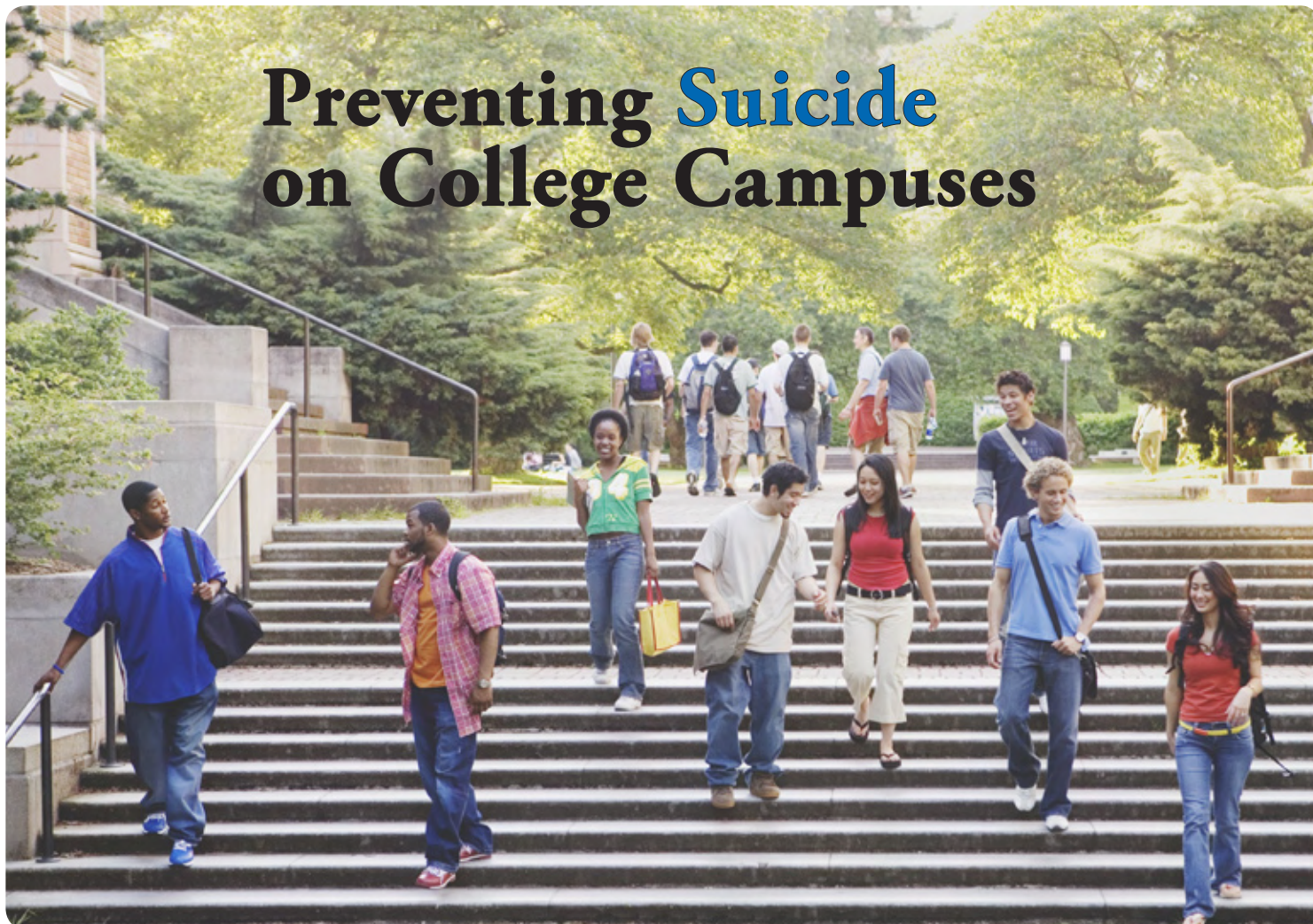


SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

November/December 2007, Volume 15, Number 6



Preventing Suicide on College Campuses

“I don’t care. I don’t really care about anything anymore.”

Those red-flag words, even if they don’t explicitly say “suicide,” can be a troubled college student’s only call for help.

Fortunately, from coast to coast, college campuses are more prepared than ever to provide assistance to students who

are overwhelmed, depressed, and at risk for suicide.

SAMHSA’s Campus Suicide Prevention grant program, administered by the Agency’s Center for Mental Health Services (CMHS), is helping more than 50 colleges and universities enhance services for students with mental and behavioral health problems.

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Preventing Suicide on College Campuses

Continued from page 1



Some SAMHSA grantees—such as the University of California, Irvine (UC Irvine), in Irvine, CA, and Syracuse University (SU) in Upstate New York—had suicide prevention programs in place before they received the grants. They have been using the funds to enhance their existing programs. Other grantees are using the funds to develop programs from the very beginning.

Grants for these programs are authorized under the Garrett Lee Smith Memorial Act to provide schools with funds to help students complete their studies successfully. (For more on the Garrett Lee Smith Act, see page 10.)

All 55 of the grantees offer programs to train the campus community to

recognize the warning signs of suicide, so that students in crisis can be referred for professional assessment. They also offer awareness programming to bring attention to the problem.

“When you identify somebody at risk, you need to go get help for this person,” said Ellen Reibling, Ph.D., Director of Health Education at UC Irvine. “There’s no ‘let’s wait and see’ time.”

Rebecca S. Dayton, Ph.D., Director of the SU Counseling Center, agreed. “Stigma is one of the biggest factors that contribute not just to suicide, but to any mental health problem,” she said. “Universities are learning to educate the campus community, especially students,

on how to identify times when they’re struggling and how to get help.”

Indeed, many young people are struggling. Across the Nation, the statistics are overwhelming. Suicide is the third leading cause of death among young people age 18 to 25, according to 2004 data from the Centers for Disease Control and Prevention (CDC) at the U.S. Department of Health and Human Services.

Suicide also is strongly associated with mental illness and substance use disorders. For young people age 18 to 22, the rates of serious psychological disorders are 17.8 percent for those enrolled in college and 19.0 percent for others in that age group, according to SAMHSA’s 2006 National Survey on Drug Use and Health.

“Suicide prevention is a priority area for SAMHSA,” said Terry L. Cline, Ph.D., SAMHSA Administrator. “When schools promote mental health services, it makes a difference.”

More than 30,000 adults age 18 or older die by suicide each year, according to the CDC. A 2006 report from SAMHSA’s Office of Applied Studies also suggests that there may be between 8 and 25 attempted suicides for every suicide death. (See “Resources.”)

With these statistics in mind, CMHS Director A. Kathryn Power, M.Ed., views suicide as a public health crisis. “The reality is that suicide is still greatly misunderstood and not accepted by the general public as something that we can prevent,” she said. “We must build awareness to change that perception.”

Resources

For an overview of the suicide prevention initiatives within the U.S. Department of Health and Human Services (HHS), visit <http://mentalhealth.samhsa.gov/suicideprevention/glance.asp>. Resources from SAMHSA include:

- **National Strategy for Suicide Prevention:** The Strategy represents the combined work of advocates, clinicians, researchers, and survivors. Visit <http://mentalhealth.samhsa.gov/suicideprevention> for information.
- **The Surgeon General’s Call To Action To Prevent Suicide:** The full text is available at <http://mentalhealth.samhsa.gov/suicideprevention/calltoaction.asp>.

- **Statistics from SAMHSA:** A recent report from SAMHSA’s Office of Applied Studies, *Suicidal Thoughts, Suicide Attempts, Major Depressive Episode, and Substance Use among Adults*, is available at www.oas.samhsa.gov/2k6/suicide/suicide.htm. For the latest data, visit <http://oas.samhsa.gov/suicide.cfm>.
- **National Suicide Prevention Initiative:** For links to SAMHSA’s other efforts, including the Suicide Prevention Resource Center, visit the Web site of SAMHSA’s Center for Mental Health Services at <http://mentalhealth.samhsa.gov/cmhs/nspi>.

For additional resources, see *SAMHSA News* online. ▶

All of the grantees are working to build awareness. Grantees share suicide prevention knowledge with each other, and some offer classes to help students manage stress. But it is the gatekeepers who often serve as the link between professional counseling staff and students.

Gatekeeper Training

Traditionally, campus gatekeepers are those people—such as resident life staff, academic advisors, faculty, and health center staff—who come into contact with students. After receiving training on suicide prevention and warning signs, these gatekeepers connect with students in distress and refer them to mental health professionals.

“A big part of suicide prevention involves getting people into treatment,” said SAMHSA’s Richard McKeon, Ph.D., M.P.H., Special Advisor on Suicide Prevention at CMHS. “Predicting suicide with certainty is not possible, but assessments are possible. Gatekeepers help in that first critical step toward counseling.”

Just 18 percent of those who commit suicide report suicidal ideation to a health professional prior to their deaths, according to the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. (See *SAMHSA News* online, Fall 2002.)

If students aren’t talking to campus counselors—and aren’t receiving help elsewhere—other people may recognize the warning signs of suicide and steer affected students toward professional help.

For example, Dr. Reibling recalled a student employee who seemed to be having problems. Always on time before, the student was arriving chronically late, and her appearance had deteriorated. In her gatekeeper role, Dr. Reibling caught up with the student to talk.

As it turned out, the student was struggling to get by in a class and wasn’t feeling supported by her family. “She just needed extra attention,” Dr. Reibling explained,

Continued on page 10

From the Administrator

Making a Difference, Saving a Life

When it comes to suicide prevention, SAMHSA is making every effort to fund effective programs for at-risk populations, including students on college campuses.

SAMHSA’s efforts are guided by the National Strategy for Suicide Prevention (NSSP), which represents the combined work of advocates, clinicians, researchers, and survivors around the Nation.

The NSSP is a collaborative effort among public and private organizations, including several agencies of the U.S. Department of Health and Human Services. Federal agencies include SAMHSA, the Centers for Disease Control and Prevention, Health Resources and Services Administration, Indian Health Service, and the National Institutes of Health.

The Strategy lays out a framework for action to prevent suicide, following goals and objectives designed with leadership from the Surgeon General. The NSSP is designed to be a catalyst for social change to transform attitudes, policies, and services.

As a result of enactment of the Garrett Lee Smith Memorial Act, SAMHSA’s activity in suicide prevention has increased dramatically. At the start of 2005, there were two competitive grant awards for suicide prevention. At the end of 2005, there were 46. At the end of 2006, there were more than 100.

These awards included State/Tribal Youth Suicide Prevention and Early Intervention grants.

Other grants have been made under the Linking Adolescents at Risk to Mental Health Services Grant program, which focuses on



Terry L. Cline, Ph.D.

school-based suicide prevention programs to assess whether youth at risk can be identified and families engaged.

The Suicide Prevention Resource Center, another activity of the NSSP, serves as a national resource for suicide prevention information and provides technical assistance to Garrett Lee Smith grantees. It also helps states develop statewide suicide prevention plans.

Another key SAMHSA suicide prevention program is the National Suicide Prevention Lifeline. The national toll-free number is 1-800-273-TALK. Calls are routed automatically to the closest crisis center within a nationwide network of 120 centers.

Beginning in 2008, SAMHSA’s National Survey on Drug Use and Health will ask all respondents age 18 or older about suicidal thoughts, plans, and attempts. This is an important step forward.

SAMHSA considers suicide prevention a critical investment in our Nation’s future. For every life we save through our prevention efforts, we make a difference. ▶

Terry L. Cline, Ph.D.
Administrator, SAMHSA

Access to Recovery: Enhancing Consumer Choice

SAMHSA's Access to Recovery (ATR) program offers multiple ways for individuals with substance abuse problems to seek treatment.

Some individuals prefer to receive treatment from a traditional clinic in their community. Others prefer to seek help from a faith-based organization. Some may need intensive in-patient treatment. Others may need "recovery support services," such as peer support groups, job training, housing assistance, or even something as simple as transportation to a treatment session.

"Providing people who have substance abuse problems with choices regarding their treatment and recovery supports makes sense," said SAMHSA Administrator Terry L. Cline, Ph.D. "It helps empower them from the very beginning to find their own path to recovery."

Launched in 2004 by SAMHSA's Center for Substance Abuse Treatment (CSAT), ATR uses a voucher system to give people greater choice when it comes to choosing the substance abuse treatment and recovery support services they need.

The program, a presidential initiative, exceeded expectations in its first round. Hoping to serve 125,000 people, the first group of grantees instead served 190,144 individuals. Now the program has expanded. In September 2007, SAMHSA announced \$98 million in new 3-year grants to more than 20 states and tribal organizations.

Expanding Access to Services

ATR is based on three principles, according to CSAT Director H. Westley Clark, M.D., J.D., M.P.H.

- **Giving consumers a choice.** "ATR empowers the consumer to purchase the care they need," he explained. Each consumer receives a voucher worth approximately \$1,600, chooses a provider from a list of approved providers, and then uses

the voucher to pay for whatever care is needed. That choice, added Dr. Clark, also encourages providers to provide high-quality care to attract and retain consumers.

- **Expanding capacity.** "ATR acknowledges that there are many pathways to recovery—mental, physical, emotional, and spiritual," said Dr. Clark. The program allows hundreds of new faith-based and community-based organizations to participate. In addition, ATR emphasizes recovery support services as well as clinical services.

- **Focusing on outcomes.** ATR relies on data to measure success, said Dr. Clark. Outcomes measured include abstinence from drugs and alcohol, employment or enrollment in school, stable housing, social support, no or decreased involvement in the criminal justice system, access to care, and retention in services.

The focus on recovery support services is especially important, added Jack B. Stein, Ph.D., Director of the Division of Services Improvement at CSAT. "ATR is an opportunity to expand the concept of a recovery-oriented system of care nationwide," he explained. "We have learned over the last number of years that recovery support services are an essential component of truly comprehensive care."

Designed to prevent relapse and promote recovery, recovery support encompasses a wide range of nonclinical services.

These may be services directly related to recovery from substance abuse, such as self-help groups, mentoring and coaching, or case management. They may be services that make it easier for people to stay in treatment, such as transportation to treatment appointments or child care while they're there. Or, they may be services that help people rebuild their lives, such as job training or housing-related assistance. The people offering



these services can be just about anyone: professionals, faith leaders, family members, or peers who are themselves in recovery.

Impressive Results

That new approach is paying off, according to data from the 15 grantees in the first round of ATR.

Data on 130,978 clients show that their lives changed dramatically as a result of participation in ATR. Among clients who were using alcohol or drugs at intake, for instance, more than 73 percent were abstinent by the time they were discharged.

Substance abuse wasn't the only area of improvement, however. Of clients who were involved with the criminal justice system at intake, almost 86 percent reported no involvement at discharge. Of those who reported not being connected to friends they could turn to in times of trouble, self-help groups, or other sources of social support, more than 62 percent reported being socially connected at discharge. Of those who were unemployed at intake, 30 percent were employed at discharge. More than 23 percent of those who didn't have stable housing at intake had it at discharge.

Data show important shifts within the service delivery system. For example, the



data show the importance of recovery-oriented services within ATR. About 65 percent of clients had received recovery support services. And nearly half the dollars paid were for such services.

The data also reveal the active participation of faith-based organizations. A third of dollars spent on recovery support and clinical services went to faith-based organizations. Faith-based providers accounted for 23 percent of the recovery support providers involved in ATR and 31 percent of the clinical treatment providers.

A Closer Look: Louisiana

The experience of Louisiana, a two-time ATR grantee, parallels the national trends.

“Whenever we do our needs assessment each year, it shows that we’re meeting less than 10 percent of the need for substance abuse treatment in our state,” said Charlene M. Gradney, M.S.W., L.C.S.W., ATR Project Director in the Office for Addictive Disorders in the Louisiana Department of Health and Hospitals. “ATR was an opportunity to expand services.”

When it came to women and adolescents, said Ms. Gradney, the situation was even more dire. The state couldn’t fund case management, aftercare, education, and other recovery support services women needed.

That’s why the state jumped at the opportunity to participate in ATR, said Ms. Gradney, and why it decided to focus its first round of funding on women and adolescents across the state.

No matter who the target population is, the process is the same: After a referral from a court, school, or some other source, the client undergoes an assessment to determine whether she has an alcohol or drug problem and whether she meets the financial criteria for participation in ATR. If the answer to both questions is “yes,” she then undergoes a thorough clinical assessment. “We look at all aspects of their lives—their family, work and employment history, educational background, and psychiatric issues as well as their substance abuse history,” said Ms. Gradney.

Once the client and clinician decide on a treatment plan, the client receives a list of ATR-approved providers for the level of treatment or recovery support she needs. She then selects the provider she wants and uses a voucher to pay for the care. Each voucher is good for 6 months and for whatever level of care a client needs.

Like other grantees, Louisiana has a Web-based voucher system that tracks how vouchers are used. The system also contains clients’ clinical records. When a client chooses a particular provider, that provider gets access

to an electronic version of the client’s clinical records. “Our Web-based system also allows for good continuity of services,” said Ms. Gradney. “Clients can easily transition to the next level of care, because the progress notes in their electronic records can easily be transferred.”

Like the program overall, Louisiana has served more clients than expected. As of June 2007, the program had served 17,113 clients—115 percent more than targeted.

Part of the explanation for that success is the heavy involvement of faith-based organizations, said Ms. Gradney. “Faith-based organizations have been able to reach out to clients that our traditional providers may not have been able to engage,” she explained. “They’ve been a big help.” Faith-based organizations represent 28 percent of providers in the state’s program and received 56 percent of all ATR reimbursements in the state.

Good Results

The percentage of clients reporting no alcohol or drug use in the past 30 days jumped from 37 percent at intake to 87 percent at discharge. Those who were employed or enrolled in school jumped from 36 percent to 59 percent. And the percentage who had no involvement with the criminal justice system went from 89 percent to almost 97 percent.

Louisiana’s state legislature was so impressed with those results that it decided to provide \$9 million a year for the next 3 years.

In the meantime, the state won another ATR grant and is now starting its second initiative. The focus this time will be another underserved population: juvenile and adult criminal offenders who are re-entering the community.

“The emphasis on client choice starts clients in the process of making positive decisions in their lives,” said Ms. Gradney. “We’re empowering them to make better decisions.”

For more information about ATR, visit www.atr.samhsa.gov. **▶**

—By *Rebecca A. Clay*

Co-Occurring Disorders: Systems Integration, Epidemiology

Improving services for individuals with co-occurring mental health and substance use disorders is one of SAMHSA's priorities.

As part of the Agency's continuing series on this subject, SAMHSA's Co-Occurring Center for Excellence (COCE) recently released two new publications based on current science, research, and practices.

- *Systems Integration: Overview Paper 7* describes organizational structures and processes that can promote or inhibit integration.

- *The Epidemiology of Co-Occurring Substance Use and Mental Disorders: Overview Paper 8* describes the need for epidemiologic data and identifies current data sources on co-occurring disorders.

The COCE series is intended to inform mental health and substance abuse administrators and policymakers about the most current research and treatment practices.

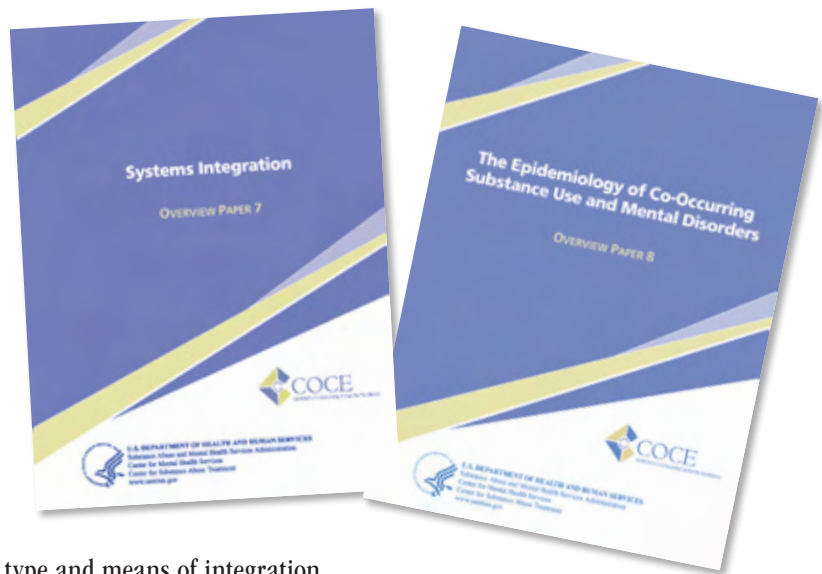
Overview Paper 7

An integrated approach to services—systems integration—improves treatment outcomes for individuals with co-occurring disorders.

Overview Paper 7 defines systems integration as the process through which health and behavioral systems (i.e., agencies, organizations, and individuals) organize themselves to combine services for patients with co-occurring disorders.

The paper explains how this integrated approach can help clinicians treat clients with co-occurring disorders. It also explains the types of organizational structures that support systems integration and addresses funding challenges.

Systems integration is a developing field; however, the paper presents real-world examples of integration and the organizational processes that support it.



The type and means of integration will vary for different service components and levels of care. Integration can refer to the combination of services (such as screening and assessment), or it can refer to the combination of service levels (such as individual practitioners and states).

Still, the goal of systems integration remains the same: To identify and manage co-occurring disorders and the interactions between them.

Overview Paper 8

High-quality epidemiologic data are important for planning services and building service systems for affected populations.

Epidemiology is the study of the number of people who have a condition, the rate that new cases are occurring, and the distribution of the illness in the population.

For example, an epidemiologist may study the number of people with co-occurring disorders, where they live, and if they are receiving treatment.

Overview Paper 8 defines the study of epidemiology and how it can be useful to practitioners, administrators, and policymakers.

Part 1 of the paper introduces three major national studies and presents

highlights from past epidemiological studies of co-occurring disorders. Part 2 delves into these studies in more detail, including methods and findings.

Knowing that rates of co-occurring disorders are higher for certain people can help providers with screening. Administrators can use these data to identify areas where specialized services and targeted outreach may be appropriate. Policymakers can identify treatment and prevention needs and determine appropriate resource allocation.

To read about other publications in this series, see *SAMHSA News* online, September/October 2007 and July/August 2007.

To Order

For free print copies, call 1-877-SAMHSA-7 (1-877-726-4727). For *Overview Paper 7*, request inventory number SMA07-4295. For *Overview Paper 8*, request number SMA07-4308.

On the SAMHSA Web site, all the COCE papers are available for free download at http://coce.samhsa.gov/products/overview_papers.aspx. ▾

—By Erin Bryant

Mental Health Report to Congress

Focus on Promotion, Prevention

A new SAMHSA report to Congress promotes the use of research-based approaches that enhance parenting support skills and child resilience—even in the face of adversity.

Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience emphasizes that these proactive approaches help prevent mental health problems from developing or can greatly mitigate them if they do occur—especially among children and youth.

Written by SAMHSA's Center for Mental Health Services, the report is a response to a request from the Senate Appropriations

Subcommittee on Labor, Health and Human Services, and Education.

SAMHSA Administrator Terry L. Cline, Ph.D., announced the report before the 23rd Annual Rosalynn Carter Symposium on Mental Health Policy in Atlanta, GA.

Dr. Cline noted that the report's recommendations advance the growing medical consensus that mental health needs must be aggressively addressed early in life in order to fully promote the Nation's public health interests.

In the report, SAMHSA identifies opportunities and makes recommendations on how to expand these programs to reach and assist families in need. Those recommendations include:

- Communicate the economic and social benefits of prevention.
- Ensure families help make decisions about programs, from the planning phase through the evaluation phase.
- Provide family members, caregivers, community leaders, and educators with the latest knowledge for strengthening parenting and building child resilience so that informed decisions about appropriate interventions can be made easily.
- Assemble a workforce capable of effectively using age- and culturally appropriate evidence-based practices.
- Build on existing programs to maximize available knowledge and resources.

A Public Health Approach

"Mental health is everyone's responsibility" is a message at the core of the public health approach. Focusing promotion and prevention efforts on children and their parents increases the likelihood that mental health problems will be addressed before they evolve into serious mental illnesses.



Statistics show, according to the SAMHSA report, that half of all diagnosable mental illnesses begin by age 14, and three-fourths of all lifetime cases start by age 24.

Accordingly, the report says promotion and prevention programs should include families, schools, primary health care, juvenile justice, child welfare, and substance abuse services.

Furthermore, successful promotion and prevention efforts hinge on the identification of risk and protective factors (see box). Left untreated, behavioral problems in young children can lead to conditions such as substance abuse, delinquency, and violence.

Parents and caregivers are more likely to be involved in services if services are provided in accessible settings—such as in schools or doctors' offices—and if they are culturally appropriate.

In short, addressing the needs and issues of parents and primary caregivers increases the potential for positive outcomes for children's mental health.

While many evidence-based prevention programs already exist, according to the report, the critical next step is for more communities to engage in a broad-based effort to put these programs into action.

To access the report online, visit SAMHSA's Web site at <http://mentalhealth.samhsa.gov/publications/allpubs/svp-0186>. For a free print copy, call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). Request inventory number SMA07-0186. ▶

Risk and Protective Factors

Promoting resilience in children includes building awareness of the complex interaction of risk and protective factors that affect mental wellness or mental illness in children. These factors include the following:

Risk factors

- Poor social skills
- Family poverty
- Classroom aggression
- Harsh or ineffective parenting skills.

Protective factors

For an individual:

- Positive temperament
- Self-confidence
- Sense of identity.

For a family:

- Parenting that's structured and caring
- Connections with supportive family networks
- Recognition for accomplishments.

For more information on children's mental health, read *SAMHSA News* online, May/June 2007, and visit SAMHSA's Web site at www.samhsa.gov. ▶

Grant Updates

Funding Opportunities

SAMHSA recently announced the following funding opportunities for Fiscal Year 2008.

Comprehensive Community Mental Health Services for Children and Their Families (Application due date: February 1, 2008)—Up to 19 cooperative agreement grant awards for up to \$1 million in year 1, \$1.5 million in year 2, \$2 million in years 3 and 4, up to \$1.5 million in year 5, and up to \$1 million in year 6, to expand systems of care for children and youth with serious emotional disturbances and their families. These agreements will support integrated home and community-based services for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring systems of care. SAMHSA's Center for Mental Health Services will administer the cooperative agreements. (SM-08-004, \$19 million)

Screening, Brief Intervention, Referral, and Treatment (SBIRT) (Application due date: January 31, 2008)—4 grant awards for up to \$2.52 million per year for up to 5 years, for SBIRT programs at the state and tribal level.

SBIRT programs, one of the key elements of the National Drug Control Strategy, are

proactive approaches that provide early identification and early intervention for persons at risk for, or diagnosed with, a substance use disorder. The grants will be awarded by SAMHSA's Center for Substance Abuse Treatment. (TI-08-001, \$10 million)

Campus Suicide Prevention (Application due date: January 18, 2008)—15 grant awards for up to \$100,000 per year for up to 3 years, to prevent suicide on college campuses, pending the availability of FY 2008 funds.

This program is designed to assist colleges and universities in their efforts to prevent suicide attempts and completions and to enhance services for students with mental and behavioral health problems, such as depression and substance abuse, which put them at risk for suicide. The grants will be awarded by SAMHSA's Center for Mental Health Services. (SM-08-002, \$1.5 million)

Awards

SAMHSA recently announced grant awards for the following programs.

Family-Centered Substance Abuse Treatment for Adolescents and Their Families—\$15 million for 17 grant awards over 3 years to community-based organizations that provide treatment

services to adolescents with substance abuse problems. Grantees receiving these awards will use known, effective strategies that include families as an integral part of the treatment process. Each recipient will receive \$300,000 per year for up to 3 years. Total funding for year 1 is \$5.1 million. [TI-06-007]

Statewide Family Network Program—\$8 million for 42 grant awards over 3 years to state-based organizations focused on improving programs that serve children and adolescents with serious emotional disturbances by strengthening relationships among family members and coalitions of family members, policymakers, and service providers. Each award is funded up to \$70,000 per year. Total funding for year 1 is nearly \$2.7 million. [SM-07-001]

Consumer and Consumer Supporter Technical Assistance Centers—\$5.4 million for 5 grant awards over 3 years to consumer and consumer supporter technical assistance centers to promote consumer involvement in the transformation of the mental health system. These centers will teach consumers of mental health services the necessary skills to enhance consumer/peer-run programs. Grants to each center will not exceed \$340,000 for each of 3 years. Total funding for year 1 is nearly \$1.7 million. [SM-07-003]

Statewide Consumer Network—\$4.2 million for 20 grant awards over 3 years to help consumer organizations around the country work with policymakers and service providers to improve services for persons living with serious mental illnesses. Grantees are encouraged to work in partnership with their state's Mental Health Transformation State Incentive Grant staff. Each recipient will receive approximately \$70,000 per year for up to 3 years. Total funding for year 1 is \$1.4 million. [SM-07-002]

For more information on grant awards, visit SAMHSA's Web site at www.samhsa.gov/grants.

Grants: How To Apply

SAMHSA's Web site offers the most up-to-date information on funding opportunities for 2008 and recent grant awards. All the materials needed to apply for a SAMHSA grant also are available for download. Visit www.samhsa.gov/grants.

Print copies of a Request for Applications (RFA), including copies of all forms, are available from SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). Be ready to reference the RFA number.

Grants.gov

The Federal Government's Web site, grants.gov, streamlines the process of finding and applying for Federal grant opportunities and is a central source for information on over 1,000 grant programs. Visit grants.gov for details. ▶

Campaign: Proper Disposal of Prescription Drugs

Educating people about safe disposal of prescription medicines, especially painkillers and sleep aids, is the focus of a new SAMHSA pilot program.

Prescription drug misuse is a growing problem. To help, SAMHSA is providing point-of-sale information sheets at more than 6,000 pharmacy counters across the Nation.

The pilot program is intended to combat the increasing abuse of prescription drugs—particularly among teens and young adults.

These information sheets highlight the need for preventing abuse of these medications and provide practical advice on how to store medication properly and dispose of unused amounts.

“This program is so important because most prescription drug abusers get these drugs through a friend or relative,” said SAMHSA Administrator Terry L. Cline, Ph.D.

In fact, 55.7 percent of people age 12 and older who used pain relievers nonmedically in the past year reported that they obtained the drugs from a friend or relative for free during the most

recent time of use, according to recently released results from SAMHSA’s 2006 National Survey on Drug Use and Health.

Although levels of illicit drug abuse among youth had declined in many areas over the past few years, the survey found that prescription drug abuse has grown significantly. The level of nonmedical use of prescription drugs among young adults increased from 5.4 percent in 2002 to 6.4 percent in 2006, due largely to an increase in the nonmedical use of pain relievers.

Educating Consumers

Because a high percentage of teens and young adults report that they have access to prescription drugs in family medicine cabinets, SAMHSA is focusing on teaching people how to reduce and eliminate this access.

To help educate parents and other members of the public, SAMHSA is disseminating point-of-sale information to consumers who purchase highly abused prescription drugs such

Is Someone Misusing Your Prescription Drugs?

One in five teens reports intentionally misusing someone else's prescription drugs to get high. Nearly half say they get the medications from friends and relatives for free.

Prevent Prescription Drug Abuse.

- ▶ Store your prescription drugs in a safe, secure place and count your pills regularly.
- ▶ Mix unused medications with an undesirable substance and place in a sealed container before disposing in the trash.

For more information, visit www.samhsa.gov/rxsafety, call 1-877-SAMHSA-7 (728-4727), or talk to your pharmacist.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

as hydrocodone, select sleep aids, and oxycodone (OxyContin®).

Using new technology that automatically selects the appropriate information sheet for the medication being purchased, consumers will receive one of three information sheets on abuse prevention when they fill prescriptions for one of these drugs at pharmacies participating in the program.

Additional information on this program can be found on the SAMHSA Web site at <http://www.samhsa.gov/rxsafety>. For additional information, studies, data, and reports on prescription drug abuse, including data from the Agency’s Drug Abuse Warning Network, visit SAMHSA’s Web site at www.oas.samhsa.gov/prescription.htm. ▶

What Consumers Need To Know

SAMHSA’s information sheets on substance abuse prevention address the following themes:

- Prescription drug abuse is a growing problem—particularly among young adults and teens.
- A high percentage of teens and young adults report that they can get ready access to someone else’s prescription drugs from the family medicine cabinet.
- Prescription drugs should be stored in a safe, secure place and counted regularly to help ensure that they don’t get into the hands of unauthorized users.

- Consumers should always check patient information accompanying the product to see if it contains specific directions for disposing of unused medication and should follow those instructions. If no specific directions are provided, unused medication should be discarded by mixing it with undesirable substances (e.g., old coffee grounds, used kitty litter), sealing the mixture in a container, and placing it in the trash. Whenever possible, unused medication may also be donated to authorized community take-back programs for prescription drugs. ▶



Preventing Suicide on College Campuses

Continued from page 1

noting that the two visited the Counseling Center, and the girl ended up dropping the problematic class. “The outcome isn’t always this easy. She just needed to know I was there to listen, and I cared enough to get her help.”

That’s the premise of gatekeeper training.

“We don’t want gatekeepers to be therapists,” said Cory Wallack, Ph.D., Staff

Therapist at the SU Counseling Center. “A gatekeeper’s first task is to connect to students and help students feel supported. Then, a gatekeeper helps to increase the likelihood that students will follow through with referrals to the Counseling Center. Because it’s a trusted person telling them, ‘You know, I really think you should do this. Get some help.’ ”

Gatekeeper training is so important that it’s one of the objectives of the National Strategy for Suicide Prevention—a strategy in which SAMHSA plays a key role.

“Many young adults will not seek out interventions or counseling by adults unless they feel that they can trust the adult to maintain respect, confidentiality, and provide knowledge and appropriate information,” said Dr. McKeon. “So, it makes sense to train those school personnel who are most likely to come in contact with students at risk.”

All told, staff at colleges and universities operating under SAMHSA’s Campus Suicide Prevention grants trained more than 10,000 lay gatekeepers successfully during the first year of the program.

SU has trained about 300 resident life and health center staff in 3-hour sessions. There are plans to train academic advisors and counselors in the near future. UC Irvine has trained 2,200 gatekeepers in just 2 years, with school staff members, campus police, and even some students learning how to relate to young people in crisis.

SU has even worked with 10 other schools receiving SAMHSA Campus Suicide Prevention grants to train additional staff members about their Campus Connect gatekeeper training program.

Stress Reduction

In addition to gatekeeper training, the SU Counseling Center offers an 8-week class—Mindfulness Based Stress Reduction—

SAMHSA’s Suicide Prevention Grants

Campus Suicide Prevention Grants

SAMHSA’s Campus Suicide Prevention program is funded by Congress under the Garrett Lee Smith Memorial Act (the Act).

Signed by President George W. Bush in 2004, the Act is the first Federal legislation to provide specific funding for youth suicide prevention programs, and it authorized \$82 million over 3 years for SAMHSA to fund these programs (see cover story).

Campus Activities

Campus grantees use funds to:

- Develop training programs to teach effective responses to students with mental and behavioral health problems.
- Create networks of student services to identify and assess mental and behavioral health problems.
- Develop seminars to promote help-seeking behaviors; reduce stigma; and provide information on suicide prevention, identification, and reduction of risk factors.
- Create college-based helplines or promote SAMHSA’s National Suicide Prevention Lifeline (1-800-273-TALK).

- Prepare materials that address warning signs of suicide, describe risk and protective factors, and identify actions to take with students in distress.
- Prepare materials for families of college students to increase awareness of potential mental and behavioral health issues.

For information on other Agency grants for suicide prevention, visit www.samhsa.gov/matrix2/matrix_suicide.aspx.

Garrett’s Story

“Senator Gordon Smith has demonstrated the ability to turn a great personal loss into a selfless act that benefits the Nation,” said A. Kathryn Power, M.Ed., Director of SAMHSA’s Center for Mental Health Services.

The son of U.S. Senator Gordon Smith, J.D. (D-OR), Garrett Lee Smith loved the outdoors and spending time with family and friends.

Garrett also suffered from depression. He committed suicide the day before his twenty-second birthday.

Since then, Senator Smith has supported bipartisan legislation in Garrett’s memory to help other families and communities stop suicide among the young. ▶

to teach students how to manage difficult situations before severe distress occurs.

Specifically, the class teaches students how to respond to situations with choice rather than knee-jerk reactions. Participants engage in gentle yoga and body scan meditations to focus on and work through what's going on in their minds.

While the program isn't designed to eliminate stress, it does help students learn how to reflect. "If you don't know you're in distress, you can't seek help," Dr. Dayton explained. "We believe that students need help in learning how to be self-aware."

By the end of the grant term, about 180 students will have taken the class. Preliminary evaluations suggest that participants have seen a reduction in perceived stress.

Building Awareness

A key component of both programs is awareness programming.

Grantees use posters, brochures, and public service announcements to promote knowledge and understanding of mental health problems on campus, reduce stigma, and increase help-seeking behaviors.

On the West Coast, UC Irvine's award-winning *Don't Erase Your Future* campaign

(donteraseyourfuture.org) is an important resource. Online, the university posts SAMHSA's National Suicide Prevention Lifeline phone number (1-800-273-TALK), describes suicide warning signs, and uses stories about famous historical figures to show visitors why they should look toward the future. (See *SAMHSA News* online, September/October 2005.)

The Lifeline has saved lives at UC Irvine. Dr. Reibling recalled at least three documented instances in which students in crisis called the hotline and were directed to local resources for treatment.

Lessons Learned

About 18 million students will be enrolled in colleges and universities across the Nation in 2008. In light of the big-picture needs of students, campus suicide prevention cannot be the sole responsibility of school counseling centers, Dr. Dayton said. Faculty and university administration staff at institutions across the Nation must collaborate with counseling center staff to help college students address mental health issues.

The hope for the campus program is that, over time, grantees will be able to bring about a cultural shift on campus that will actually *decrease the need* for mental health services. In the meantime, however, as awareness of

suicide increases, so does the demand for SU Counseling Center services. No doubt multiple factors are responsible for this growth, and grantees report more students are asking for help. So many more, in fact, that the Counseling Center may hire additional staff next year.

"Connecting with people, helping people feel understood, improving communication skills, enhancing relationships—those are important protective factors that help reduce suicidality," Dr. Dayton said. "Universities need to be educating students on how to get help when they need it."

Ms. Power noted that students in distress must be encouraged to seek assistance. "Each and every one of us has a role to play in suicide prevention," she said. "SAMHSA is here to help."

For more information about SAMHSA's National Strategy for Suicide Prevention, visit <http://mentalhealth.samhsa.gov/suicideprevention/strategy.asp>. For details on SAMHSA's Campus Suicide Prevention program and other mental health programs, visit www.samhsa.gov. ▀

—By Leslie Quander Wooldridge

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Adolescents Do *What* Every Day?

Go to school. Spend time at the mall. Listen to music. Text-message friends. Isn't this a typical day for an American adolescent? That's what many of us think.

But something much more serious is going on. According to a recent report from SAMHSA, a young person's average day often includes drinking, smoking, or using illicit drugs.

A Day in the Life of American Adolescents: Substance Use Facts, from SAMHSA's Office of Applied Studies (OAS), provides a startling look at how many youth are abusing illicit drugs and alcohol. The report uses three SAMHSA data sources.*

"By breaking down and analyzing the data on a day-to-day basis," said SAMHSA Administrator Terry L. Cline, Ph.D., "we gain fresh perspective on how deeply substance abuse pervades the lives of many young people and their families."

The Numbers

The report reveals that on an average day in 2006, about 1.2 million adolescents age 12 to 17 smoked cigarettes; 631,000 drank alcohol; and 586,000 used marijuana.

In addition, about 49,000 adolescents used inhalants; 27,000 used hallucinogens; 13,000 used cocaine; and 3,800 used heroin.

The OAS report also sheds light on how many youth age 12 to 17 used illegal substances for the first time.

On an average day in 2006, nearly 8,000 adolescents drank alcohol for the first time; 4,300 used an illicit drug for the first time; 4,000 smoked their first cigarette; 3,600 smoked marijuana for the first time; and 2,500 used pain relievers for non-medical reasons for the first time.

Treatment

How many teens under age 18 are in treatment on an average day? Using the most recent data (2005), the report shows more than 76,000 youth in outpatient treatment; 10,000 in non-hospital residential treatment; and 1,000 in hospital inpatient treatment.

The report also provides information on the main substances of abuse reported by youth in treatment and the sources of referral for their treatment.

A Day in the Life of American Adolescents: Substance Use Facts is available on SAMHSA's Web site at <http://oas.samhsa.gov/2k7/youthFacts/youth.pdf>. ▶

—By Kristin Blank



* The data presented in this report are from these three SAMHSA surveys: the 2006 National Survey on Drug Use and Health (NSDUH), the 2005 Treatment Episode Data Set (TEDS), and the 2005 National Survey of Substance Abuse Treatment Services (N-SSATS).

Booklet Available in Chinese, Korean, and Vietnamese

SAMHSA recently introduced several new versions of a family-oriented publication under its Multi-Language Initiative (MLI), part of the Agency's Knowledge Application Program.

What Is Substance Abuse Treatment? A Booklet for Families is now available in Chinese, Korean, and Vietnamese. The booklet also is available online and in print in Spanish, and online in Russian (see *SAMHSA News* online, July/August 2007).

This publication answers questions often asked by the family members and significant others of people entering treatment. The booklet also includes a resource section with a list of support groups.

Under the initiative, SAMHSA products are translated and culturally adapted for people who do not speak English or have limited English-language abilities.

To download free copies of this publication in various languages, or to learn more about the initiative, visit SAMHSA's MLI Web site at www.kap.samhsa.gov/mli. ▶



Gilberto Romero Appointed Expert Consultant

SAMHSA recently appointed Gilberto Romero to serve a 4-year term as an expert consultant for SAMHSA's Center for Mental Health Services (CMHS) National Advisory Council Subcommittee on Consumer/Survivor Issues.

Mr. Romero has served on the Governor's Mental Health Planning Council and the Social Worker Board of Examiners in New Mexico. In addition, he served on the Consumer Council for the National Alliance on Mental Illness.

The CMHS Subcommittee on Consumer/Survivor Issues provides suggestions to the CMHS Advisory Council from the consumer's perspective. Recommendations generated by the Subcommittee include issues of stigma and discrimination, trauma, employment, and recovery.

For more information, read SAMHSA's press release at www.samhsa.gov/newsroom/advisories/0711195750.aspx. ▶

Evidence-Based Programs: New Web Resource

SAMHSA recently developed a new Web page to help identify evidence-based programs and practices.

The new page—A Guide to Evidence-Based Practices on the Web—is a component of SAMHSA's Science and Service initiative.

The page features direct links to more than 37 Web sites that contain information about specific evidence-based interventions or provide reviews of research findings.

To simplify searches, information is grouped in two main categories—"Behavioral Health" and "Intended Age Group." Each site listing includes the sponsor's name, a link, a statement of purpose, and key features, which include sources of evidence.

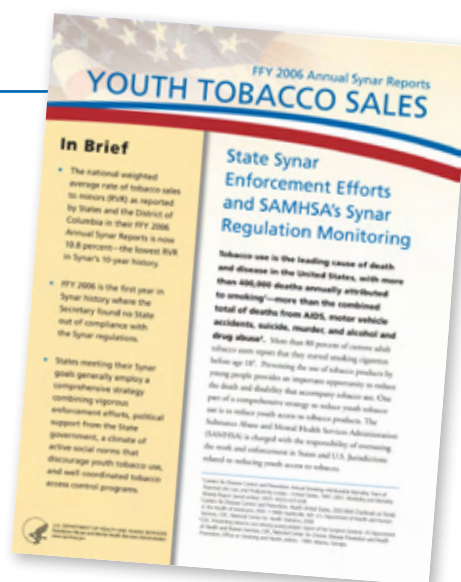
For more information, visit SAMHSA's Web site at www.samhsa.gov/ebpWebguide. ▶

Youth Tobacco Sales Lowest in 10 Years

SAMHSA recently released a report showing that sales of tobacco to underage youth have reached all-time lows under the Synar program—a Federal and state partnership program seeking to end illegal tobacco sales to minors.

The report, *FFY 2006 Annual Synar Reports: Youth Tobacco Sales*, shows all states and the District of Columbia in compliance for the first time, with all reporting the retailer violation rate of less than the maximum 20 percent.

The report lists the national weighted average rate of overall tobacco sales to minors as 10.9 percent. This is the lowest rate in the 10-year history of the Synar enforcement effort. (See *SAMHSA News* online, September/October 2005.)



The Synar Amendment is named for the late U.S. Representative Mike Synar of Oklahoma.

Online, the report is available on SAMHSA's Web site at <http://download.ncadi.samhsa.gov/Prevline/pdfs/sma07-4300.pdf>. ▶

This index includes entries for six issues of SAMHSA News for 2007. Each issue is numbered: January/February (1), March/April (2), May/June (3), July/August (4), September/October (5), and November/December (6). Specific pages follow. Entries in *italics* are publications.

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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 available resources and new publications.

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- Co-Occurring Disorders: Systems Integration, Epidemiology
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- Grant Updates
- Campaign: Proper Disposal of Prescription Drugs
- Adolescents Do *What* Every Day?
- In Brief . . .
- Employers Honored for Behavioral Health Services
- Annual Index 2007
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Employers Honored for Behavioral Health Services

Innovative Programs Reduce Absenteeism, Disability Claims

Five employers recently received top honors at the inaugural Behavioral Health Awards ceremony in Washington, DC. SAMHSA's Center for Mental Health Services (CMHS) sponsored the program.

These awards honor businesses that create innovative programs to improve employee access to mental health and substance abuse services.

"Research and experience show that behavioral health programs that address prevention and early intervention may help employers reduce absenteeism and disability claims associated with mental health and substance abuse disorders," said A. Kathryn Power, M.Ed., CMHS Director.

The National Business Group on Health, a nonprofit association of 285 large U.S. employers, presented Employer Implementation Awards to Aetna, Cisco Systems, Delta Air Lines, and Pitney Bowes. Cisco Systems and GlaxoSmithKline received Best Practice Awards.

"About 217 million days of work are lost annually due to productivity decline related to mental health and substance abuse disorders, costing U.S. employers \$17 billion annually," said Helen Darling, President of the National Business Group on Health.

Federal and Private Partnerships

The inaugural awards were presented at a ceremony during the 2007 Joint Forum on Health, Productivity, and Absence. In her address to attendees, Ms. Power emphasized the importance of partnerships between the Federal and private sectors.

"For CMHS, partnership with the private sector is an essential element of our mission

to support the mental health and well-being of all Americans," she said. "We have a mutual goal of having a healthy and productive workforce and successful and stable families."

The goal of the Behavioral Health Awards is to recognize employers that develop, use, and evaluate innovative behavioral health benefits and programs to improve an employer's business operations and the health of beneficiaries.

Emphasizing mental wellness, Ms. Power explained the importance of early intervention as mental health issues emerge for an individual.

"After all," she said. "People, not organizations, are our most valuable assets."



Descriptions of the winning programs are available at the National Business Group on Health's Web site at www.businessgrouphealth.org.

For more information about mental health, visit SAMHSA's Web site at www.mentalhealth.samhsa.gov. ▀

Workplace Statistics

According to the 2006 National Survey on Drug Use and Health (NSDUH), 6.6 percent of full-time employed adults and 7.6 percent of part-time employed adults experienced a mental illness in the past year.

In addition, NSDUH recently reported that an annual average of 7.0 percent of full-time workers age 18 to 64 experienced a major depressive episode (MDE) in the past year.

A full 14.8 percent of full-time female workers in some occupations experienced an MDE in the last year.

Additional statistics on mental health and substance abuse among American workers are available from SAMHSA's Office of Applied Studies. Reports include the following:

- *Worker Substance Use and Workplace Policies and Programs:* For a feature article on this 188-page report, see *SAMHSA News* online, September/October 2007. To access

the full report, visit <http://oas.samhsa.gov/work2k7/work.pdf>.

- *Worker Substance Use, by Industry Category:* According to combined data from 2002 to 2004, an annual average of 8.2 percent of full-time workers age 18 to 64 used illicit drugs in the past month, and 8.8 percent used alcohol heavily in the past month. Read more at <http://oas.samhsa.gov/2k7/industry/worker.pdf>.

- *Depression among Adults Employed Full-Time, by Occupational Category:* Combined data from 2004 to 2006 find that the highest rates of past-year MDE among full-time workers age 18 to 64 were found in the personal care and service occupations (10.8 percent) and the food preparation and serving-related occupations (10.3 percent). Read more at <http://oas.samhsa.gov/2k7/depression/occupation.pdf>. ▀



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Rockville, MD 20857

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