAMHSA-funded study of facilities serving significant adolescent populations indicates that these facilities may not provide comprehensive services for this group, especially when other co-occurring illnesses are involved.

Approximately 2.2 million adolescents (8.9 percent of the total adolescent population) suffered from alcohol and drug abuse in 2003, according to SAMHSA's National Survey on Drug Use and Health. Almost all facilities that treat significant numbers of children and adolescents for substance abuse conduct comprehensive substance abuse assessments. However, according to an article, "Characterizing Substance Abuse Programs that Treat Adolescents," recently published in the *Journal of Substance Abuse Treatment,* only half of these facilities also conduct comprehensive mental health assessments, which are recommended as part of an integrated treatment approach.

The article was written by researchers from SAMHSA's Spending Estimates team, Thomson/Medstat, and SAMHSA staff.

To determine if treatment centers were following "best practice" recommendations, researchers compared data from SAMHSA's 2003 National Survey of Substance Abuse Treatment Services (N-SSATS) with nine key quality elements identified by experts. Best practices, for example, include use of developmentally appropriate programs and continuing care for adolescents.

The study found that substance abuse programs with significant adolescent "volume," or population, have "room for improvement" to meet quality standards.

"On the positive side, results show that facilities are willing to admit clients with other co-occurring mental or medical conditions," said Rita Vandivort, M.S.W., a public health analyst in the Division of Services Improvement at SAMHSA's Center for Substance Abuse Treatment (CSAT). "But results also reinforce what many have already said: that mental health and substance abuse providers have a way to go to attain truly integrated treatment."

Areas needing improvement include mental health, medical issues in comprehensive assessments, and curricula to meet the developmental and cultural needs of adolescent clients.

The study found that only half (50.2 percent) of significant adolescent-volume facilities offer special programs for adolescents with co-occurring mental and substance use disorders. Although the programs provide comprehensive assessments of substance abuse needs, researchers found that these programs rarely attend to the mental or other medical health needs that frequently co-occur with adolescent substance abuse.

N-SSATS results show that almost all facilities that treat adolescents are conducting substance abuse assessments (96.6 percent), but far fewer facilities are conducting mental health assessments (50 percent), and even fewer facilities (38.9 percent) are screening for medical conditions such as HIV.

Although lower rates of mental health assessments and medical screenings were reported, researchers did find relatively high rates of other recommended practices among facilities, specifically discharge planning (84.8 percent), aftercare counseling (82.2 percent), and relapse prevention groups (84.4 percent).

Researchers found the relatively high rates of these activities to be encouraging, noting that continuing care must be improved in order to ensure the "best possible outcomes" for treatment.

A total of 2,499 significant adolescent-volume facilities were examined in the study, which was conducted under the SAMHSA Spending Estimates Project.

For more information, visit SAMHSA's Web site at **http://csat.samhsa.gov/IDBSE/index.aspx.**

***—By Leslie Quander Wooldridge***

**Citation:** Mark T.L., Song X., Vandivort R., Duffy S., Butler J., Coffey R., Shabert V.F. "Characterizing Substance Abuse Programs that Treat Adolescents." *Journal of Substance Abuse Treatment,* 2006. 31:59–65.

## Adolescents and Need for Treatment

SAMHSA's National Survey on Drug Use and Health recently asked persons age 12 and older to report on their symptoms of dependence on or abuse of alcohol or illicit drugs.

According to the report, *Substance Use Treatment Need among Adolescents: 2003-2004,* about 1.4 million youth (5.4 percent) were classified as needing treatment for illicit drug use in the past year.

Data also show that:

- Between 2003 and 2004, 6.1 percent of youth age 12 to 17 were classified as needing treatment for alcohol use.
- Of the young people classified as needing treatment for alcohol use, 7.2 percent received specialty alcohol use treatment. And, 9.1 percent of youth classified as needing treatment for illicit drug use received specialty illicit drug use treatment.

For a copy of this report from SAMHSA's Office of Applied Studies, visit the SAMHSA Web site at **www.oas.samhsa.gov/2k6/youthTXneed/youthTXneed.cfm.**

For other recent statistical reports, visit **www.oas.samhsa.gov.**

# Monitoring Residential Facilities

SAMHSA recently released two reports to help Federal and state policymakers improve procedures for monitoring the quality of care provided in residential facilities for adults and children living with mental illness.

*State Regulation of Residential Facilities for Adults with Mental Illness* includes responses from officials in 34 states and the District of Columbia who provided information on 63 types of residential facilities. These include 7,327 facilities that, in total, had 103,393 beds as of September 30, 2003.

*State Regulation of Residential Facilities for Children with Mental Illness* includes responses from officials in 38 states who reported on 71 types of facilities. These include 3,628 facilities that, in total, had 50,507 beds as of September 30, 2003.

Using a national survey of state officials, the two reports present a systematic overview of the states' regulatory methods. The reports provide the most accurate national data available concerning methods that states use to license, regulate, and monitor residential facilities for children and adults with mental illnesses.

## Background

Since deinstitutionalization of individuals with mental illness began in the 1960s, residential facilities for adults with mental illness have changed substantially. They are now an important component of state mental health service systems.

Despite their importance, little comprehensive information exists on the policies and procedures used by states to regulate residential treatment facilities for adults and children with mental illnesses. As a result, policymakers and program administrators faced major difficulties in determining both the effectiveness of current policies and the potential need for new policies that are responsive to emerging trends in mental health care.

## The Studies

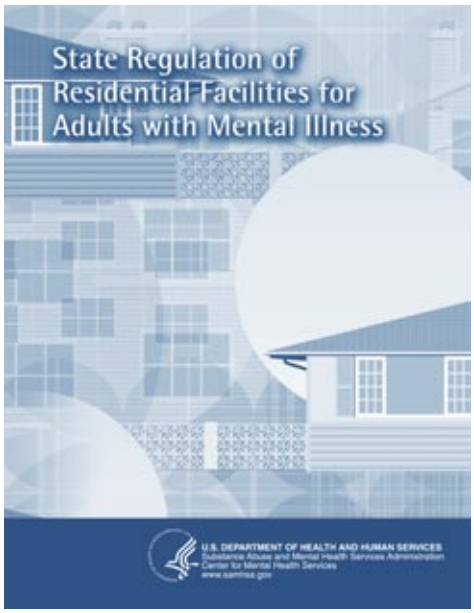
To be included in the study, residential facilities for adults and children with mental illness had to be licensed or certified by the state as providers of therapeutic services in addition to room and board.

In addition, officials in state departments of mental health, social services, and health and human services responded to a structured questionnaire on facility characteristics and programs, licensing and oversight procedures, and sources of financing.

The two studies found that states use a variety of methods to monitor residential facilities for adults and children with mental illness, and that states vary in the extent to which they use one method or another.

Typical monitoring methods included onsite inspections, documentation of staff training and qualifications, record reviews, resident interviews, critical-incident reports, standards for resident-to-staff ratios, and educational levels of facility directors. All states used at least several of these methods, but few states used all of them.

The studies also found that the regulatory and monitoring environment for




residential facilities is complex. In most states, several agencies, each with a different mission and function, are involved in facility licensing, funding, and oversight.

Copies of both reports are available online from SAMHSA's National Mental Health Information Center at **www.mentalhealth.samhsa.gov** or by calling 1 (800) 789-2647 (English and Spanish) or 1 (866) 889-2647 (TTY).

## Criteria for Residential Facilities

To be part of this study, "residential facilities" all shared certain characteristics. They:

- Specialize in the treatment of individuals with serious emotional or behavioral disorders, including those who are dually diagnosed (mental illness and substance abuse or mental illness and developmental disability) as long as mental illness was the primary problem.
- Are establishments that furnished (in single or several facilities) food, shelter, and some treatment or services to three or more persons unrelated to the proprietor.
- Provide staffing 24 hours per day, 7 days per week.
- Operate under a state authority, such as a state office granting pertinent licenses or a state mental health authority.
- Include 50 percent (minimum) of residents whose need for placement was based on mental illness.
- Include individuals with average stays of 30 days or longer.
- Provide at least some onsite therapeutic services beyond housing (e.g., group therapy, individual therapy, medication management) either by staff or under contract.

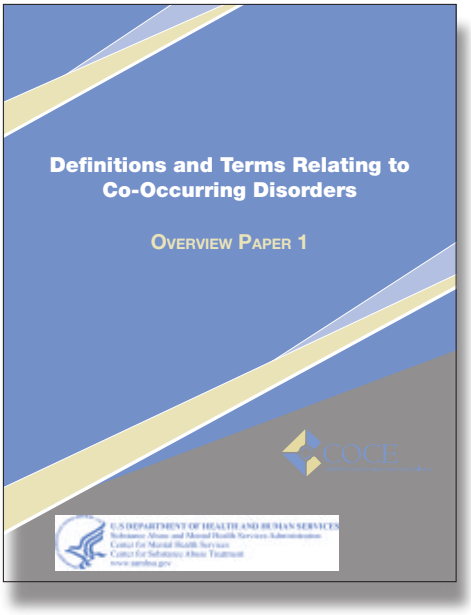
# Series on Co-Occurring Disorders Available

Co-occurring substance abuse and mental disorders affect approximately 4.6 million people in the United States. However, only a small percentage of these people receive treatment that addresses both disorders, and many do not receive treatment of any kind.

To better educate states, communities, and behavioral health care providers, SAMHSA's Co-Occurring Center for Excellence (COCE) recently released the first 3 in a series of 10 overview papers for treatment professionals on co-occurring substance abuse and mental disorders.

Concise and easy to read, these three COCE overview papers are introductions to the latest information on this issue. Following is a synopsis of each COCE overview paper:

**1. Definitions and Terms Relating to Co-Occurring Disorders.** To avoid confusion in terminology and to provide a starting point for dialogue among service providers, administrators, financing agencies, and policymakers, this overview paper compiles definitions consistent with state-of-the-art science and treatment practices relating to co-occurring disorders (COD).




**2. Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders.** Clients with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other. This overview paper discusses the purpose, appropriate staffing, protocols, methods, advantages and disadvantages, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and financing.

**3. Overarching Principles To Address the Needs of Persons with Co-Occurring Disorders.** This overview paper outlines 12 basic principles for working with persons with COD. These principles are intended to guide—but not define—systemic and clinical responses. There are two sets of principles—one for systems of care and another for individual providers. They can be used as benchmarks to assess whether plans or programs are consistent with the best information in the field.

The overview papers span topics such as epidemiology, treatment, workforce and systems issues, prevention and early intervention, and evaluation and monitoring. Intended audiences include mental health and substance abuse treatment providers and policymakers at state and local levels, as well as their counterparts in American Indian tribes.

SAMHSA developed these materials following the November 2002 release of the *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.*

Co-occurring disorders are more common than most professional counselors, medical personnel, or the general public realize. The significant effects of untreated COD—homelessness, unemployment, incarceration, physical health problems, separation from family and friends, and often suicide—led SAMHSA not only to establish COCE, but also to create a broad range of grant programs, policy academies, and training opportunities. SAMHSA also developed a Treatment Improvement Protocol (TIP)—*Substance Abuse Treatment for Persons with Co-Occurring Disorders* (TIP 42).

As a result, the diagnosis and treatment of COD are now better defined, and treatment is becoming more integrated.

These free overview papers can be ordered by calling SAMHSA's National Mental Health Information Center at 1 (800) 789-2647 (English and Spanish) or 1 (866) 889-2647 (TTY). Online, visit SAMHSA's Co-Occurring Center for Excellence Web site at **www.coce.samhsa.gov.**

# "Quick Access" Tools for Treatment Improvement Protocols

For busy substance abuse treatment providers, counselors, and other professionals who use SAMHSA's Treatment Improvement Protocols (TIPs), SAMHSA offers "quick access" reference tools—KAP Keys and Quick Guides. Compact and easy to use, these tools are helpful supplements to specific TIPs.

Developed by SAMHSA's Center for Substance Abuse Treatment (CSAT) through its Knowledge Application Program (KAP), TIPs are best-practice guidelines for the treatment of substance abuse. Corresponding Quick Guides and KAP Keys offer useful shortcuts to navigate the 200-plus pages of an average TIP.

CSAT's Division of Services Improvement draws on the experience and knowledge of clinical, research, and administrative experts to produce publications in the TIP series. Currently, there are approximately 45 TIPs available on SAMHSA's KAP Web site, and most of these TIPs have accompanying Quick Guides and KAP Keys. They include concise evidence-based information that corresponds to the page numbers and chapters in a specific TIP.

Most TIPs usually focus on a single topic such as medication-assisted treatment (MAT), co-occurring disorders, or screening. For example, TIP 43—*Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs,* presents current information about opioid use disorders and treatment options.

## KAP Keys

KAP Keys are handy, durable tools that contain assessment or screening instruments, checklists, summaries of treatment phases, lists of "red flags," and other information from the source TIP. KAP Keys provide information in short tables or bulleted lists to encourage easy access to specific facts about treatment services.

Printed on coated card stock, KAP Keys are looped together by a metal ring that can be opened as needed.

A set of KAP Keys can be kept within reach in almost any clinical setting to allow providers to reference information easily and ensure accuracy.


In the case of TIP 43, the KAP Keys address topics including assessments for MAT, information obtained about and provided to patients during screening and admission, medications or substances that alter opioid medication levels in the body, and characteristics of a treatment plan and a multidisciplinary team.

## Quick Guides

In a pocket-sized format, Quick Guides are divided into sections to help clinicians or administrators locate relevant material conveniently. For most TIPs, there is a companion Quick Guide for Clinicians and a Quick Guide for Administrators.

For example, the Quick Guide for Clinicians Based on TIP 43 is divided into 13 sections to help readers locate specific information including basic MAT principles, regulatory requirements, and evidence-based best practices in opioid treatment programs.

TIP 43's Quick Guide includes coverage of screening, admission, and assessment, phases of treatment, patient retention, drug testing, and treatment planning for patients with special needs.

Other KAP products include screening tools, periodicals, treatment manuals, and consumer brochures, as well as the TIP series. To date, SAMHSA has disseminated more than 4 million KAP products since the launch of the program in 1999.

To obtain free copies of TIPs, Quick Guides, and KAP Keys, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD).

Online, TIPS, Quick Guides, and KAP Keys are available from SAMHSA's KAP Web site at **www.kap.samhsa.gov.**

***—By Riggin Waugh***

# SAMHSA Awards New Grants

SAMHSA recently announced funding for several grant programs that support state and community substance abuse and mental health efforts around the Nation. Awards include the following:

## Strategic Prevention Framework

SAMHSA announced 16 awards totaling $145 million over 5 years to advance Strategic Prevention Framework State Incentive Grants (SPF SIGs) to support community-based programs for substance abuse prevention, mental health promotion, and mental illness prevention. The 16 awards—to 15 states and American Samoa—are for up to $2.1 million in the first year and are renewable for up to a total of 5 years. Total funding for 2006 is $29 million. [SP-06-002]

## Suicide Prevention

SAMHSA announced the award of 46 grants, totaling $25.7 million, to support a broad array of activities nationwide to prevent suicide, including grants funded through appropriations under the Garrett Lee Smith Memorial Act for youth suicide prevention.

Introduced in Congress by Senator Gordon Smith (R-OR) in memory of his son who died by suicide, the Garrett Lee Smith Memorial Act is bipartisan legislation that aims to reduce suicide among youth.

**Campus Suicide Prevention, and Youth Suicide Prevention and Early Intervention.** These grants are awarded under both the Campus Suicide Prevention Grant program, with up to $75,000 per year for up to 3 years, and the state-sponsored Youth Suicide Prevention and Early Intervention Program, with up to $400,000 per year for up to 3 years.

Funded for $2.3 million in 2006, the Campus Suicide Prevention grants assist colleges and universities in their efforts to prevent suicide and to enhance services for students with mental health problems and substance abuse that place them at risk for suicide.

With almost $4.8 million in 2006 funding, the Youth Suicide Prevention program supports statewide and tribal activities to develop and implement youth suicide prevention and early intervention strategies that are grounded in collaborations between the public and private sectors. [SM-06-004, SM-06-005]

**Hurricane Katrina-Related State-Sponsored Youth Suicide Prevention and Early Intervention.** SAMHSA announced awards of $2.4 million over 3 years to Louisiana and Mississippi to develop and implement statewide suicide prevention and early intervention activities to benefit youth who were adversely impacted by the hurricanes of 1 year ago.

The state of Louisiana Department of Health and Hospitals will receive $400,000 per year, and the state of Mississippi's Department of Mental Health will receive $400,000 per year. These grants were released during the week of September 10 to coincide with Suicide Prevention Week. [SM-06-010]

**Additional Suicide Prevention Awards.** SAMHSA has made almost $1 million in supplemental grant funds available this year to the National Suicide Prevention Resource Center, which provides training, resources, and prevention support information to organizations and individuals developing suicide prevention programs, interventions, and policies.

Similarly, SAMHSA supplemental funds of $369,000 in 2006 will continue the grant program that manages the National Suicide Prevention Lifeline and networks.

## Other Awards

**Comprehensive Community Mental Health Services for Children and Their Families.** SAMHSA announced the award of 5 cooperative agreements totaling $41 million over 6 years to implement a "systems of care" approach to services.

Programs in Arizona, Iowa, Minnesota, Mississippi, and Missouri received awards. These awards are for up to $1 million in the first year and are renewable for up to 6 years. Total funding for 2006 is $5 million. [SM-05-010]

**Family-Centered Substance Abuse Treatment for Adolescents.** SAMHSA announced the award of 15 grants to community-based organizations totaling almost $13.5 million over 3 years to provide treatment services to adolescents with substance abuse problems. Grantees receiving these awards will use strategies that include families as an integral part of the treatment process.

Awards are for up to $300,000 per year for up to 3 years, with first-year funding totaling nearly $4.5 million. [TI-06-007]

**Peer-to-Peer Recovery.** SAMHSA recently announced the award of $9.8 million to be disbursed over 4 years to 7 grantees in 5 states. These grants to community-based organizations are designed to deliver and evaluate peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders.

**Recovery Community Services Program** grants were awarded to programs located in Arizona, Georgia, New York, Oklahoma, and Texas.

Total funding for year one is $2.4 million, with these awards each funded up to $350,000 per year in total costs. [TI-06-004].

## Awards Pending

As *SAMHSA News* was going to press, SAMHSA was about to make additional grant awards, including awards for mental health transformation, methamphetamine prevention, co-occurring disorders, and screening, brief intervention, and treatment. For a complete listing of the latest grant awards, see *SAMHSA News* online at **www.samhsa.gov/SAMHSA_News** or visit SAMHSA's grants page at **www.samhsa.gov/grants.**

## Drugs, Alcohol, and HIV/AIDS: A Consumer Guide

SAMHSA's Center for Substance Abuse Treatment recently released English- and Spanish-language versions of a new brochure, *Drugs, Alcohol and HIV/AIDS: A Consumer Guide*


The brochure targets clients in substance abuse treatment programs who may be involved in risky behaviors associated with HIV/AIDS.

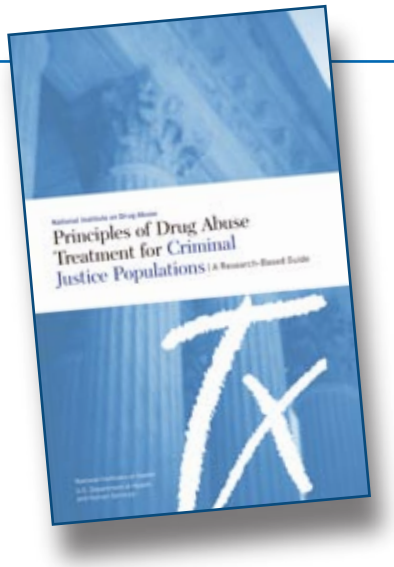
Based on SAMHSA's Treatment Improvement Protocol 37, *Substance Abuse Treatment for Persons with HIV/AIDS,* the brochure provides answers to frequently asked questions, helpful phone numbers, and Web links including SAMHSA's Treatment Facility Locator at **www.findtreatment.samhsa.gov.**

To order free copies of *Drugs, Alcohol and HIV/AIDS* or *Drogas, Alcohol y el VIH/SIDA,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for publication order number PHD1126 (English) or PHD1134 (Spanish).

## Drug Abuse Treatment & Criminal Justice Populations

A new scientific report shows that effective treatment of drug abuse and addiction can help lower rates of criminal activity in the Nation's communities.

*Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide,* developed by the National Institute on Drug Abuse (NIDA), outlines proven components for successful treatment of drug abusers who have entered the criminal justice system. The report also includes extensive resources and answers to frequently asked questions on this subject.




To order this free report, call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the publication is available on NIDA's Web site at **www.drugabuse.gov/drugpages/CJ.html.**

## The New DAWN Report

DRUG ABUSE WARNING NETWORK

## ADHD Medication Misuse

Young adults age 18 to 25 have a higher rate of nonmedical use of the two medications used to treat attention-deficit/hyperactivity disorder (ADHD), but those 12 to 17 may be at greater risk for adverse health effects, particularly from nonmedical use, according to a new report from SAMHSA.

The latest Drug Abuse Warning Network (DAWN) Report, *Emergency Department Visits Involving ADHD Stimulant Medications,* explains that during 2004 almost 8,000 visits to the emergency department involved methylphenidate (marketed as Ritalin or Concerta) or amphetamine-dextroamphetamine (marketed as Adderal), two medications used to treat ADHD.

The rates of emergency department visits resulting from use of either of these two drugs by patients age 12 to 17 were higher in 2004 than the rates for patients age 18 and older. In addition, the data suggest that "polydrug use"—one or more drugs being used in addition to ADHD medication—was common in the emergency department visits involving the misuse of ADHD medication and may increase the possible health risks.

SAMHSA's DAWN is a public health surveillance system that measures some of the health consequences of drug use by monitoring drug-related visits to hospital emergency departments.

For this complete report, visit the SAMHSA Web site at **www.oas.samhsa.gov.**

# We'd Like To Hear From You!

*SAMHSA News* strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies and programs, and available print and Web resources.

Are we succeeding? We'd like to know what you think.

Comments: _____

_____

_____

I'd like to see an article about: _____

_____

_____

Name and title: _____

Address and affiliation: _____

_____

Phone number: _____ Email address: _____

Field of specialization: _____

In the current issue, I found these articles particularly interesting or useful:

- ❑ Initiative Blends Research & Practice
  - ❑ Blending Initiative Resources
- ❑ From Dr. Broderick: Bringing Science to Services
- ❑ Dr. Broderick Tapped for Interim Post
- ❑ Disaster Response: Digital Access to Medication
- ❑ Exhibit Debuts at SAMHSA
- ❑ SAMHSA Honors Television, Film, Radio
- ❑ Ads Encourage Hurricane Survivors To Seek Help
- ❑ Decline Continues in Youth Drug Use
- ❑ Teen Treatment Programs Need Improvement
- ❑ Monitoring Residential Facilities
- ❑ Series on Co-Occurring Disorders Available
- ❑ "Quick Access" Tools for Treatment Improvement Protocols
- ❑ SAMHSA Awards New Grants
- ❑ In Brief . . .
- ❑ Depression, Substance Abuse: Significant Risk Factors for Suicide
- ❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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**Thank you for your comments!**

# Depression, Substance Abuse: Significant Risk Factors for Suicide

Suicide is the 11th leading cause of death among adults and is considered a major public health problem. But those who die from suicide represent only a fraction of those who consider or attempt suicide, according to a new Office of Applied Studies report from SAMHSA.

For those with a major depressive episode (MDE) who also engaged in alcohol or drug abuse, the likelihood of suicide attempts or suicidal thoughts is even greater.

According to the new short report from SAMHSA, *Suicidal Thoughts, Suicide Attempts, Major Depressive Episode, and Substance Use among Adults,* 10.4 percent (1.7 million people) of adults age 18 or older who experienced an MDE made a suicide attempt, 14.5 percent (2.4 million people) made a suicide plan, 40.3 percent (6.6 million people) thought about committing suicide, and 56.3 percent (9.2 million people) thought that it would be better if they were dead.

When alcohol abuse—particularly binge drinking or the use of illicit drugs—is added to an MDE, the proportion of suicide attempts rises to nearly 14 percent for alcohol abuse and nearly 20 percent for illicit drug use.

"These new findings show the scope of the problem and underscore the importance of suicide prevention efforts," said Assistant Surgeon General Eric B. Broderick, D.D.S., M.P.H., SAMHSA's Acting Deputy Administrator. "For people in crisis, the National Suicide Prevention Lifeline at 1 (800) 273-TALK offers immediate assistance."

The report also found that, in 2004, an estimated 106,000 visits to emergency departments were attributable to suicide attempts. A mental disorder was diagnosed in 41 percent of the drug-related suicide attempts treated in emergency rooms; the foremost of these disorders was depression.


These data were released during Suicide Prevention Week 2006—September 10 to September 16. The report is available for free download on SAMHSA's Web site at **www.oas.samhsa.gov.**

## Action Alliance

To further support suicide prevention efforts, SAMHSA recently announced that the Suicide Prevention Action Network (SPAN USA), a national suicide prevention organization, will join with the Agency to establish and administer the National Action Alliance for Suicide Prevention.

The Action Alliance, a public-private partnership, will reframe the goals and objectives of the National Strategy for Suicide Prevention from paper to practice. Measurable actions will be generated for Government, industry, general and specialty health care sectors, academia, communities, and consumers and families.

The creation of this Action Alliance was one of the key recommendations of the National Strategy for Suicide Prevention (2001), the President's New Freedom Commission on Mental Health (2003), and the Federal Mental Health Action Agenda (2005), a recommendation echoed by Congress in 2005.

In addition, SAMHSA recently announced the award of 46 grants totaling $25.7 million to support other activities, including grants funded under the Garrett Lee Smith Memorial Act for youth suicide prevention. The grants support initiatives by states and on college campuses to prevent suicide and to enhance services for youth depression, other mental health problems, and substance abuse, which put young people at risk for suicide. (See *SAMHSA News,* p. 16.)

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