A Life in the Community for Everyone
SAMHSA NEWS
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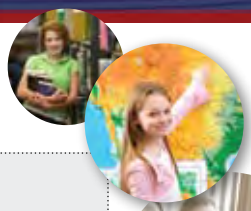

Drug Free Communities

Coming Together To Prevent Teen Drug Use

Local problems demand local solutions. That's the basic philosophy behind the Drug Free Communities Support program, which harnesses the power of community coalitions to reduce and ultimately prevent substance use among young people.

Established under the Drug Free Communities Act of 1997, the Drug Free Communities Support program now supports 769 community coalitions across the country. (At left is 2009 funding information.)

The White House Office of National Drug Control Policy (ONDCP) oversees the program, while SAMHSA's Center for Substance Abuse Prevention (CSAP) manages the grants administration. A recent evaluation suggests that the program is successful. (See bottom of page 3 for details.)

"The partnership between ONDCP and SAMHSA

continued on page 2

Funding Opportunity: Drug Free Communities

March 20 Deadline for Applications

There's still time to send in your coalition's application for a 2009 Drug Free Communities program grant. The deadline is March 20.

Approximately $17 million is available for up to 130 Drug Free Communities (DFC) program grants. These grants will be available to eligible coalitions in amounts of up to $125,000 per year over a 5-year period, known as a "funding cycle."

For details, visit SAMHSA's grants page at **www.samhsa.gov/grants/2009/sp_09_002.aspx** or visit the DFC Web site at **www.ondcp.gov/dfc.**

All DFC applications will be jointly screened by the Office of National Drug Control Policy and SAMHSA's Center for Substance Abuse Prevention to ensure applicants meet all the DFC program coalition eligibility requirements.

For questions regarding all prevention program and coalitions-related issues, including those pertaining to the completion of an application for this grant program, contact CSAP's Dan Fletcher at 240-276-1270 or email dfcnew2009@samhsa.hhs.gov.

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View
From Dr. Broderick

Building Healthy Communities

The grassroots efforts of community coalitions hard at work across the country set a strong example of how states and local communities can partner with the Federal Government to extend our reach and make an impact greater than any one organization working alone.

As I visit towns and cities across the Nation, I have the continuing opportunity to experience this "synergy" firsthand as community leaders come together to build neighborhood coalitions to address substance abuse and mental health issues.

SAMHSA is an important part of this grassroots effort. The Agency's mission is to build resilience and facilitate recovery so that we can reach our vision of "A Life in the Community for Everyone."

We know that substance abuse problems are better addressed locally at the community level because they manifest locally—sometimes, right in our own backyards.

The goal of prevention, however, is to stop substance use before it ever begins.

The Drug Free Communities Support (DFC) program is one of SAMHSA's most successful coalition-building, prevention efforts in this regard. Working collaboratively with the White House Office of National Drug Control Policy, SAMHSA is currently funding more than 750 DFC grantees.

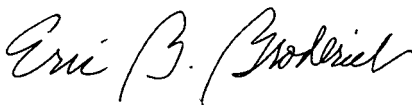
The *SAMHSA News* cover story highlights the success of this grant program.

Engaging young people in positive, drug-free activities takes time, planning, and commitment from a lot of people, not just parents. Local firefighters, law enforcement, volunteers, the state National Guard, shop owners, restaurant managers, coaches, and many others play their part.

Our efforts to reach young people with positive messages now include new media and social networks such as YouTube, Facebook, Twitter, MySpace, and other innovative, virtual communities on the Web.

We're working to bring new knowledge and new technology to daily community-based practice. Emphasizing connections across disciplines helps create a larger context for the care of the whole person.

Our work is far from done. While we have made tremendous strides through prevention efforts, we still face a vast public health risk with regard to substance abuse among young people. Community coalitions are a step in the right direction.



Eric B. Broderick, D.D.S., M.P.H.
Acting Administrator, SAMHSA

Drug Free Communities

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has been key," said CSAP Director Frances M. Harding, explaining that working together at the Federal level offers grantees a model of the power of collaboration. "Changing community norms isn't going to happen without all members of the community coming together in partnerships of their own."

HOW IT WORKS

Fortunately, communities coming together is exactly what's happening. There are now coalitions in every state, plus the District of Columbia, Puerto Rico, the U.S. Virgin Islands, American Samoa, and Palau.

The program gives community organizations grants of up to $625,000 over 5 years to expand citizen participation in drug abuse prevention activities in their own communities. The goals are twofold: to establish and strengthen community coalitions and to reduce substance use among youth and adults.

To achieve those goals, the coalitions focus on changing community norms, explained Ms. Harding. "We're trying to change the environment for young people, so they no longer have to grow up in environments where alcohol and drugs are tolerated," she said.

This "environmental" approach can be extremely effective, said Michael J. Koscinski, M.S., M.S.W., a Drug Free Communities project officer at CSAP, pointing to national environmental changes over the years.

"Just look what happened when we changed the drinking age from 18 back to 21—the number of deaths averted was incredible," said Mr. Koscinski. The same thing is happening with cigarette smoking, he said, noting that he grew up in an era when both teachers and students were allowed to smoke at school. "When you start banning smoking on trains, in hospitals, in restaurants, the level of addiction to cigarettes goes down and the

Read about the success of a Maryland DFC grantee. See page 5.

number of new cases of cancer goes down as well."

The Drug Free Communities coalitions strive to bring about similar changes on a local level, working to reduce risk factors and increase protective factors. Each community may focus on different factors depending on the local situation, said Mr. Koscinski.

In the urban east, for instance, coalitions might target liquor stores that fail to check young people's IDs. They might try a variety of tactics, explained Mr. Koscinski. If they wanted to be confrontational, for example, they could have a young-looking police officer try to buy alcohol and then publicize names of stores that don't comply.

If they wanted to use positive reinforcement, they could reward stores that pledge to check IDs by publicizing those that agree to follow the law. Or they could take a regulatory approach, such as making IDs for people under 21 easier to recognize at a glance or requiring keg registration to help determine liability if a keg party gets out of hand.

In rural areas out west, said Mr. Koscinski, coalitions may have completely different problems and solutions. "The environmental approach there might be to go to ranchers and farmers and ask them to keep a lookout for meth labs or anything suspicious going on on their property," he said.

Many coalitions around the country are now using social norms marketing strategies, which use social norms theory to correct misperceived social norms around drinking and drug use. Adolescents have a great desire to want to "fit in," and this need puts kids at risk for engaging in behavior based on a potential misperception of what is "normal."

Of course, coalitions typically rely on multiple strategies simultaneously. (See pages 5 and 6 to read about a Maryland grantee's experience.)

No matter what strategies coalitions use, they have one thing in common: the involvement of just about everyone in the community.

Coalitions must include representatives from almost a dozen sectors: youth, parents, the business community, media, schools, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, health care professionals, and state, local, or tribal governmental agencies with expertise in the substance abuse field.

The coalitions are like flocks of geese, said Mr. Koscinski. "If an individual goose tried to fly from the outer reaches of Canada to South America, it would never make it," he explained. "But when geese come together and fly in formation, they can fly farther." Similarly, he said, police working alone aren't enough. When they join forces with kids, parents, schools,

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Evaluation findings.

Data show lower alcohol, tobacco, and marijuana use in "coalition communities."

Read the full report at **www.ondcp.gov/dfc/files/dfc_interim_findings_092408.pdf.**

23

Alcohol use.

Average youth alcohol use in coalition communities is more than 23 percent lower than the national average.

10

Tobacco use.

Annual tobacco use is 10 percent lower in coalition communities than the national average.

10

Marijuana use.

Current marijuana use among high schoolers in coalition communities is almost 10 percent lower than the reported national average.

Source: Office of National Drug Control Policy. Interim DFC Program Evaluation Findings Report. (2008).

> "We're trying to change the environment for young people, so they no longer have to grow up in environments where alcohol and drugs are tolerated."
>
> —Frances M. Harding, Director
> SAMHSA's Center for Substance Abuse Prevention

Drug Free Communities

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and others, they can build on each other's strengths and make an impact.

Young people themselves play a critical role in the program, emphasized Mr. Koscinski. "Kids are part of both the problem and the solution," he said, noting that young people know what will work best to keep their peers away from alcohol, tobacco, and drugs.

Getting young people involved also is a protective factor in itself for both those involved and those who see that young person as a role model, he added. "To have kids at the table with the school board president, the police chief, and all the other players in a community gives them leadership opportunities," he said. "They don't have to be part of a norm that says drug and alcohol use is okay."

The National Community Anti-Drug Coalition Institute provides training and technical assistance to grantees. Founded in 2002, the institute is part of the Community Anti-Drug Coalitions of America, a nonprofit organization based in Alexandria, VA. Its work is to strengthen the capacity of community coalitions.

In addition, the Drug Free Communities Mentoring Program is preparing a new generation of coalitions. Currently, 31 well-established Drug Free Communities grantees are serving as mentors to developing or newly formed coalitions that have not yet received a Drug Free Communities grant. "We're building a critical mass of these coalitions," said Mr. Koscinski.

PROMISING RESULTS

So far, the coalition approach appears to be working quite well.

An ONDCP-funded interim evaluation (see Resources for link) shows that the program is effective in preventing substance use and abuse among teens. The evaluation compared data from Drug Free Communities grantees to national data from the Youth Risk Behavior Surveillance System, which includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC), plus surveys conducted by state, territorial, tribal, and local education and health agencies.

According to the analysis, the number of high school students who report having used alcohol, tobacco, or marijuana in the last month is significantly lower in coalition communities than the national average.

The current use rates in Drug Free Communities areas declined between 2006 and 2007. And while drug use among teens has been declining across the Nation as a whole, it's dropping faster in communities with Drug Free Community coalitions.

"At a glance, you can see that these numbers show the effectiveness of the Drug Free Communities program. Each community's efforts are a step in the right direction," said Ms. Harding.

For more information on Drug Free Communities and grantees, visit **http://prevention.samhsa.gov/grants/drugfree.aspx.**

—By Rebecca A. Clay

Coalition Resources

For more information on SAMHSA's substance abuse prevention efforts, visit **www.samhsa.gov** or **www.prevention.samhsa.gov.** For the 2009 Drug Free Communities funding announcement, visit **www.ondcp.gov/news/press09/020409.html.**

For related information, visit the following Web sites:

- Drug Free Communities Support Program—**www.ondcp.gov/dfc**
- Drug Free Communities Support Mentoring Program—**www.ondcp.gov/dfc/mentor_grant_progr.html**
- Interim DFC Program Evaluation Findings Report—**www.ondcp.gov/dfc/files/dfc_interim_findings_092408.pdf**
- Community Anti-Drug Coalitions of America—**www.cadca.org**
- National Community Anti-Drug Coalition Institute—**www.coalitioninstitute.org.**

Drug Free Communities
A Maryland Grantee's Story

Ask Katherine E. Wright, M.H.S., LCADC, about the goal of her area's Drug Free Communities (DFC) coalition, and the answer is simple: "We want to change the values and norms in our community so it's not a rite of passage to use alcohol, tobacco, and drugs and to make non-use the norm for anyone under 18 for tobacco and 21 for alcohol," said Ms. Wright, Assistant Director and Prevention Coordinator at Alcohol and Drug Abuse Services, part of Maryland's state government.

The coalition began with the discovery that using tobacco, alcohol, and drugs was quite common for young people in Queen Anne's County, MD, located on the eastern shore of the Chesapeake Bay. The Maryland Adolescent Survey showed that usage rates among 6th through 12th graders were extremely high, said Ms. Wright, calling the results "alarming."

Led by the Queen Anne's County Community Partnership for Children and Families, the community took action. Now in its final year of a 5-year Drug Free Communities grant, the Drug Free Queen Anne's coalition uses a multi-pronged approach that aims to get everyone in the community involved.

There's a teen court, for example, where young first-time offenders who have committed minor offenses appear before their peers and receive sentences that might include community service, apology letters, or a tour of the detention center. Presided over by a real judge, teens take on the roles of prosecuting attorney, defense attorney, and bailiff as well as jurors.

A Character Counts Advisory Council enlists 109 volunteer "coaches" to go into the schools and talk about various aspects of character, such as trustworthiness, respect, and responsibility. Of course, said Ms. Wright, they also squeeze anti-drug messages into their 15-minute classroom sessions.

Another group in the coalition focuses on a mentoring program and other

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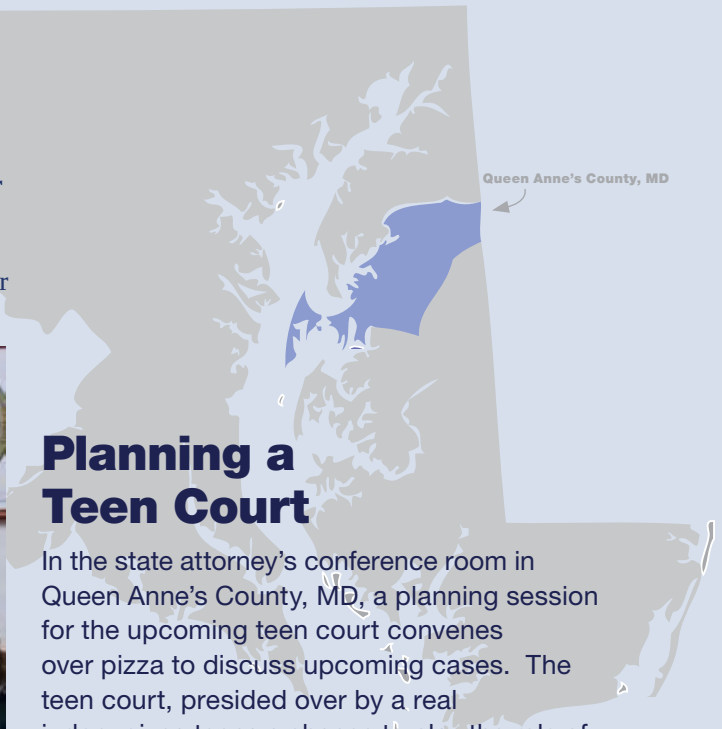
"We want to change the values and norms in our community so it's not a rite of passage to use alcohol, tobacco, and drugs and to make non-use the norm for anyone under 18 for tobacco and 21 for alcohol."

—Katherine E. Wright, Prevention Coordinator

Teens meet to review their roles in a peer court held in Queen Anne's County, MD.



Planning a Teen Court

In the state attorney's conference room in Queen Anne's County, MD, a planning session for the upcoming teen court convenes over pizza to discuss upcoming cases. The teen court, presided over by a real judge, gives teens a chance to play the role of prosecuting attorney, defense attorney, and bailiff as well as jurors.

Appearing before their peers, young first-time offenders charged with minor offenses receive "sentences" including community service.

A Maryland Grantee's Story <<P.5

strategies for keeping African American students in school and off drugs.

Young people themselves plan many of the activities, emphasized Ms. Wright. Members of the Assets Team, for instance, decide on activities and then organize and fundraise to make them a reality. Recent activities have included putting on a play, watching an Orioles game, and going to a restaurant to learn how to order a meal, which fork to use, and so on. "That boosted their self-esteem," said Ms. Wright.

A member of the Maryland National Guard gives a young person a chance to sit in the pilot's seat.

The students also help plan an annual youth summit. Hosted at the Queen Anne's County High School and organized by a church, the summit includes recognition of teen court volunteers, a summary of data on youth substance use, a dance, motivational speakers, and booths with information and giveaways.

The National Guard is also very involved, bringing a helicopter, a rock-climbing wall, and tricycles and go-carts that kids can drive while wearing goggles that simulate drunkenness. (For more on the National Guard, see *SAMHSA News* online, July/August 2008.)

The local cable television station publicizes upcoming events as well as information about substance abuse.

And those are just a few examples, said Ms. Wright, noting that the coalition's work is already paying off. Although the coalition is still analyzing the 2007 data, the preliminary analysis shows a significant drop in alcohol, tobacco, and drug use in almost all groups.

Ms. Wright is also seeing increased buy-in from community members. Last year, for instance, 400 parents signed a pledge to lock up their alcohol and not allow minors to smoke or drink at their homes. This year, she said, more than 800 have signed

Community teams played in the Annual Law Enforcement vs. Alumni basketball game, which drew a supportive crowd. From left to right, organizers include: Lt. D. Boardman, Maryland State Police, Centreville Barrack Commander; D. Fassett, Prevention ATOD staff member; T. J. Brooks, community member and former star basketball player for Queen Anne's County High School; and Queen Anne's County Sheriff Gery Hofmann III.

even before the coalition has distributed its mailing through the school system.

"We're able to mobilize everybody," said Ms. Wright. And by working together in a coalition, she said, "we're able to communicate among each other so everyone knows what the left hand and the right hand are doing."

For more information on the DFC program, visit **www.ondcp.gov/dfc.**

—By Rebecca A. Clay

"Coalition Essentials" Are Part of Core Training

More than 500 new grantees, mentors, trainers, and prevention professionals attended the first 2009 training for the Drug Free Communities Support (DFC) program, which took place in Washington, DC, January 5 to 7.

Welcomed by Frances M. Harding, Director of SAMHSA's Center for Substance Abuse Prevention, new grantees at the 3-day training participated in learning sessions on "coalition essentials" such as the core competencies and essential processes of community health promotion.

All coalitions that won a 2008 DFC grant were invited to participate. Sessions were conducted by the National Coalition Institute, which is the training and evaluation branch of Community Anti-Drug Coalitions of America (CADCA). CADCA, along with the White House Office of National Drug Control Policy and SAMHSA, sponsors the DFC program.

New grantees also had time set aside for one-on-one mentoring sessions with an experienced grantee. The sessions included review and critique of each new coalition's Logic Model, Strategic Plan, and the actual proposal written in response to SAMHSA's 2008 request for applications.

For more photos from the training, see *SAMHSA News* online.

A new Drug Free Communities (DFC) grantee reviews the information on "Coalition Essentials" in her training binder. The training was held in Washington, DC, on January 5.

Drug-Free Workplaces

Cost-Effective Ways To Help Employees

Do you have employees with substance abuse problems? Want to help them, but don't think you have the financial resources and aren't sure where to start? SAMHSA is here to help.

Fourteen two-page informational briefs are now available for employers. They outline the benefits—including financial—of helping employees receive treatment for substance abuse.

"These timely materials show that substance abuse treatment benefits under employee health plans can actually save them money while boosting employees' health and productivity," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment.

"This can help employers make informed decisions while they are considering changes related to the Wellstone/Domenici Mental Health and Addictions Parity Act of 2008," Dr. Clark added. For information on parity, see *SAMHSA News* online, November/December 2008.

The briefs include quick facts, definitions, and helpful links. For specific topics and ordering information, see below.

Informational Briefs

Find out what you can do to help your employees. Available briefs include:

- Save Your Company Money By Assuring Access to Substance Abuse Treatment
- What You Need To Know About Older Workers and Substance Abuse
- What You Need To Know About Younger Workers and Substance Abuse
- What You Need To Know About Mental and Substance Use Disorders
- Save Money By Addressing Employee Alcohol Problems
- Save Money By Addressing Employee Drug Problems
- What You Need To Know About the Cost of Substance Abuse
- Save Money By Encouraging Workers To Get Help For Substance Use Problems
- An EAP that Addresses Substance Abuse Can Save You Money
- How You Can Support Workers in Recovery
- Resources Available to Employers
- What You Need To Know About Substance Abuse Treatment
- Save by Providing Comprehensive Benefits for Substance Abuse Treatment
- You Save When Your Health Plans Improve Substance Abuse Screening.

Ordering Information

Download all 14 briefs in PDF format at **http://csat.samhsa.gov/IDBSE/employee/index.aspx.**

These 14 informational briefs are bundled together for your convenience.

Order a bundled set from SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727).

Suicide Prevention

White Paper Examines Relationship between Substance Abuse and Suicide

What's one of the biggest risk factors for suicide? According to a new SAMHSA white paper, the answer is substance abuse.

"The connection between substance abuse and suicide has not been sufficiently well understood," said Richard McKeon, Ph.D., M.P.H., Public Health Adviser for Suicide Prevention at SAMHSA's Center for Mental Health Services. "People in both the mental health and substance abuse fields have likely had experiences that would demonstrate the connection, but I think that probably few appreciate the magnitude of the relationship between substance abuse and suicide."

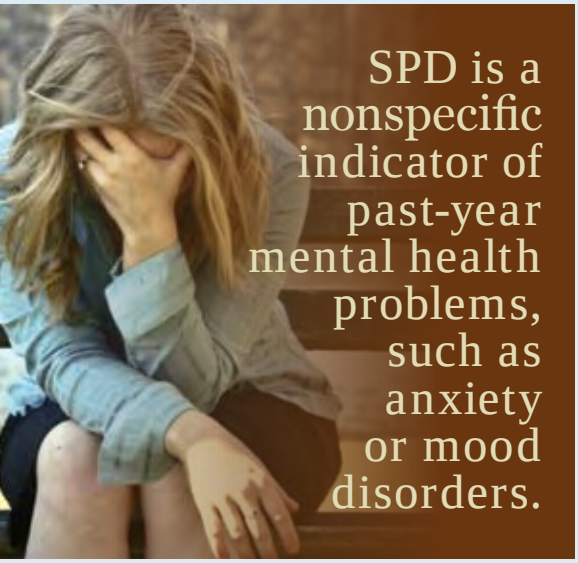
Recently released by SAMHSA's Center for Substance Abuse Treatment (CSAT), "Substance Abuse and Suicide Prevention: Evidence and Implications: A White Paper" summarizes what's known about the interrelationship. "The paper provides an overview of advances that have been made in the last decade," explained Project Officer Jorielle R. Brown, Ph.D., a public health adviser in CSAT's Co-Occurring and Homeless Activities Branch.

Calling for a public health approach to suicide prevention, the paper urges practitioners in both the mental health and substance abuse fields to use that knowledge to improve suicide prevention efforts.

"The paper underscores the need for people in the mental health field to be aware of substance abuse issues and co-occurring disorders as well as for substance abuse professionals to be aware of the risk of suicide," said Dr. McKeon. "There needs to be increased collaboration."

A COMPLEX INTERRELATIONSHIP

The white paper's first section focuses on the epidemiology of suicide. In the U.S. alone, suicide kills more than 32,000 people a year. That's the



Serious Psychological Distress

Of 24 million people, less than half get help

In 2007, 24.3 million adults age 18 or older experienced serious psychological distress (SPD) in the past year—that's 10.9 percent of adults in the United States.

These and other findings from the 2007 National Survey on Drug Use and Health (NSDUH) are discussed in the recent report, *Serious Psychological Distress and Receipt of Mental Health Services.*

- In 2007, past-year SPD was higher among young adults age 18 to 25 (17.9 percent) than among those age 26 to 49 (12.2 percent) and those age 50 or older (7.0 percent) (see chart).
- Of those adults who had past-year SPD and received mental health services (44.6 percent), 87.0 percent received prescription medication, 61.3 percent received outpatient services, and 11.4 percent received inpatient services.

To read the full report, visit SAMHSA's Office of Applied Studies (OAS) Web site at **www.oas.samhsa.gov/2k8/SPDtx/SPDtx.pdf.**

A growing body of evidence suggests that alcohol and drug abuse are second only to depression and other mood disorders when it comes to risk factors for suicide.

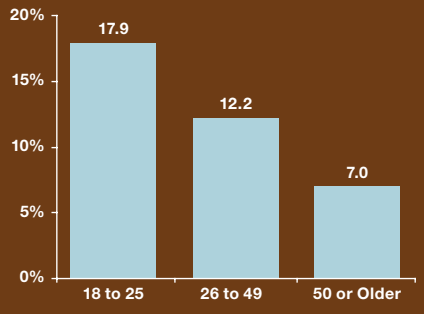
equivalent of a death by suicide every 16 minutes. In addition to the tragedy of lives lost, suicide costs the Nation almost $12 billion in lost income.

The paper's next section offers an overview of what's known and unknown about how substance abuse—both drugs and alcohol—affects the risk of suicide. Since the Surgeon General issued a call to action to prevent suicide in 1999, the paper notes, scientific knowledge about suicide prevention has increased dramatically.

EVIDENCE

According to the white paper, a growing body of evidence suggests that alcohol and drug abuse are second only to depression and other mood disorders when it comes to risk factors for suicide. In one study, for example, alcohol and drug abuse disorders were associated with a six-fold increase in the risk of suicide attempts. And substance abuse and mental disorders often go hand-in-hand, the paper emphasizes.

By Age Group: Serious Psychological Distress



Source: SAMHSA, Office of Applied Studies (December 22, 2008). Figure 1. Percentages of Adults with Past-Year Serious Psychological Distress, by Age Group: 2007.

The NSDUH Report: Serious Psychological Distress and Receipt of Mental Health Services. Rockville, MD.

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Lifeline Partners with YouTube

SAMHSA's National Suicide Prevention Lifeline has partnered with YouTube to offer suicide prevention resources to the YouTube online community.

Lifeline content on the new YouTube Abuse and Safety Center includes information on what to do if someone on YouTube may be at risk of suicide or if someone posts harmful messages about suicide.

Also posted are the Lifeline number (1-800-273-TALK), a public service announcement, and a link to the Lifeline channel, where you can find suicide warning signs.

For more information about this partnership and about SAMHSA's other efforts to prevent suicide, visit **www.suicidepreventionlifeline.org.**

The paper ends with a call for a more integrated, public health approach to preventing suicide.

Because of cultural taboos, the paper notes, it has only been in the last decade or so that the public health field has focused its attention on suicide. With the realization that people with mental health and substance abuse disorders can recover has come the recognition that people at risk for suicide can be treated.

What's needed, the paper argues, is an approach that targets the entire population, relies on best practices, and addresses the full range of risk factors, adding substance abuse to better-known risk factors such as mental illness and certain biological and environmental characteristics. The approach should focus on prevention just as much as diagnosis and treatment.

"There's a need for a comprehensive approach if we want to reduce suicide attempts and death by suicide," emphasized Dr. McKeon. "It's not sufficient to rely simply on mental health treatment, since we know that the majority of those who die by suicide have never had any mental health treatment. To reduce suicide, everyone needs to be involved."

To download a free copy of the white paper, go to **www.samhsa.gov/matrix2/508SuicidePreventionPaperFinal.pdf.**

—By Rebecca A. Clay

Suicide Prevention: A Priority

Recently added to SAMHSA's priority programs, suicide prevention efforts include:

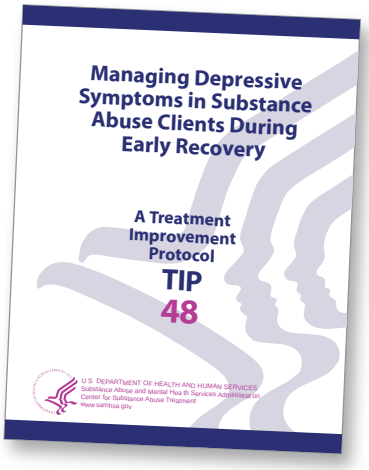
Providing grants. SAMHSA has several suicide prevention grant programs, including the Campus Suicide Prevention Grants Program **(www.samhsa.gov/grants).**

Promoting best practices. SAMHSA's Center for Substance Abuse Treatment is currently developing a Treatment Improvement Protocol on substance abuse and suicide prevention for substance abuse treatment providers.

Informing research. In 2008, SAMHSA's National Survey on Drug Use and Health began asking respondents about suicide attempts.

New Resource for Clients in Early Recovery

Managing Depressive Symptoms, Substance Abuse



Attention substance abuse counselors—a new resource is now available from SAMHSA to help you work with clients who are experiencing depressive symptoms.

Treatment Improvement Protocol (TIP) 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*, provides the "what," "why," and "how-to" of working with clients with depressive symptoms and substance use disorders. Depressive symptoms can interfere with your clients' recovery and ability to participate in treatment.

COUNSELING APPROACHES

Topics covered include counseling approaches, clinical settings, cultural concerns, counselor roles and responsibilities, screening and assessment, treatment planning and processes, and continuing care.

The TIP provides vignettes of counseling sessions and descriptions of specific techniques.

Administrators also will find information about incorporating the management of depressive symptoms into substance abuse programs, complete with a systematic approach to designing and operating a supportive infrastructure.

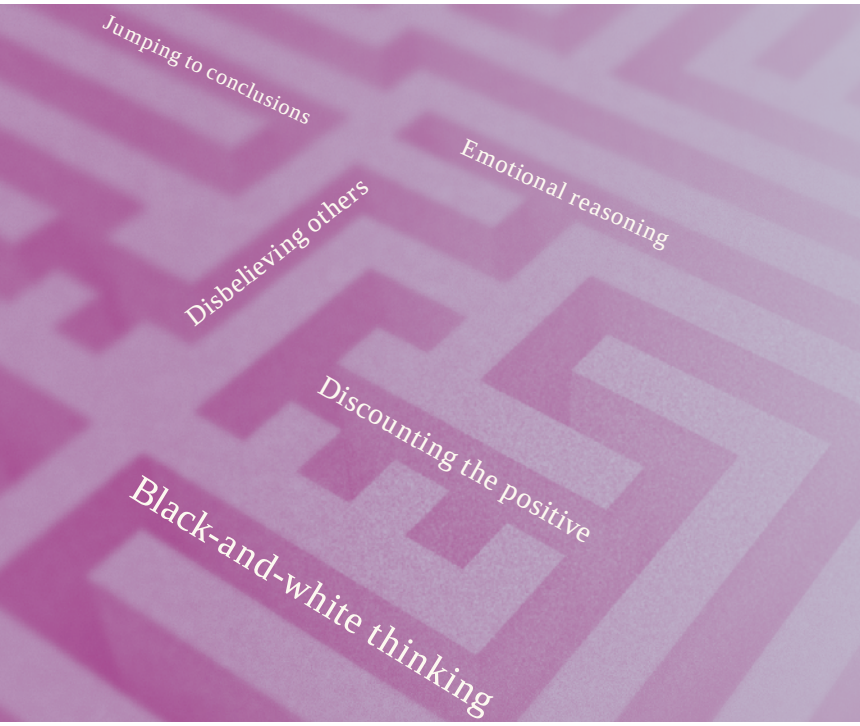
To order print copies, call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). A PDF version of TIP 48 and an online literature review will be available soon at **www.kap.samhsa.gov.**

Symptoms & Substances

According to TIP 48, depressive symptoms can result from the direct effects of alcohol or drugs on the central nervous system or withdrawal from those substances. Some withdrawal symptoms include:

- **Alcohol:** Depressed mood, poor appetite, poor concentration, insomnia, paranoia, and psychosis
- **Opioids:** Depressed mood, fatigue, low appetite, irritability, anxiety, insomnia, and poor concentration
- **Cocaine and stimulants:** Depressed mood, increased sleep, increased appetite, loss of interest, anhedonia, poor concentration, and suicidal thoughts
- **Cannabis:** Anxiety and irritability
- **Sedative-hypnotics:** Anxiety, low mood, restlessness, paranoia, and psychosis.

For the full list and details, including typical depressive symptoms of chronic use of these substances, see page 8 of the print version of TIP 48.



Typical Depressive Thinking Styles

Jumping to conclusions. People with depressive symptoms tend to jump to negative conclusions easily.

Emotional reasoning. These patients may assume their emotions give them an accurate view of the world and do not "test" further.

Discounting the positive. They may focus on what they don't have, rather than what they do, leaving them feeling deprived or disappointed.

Disbelieving others. People with depression often believe that others are being nice only because they want something—that they are manipulative.

Black-and-white thinking. Depression makes it harder to think about life in complex ways—everything is "either/or."

For more details, see page 19 of the print version of TIP 48.

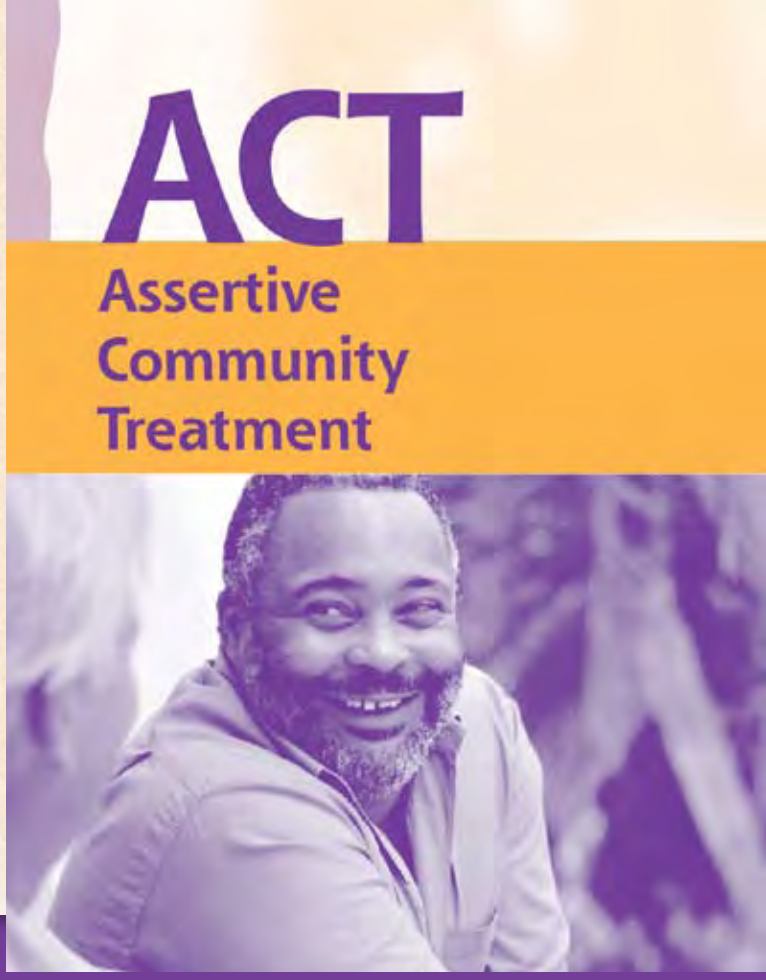
Helping People with Mental Illness Live in the Community

New Online Resource Is Available

If good supports are available, people with serious mental illnesses often can be treated effectively in their homes, rather than requiring expensive and disruptive hospitalizations. Assertive Community Treatment, or ACT, helps consumers of mental health services receive the supports they need to live successfully in the community.

To help communities build and sustain an ACT team, SAMHSA's Center for Mental Health Services (CMHS) recently released an Evidence-Based Practices Implementation Resource Kit on Assertive Community Treatment. The kit, part of the Knowledge Informing Transformation (KIT) series, is available free of charge on the Web and on CD/DVD.

"This KIT provides all of the tools states and communities need to set up services to help consumers with serious mental illnesses stay out of the hospital and live productive lives in their community," said Crystal R. Blyler, Ph.D., social science analyst at CMHS.



WHAT IS ACT?

ACT is a way of delivering a full range of services to consumers whose needs have not been well met by traditional service delivery approaches. One of its goals is to help consumers develop skills for living in the community.

Meant for consumers with the most challenging and persistent problems, ACT's primary goal is to help them achieve recovery through community treatment and habilitation.

Central to the ACT model is a transdisciplinary group of 10 to 12 people—including nurses, mental health and substance abuse professionals, and employment specialists—who provide services to about 100 people.

ACT teams get right to the basics, helping consumers manage their medications, find housing, apply for jobs, or enroll in school. The care is:

- **Flexible**—ACT teams fit their schedules around consumer needs.
- **Personalized**—The teams work with relatively small numbers of people.
- **Continuous**—Several team members work regularly with each consumer.
- **Comprehensive**—ACT teams provide an array of services to help meet consumer needs.

SUPPORTING ACT TEAMS

While these services are essential, they also require the devotion of a host of individuals. SAMHSA's ACT KIT provides information that can help mental health providers develop community-based services that are better suited to the individual needs of clients.

The KIT contains seven sections:

- How To Use the Evidence-Based Practices KITs
- Getting Started with Evidence-Based Practices
- Building Your Program
- Training Frontline Staff
- Evaluating Your Program
- The Evidence
- Using Multimedia To Introduce Your Evidence-Based Practices.

Also included is a brochure, in English and en español, to promote your ACT program, and a PowerPoint presentation, which explains in detail what ACT entails.

Find out more details about the KIT in *SAMHSA News* online.

To access the Evidence-Based Practices KIT on Assertive Community Treatment in PDF format, visit **www.mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community.** To order the CD/DVD, call 1-877-SAMHSA-7 (1-877-726-4727).

Older Adults and Substance Use

New Data Highlight Concerns

In 2006, 41 million adults age 50 and older drank alcohol in the past month, 19 million used tobacco—mostly cigarettes—and 2.2 million used illicit drugs, according to data from SAMHSA's National Survey on Drug Use and Health (NSDUH).

"The 'baby boomer' cohort—people born from 1946 to 1964—is the first in U.S. history with a majority having used illicit drugs sometime in their lives," said Joseph C. Gfroerer, Director of the Division of Population Surveys at SAMHSA's Office of Applied Studies (OAS). "As a result, we expect an increase in substance abuse among older adults."

Of the 2.2 million adults age 50 and older who used illicit drugs in the past month, 54 percent of them used only marijuana; 28 percent used only prescription drugs nonmedically; and 17 percent used a different illicit drug, such as cocaine.

ABUSE AND DEPENDENCE

In 2006, 3.2 million older adults (3.6 percent of the population) had a substance use disorder, said Mr. Gfroerer. Of these, 83 percent (2.6 million) had only an alcohol use disorder, 12 percent had only an illicit drug disorder, and 5 percent had both alcohol and illicit drug use disorders. A recent OAS study projected that the number of older adults with a substance use disorder will increase to 5.7 million by 2020, Mr. Gfroerer added.

Data from 2002 to 2006 show that each year, on average, 139,000 adults age 50 and older abused or were dependent on marijuana; 131,000 abused or were dependent on cocaine; and 120,000 abused or were dependent on pain relievers.

Are these people seeking treatment? Not in droves, according to 2005 to 2006 data, which show that 83 percent of the 3.2 million adults age 50 and older who needed treatment—a need based on standard criteria—*felt no need* for treatment and did not seek help. Eleven percent received treatment, and 6 percent felt a need for treatment but did not receive it.

TREATMENT STATS

Treatment Episode Data Set (TEDS) data relay important facts about treatment admissions of older adults. "Despite long-standing substance use, many older admissions have not been in treatment before," said Deborah H. Trunzo, DASIS Team Leader at OAS.

In 2006, data show that adults age 50 and older who entered treatment for the first time displayed the following median duration of use of their primary substance:

- Alcohol only: 38 years
- Alcohol and another drug: 37 years
- Marijuana: 35 years
- Heroin: 34 years.

The peak years of first use of alcohol, heroin, and marijuana for admissions age 50 and older were 1969 to 1971. For cocaine, the peak year of initiating use was 1986, and for narcotic analgesics, it was 2004.

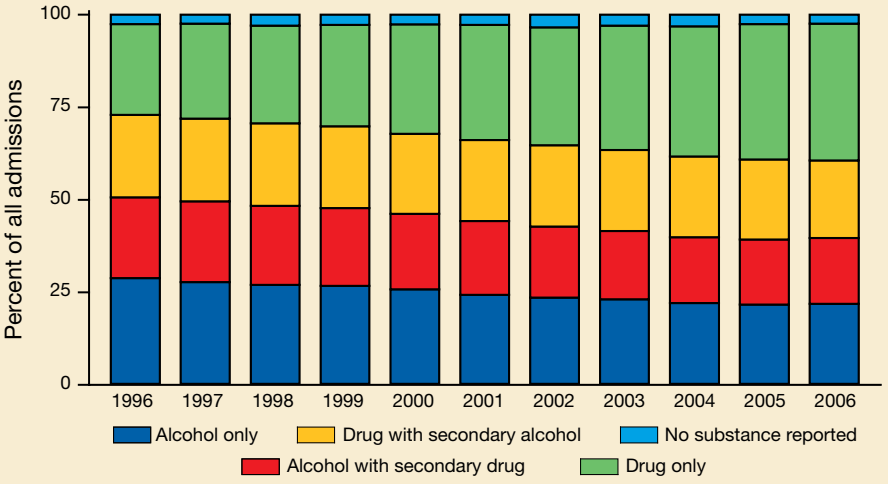
For more data on older adults, visit SAMHSA's OAS Web site at **www.oas.samhsa.gov/aging.cfm.**

—By Kristin Blank

Trends in the Co-Abuse of Alcohol and Drugs

A report on treatment admissions from 1996 to 2006—from SAMHSA's Treatment Episode Data Set (TEDS)—shows the rise and fall of alcohol and drug use over that time span. The chart at right illustrates five separate data sets represented in different colors. Primary alcohol abuse (in red) declined from 51 percent of admissions in 1996 to 40 percent of admissions 10 years later in 2006.

See *SAMHSA News* online for a full description of this chart. The report is available in PDF format on SAMHSA's Office of Applied Studies Web site at **wwwdasis.samhsa.gov/teds06/teds2k6aweb508.pdf.**



Source: SAMHSA Office of Applied Studies. *Treatment Episode Data Set (TEDS) 1996-2006.* Data received through October 9, 2007. Figure 2. Trends in the Co-Abuse of Alcohol and Drugs (p. 13). July 2008.

Powering Up Partnerships for Healthy Communities

Photo below: More than 1,000 people listened as SAMHSA's Frances M. Harding gave the keynote address at SAMHSA's 5th Annual Community Prevention Day, sponsored by the Center for Substance Abuse Prevention (CSAP).

The all-day event on February 9 included messages from Dr. Eric Broderick, Acting Administrator; Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment; and Kathryn Power, Director of the Center for Mental Health Services. Participants signed up for workshops to develop strategic organizational skills. Attendees included CSAP grantees, National Prevention Partners, the National Prevention Network, CSAP's Prevention Fellows, and the CSAP National Advisory Council. For more photos of the event, see *SAMHSA News* online.

Webcasts Highlight Homelessness Services

Tune in each month at
www.homeless.samhsa.gov

SAMHSA's Homelessness Resource Center (HRC) debuted a new Webcast series in early February.

The first topic is employment as a pathway out of homelessness. Other Webcasts include homeless youth, psychiatric rehabilitation, and supportive housing for families.

A new Webcast is planned for each month.

The HRC is a virtual community located at **www.homeless.samhsa.gov.** Using Web 2.0 technology, it connects homelessness services providers across the Nation to each other and to the latest developments in the field.

For more information, read *SAMHSA News* online, July/August 2008.

Perceptions of Risk & Marijuana Use

There's a connection between use of marijuana by young people and their perceptions of how risky that use may be.

- According to data from 2002 to 2007, adolescents who perceived great risk from smoking marijuana once a month were much less likely to have used marijuana in the past month than those who perceived moderate to no risk (1.4 versus 9.5 percent).
- Females were more likely to perceive great risk than were males (36.7 versus 32.4 percent). The percentage of adolescents who perceived great risk decreased with age, from 42.1 percent of those age 12 or 13 to 26.9 percent of those age 16 or 17.

Read more about youth and marijuana in *Marijuana Use and Perceived Risk of Use among Adolescents: 2002 to 2007*, a recent report from SAMHSA's National Survey on Drug Use and Health (NSDUH), at **www.oas.samhsa.gov/2k9/MJrisks/MJrisks.pdf.**


National Survey on Drug Use and Health

The NSDUH Report

January 8, 2009

Marijuana Use and Perceived Risk of Use among Adolescents: 2002 to 2007

In Brief

- The prevalence of past month marijuana use among adolescents (i.e., youths aged 12 to 17) generally decreased from 2002 (8.2 percent) to 2005 (6.8 percent), and then remained constant between 2005 and 2007
- The percentage of adolescents who perceived great risk from smoking marijuana once a month increased between 2002 (32.4 percent) and 2003 (34.9 percent), and then remained relatively stable between

Monitoring data on adolescents' marijuana use and their perceptions of risk in using it is vital for making decisions about implementing and targeting prevention programs. The National Survey on Drug Use and Health (NSDUH) includes questions on marijuana use and perceptions of risk from smoking marijuana.[1] This report examines trends in past month marijuana use and perceptions of its risk among adolescents aged 12 to 17 between 2002 and 2007. Additionally, this report uses 2007 data to explore demographic differences in marijuana use and perceptions of its risk, along with the correlation between use and risk perceptions.

We'd Like To **Hear** From You

We appreciate your feedback! Please send your comments, article ideas, and requests to: Kristin Blank, Associate Editor–*SAMHSA News,* IQ Solutions, Inc., 11300 Rockville Pike, Suite 901, Rockville, MD 20852. Send email to samhsanews@iqsolutions.com or fax to 301-984-4416.

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Cover Story & Related Articles

- ❑ Drug Free Communities (pp. 1-4)
- ❑ Maryland Grantee Highlight (pp. 5, 6)

Publications

- ❑ Assertive Community Treatment KIT (p. 11)
- ❑ Cost-Effective Ways To Help Employees (p. 7)
- ❑ TIP 48 (p. 10)

Suicide Prevention & Mental Health

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- ❑ White Paper (pp. 8, 9)
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Statistics & Data

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- ❑ Youth Substance Use 2002 to 2007 (p. 16)

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EDITOR
Deborah Goodman

SAMHSA News Team at IQ Solutions, Inc.

MANAGING EDITOR
Meredith Hogan Pond

ASSOCIATE EDITOR
Kristin Blank

SENIOR DESIGNER
A. Martín Castillo

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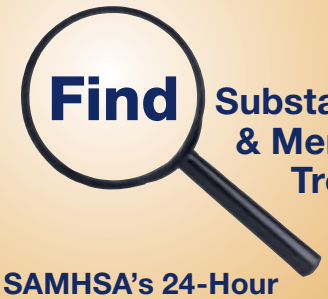

Substance Abuse & Mental Health Treatment

SAMHSA's 24-Hour Toll-Free Referral Helpline
1-800-662-HELP
www.samhsa.gov/treatment

Redesigning with Readers in Mind

New Look Mirrors Online

This issue of *SAMHSA News* launches our new print redesign. In updating the newsletter, our designers had two goals:

- Create a user-friendly design that's both informative and readable.
- Encourage you, our subscribers, to use *SAMHSA News* online—at **www.samhsa.gov/samhsaNewsletter**—for additional articles, resources, and extended story lines.

New features include:

Know It's SAMHSA. The new masthead highlights SAMHSA's brand and echoes *SAMHSA News* online.

Read More. The typefaces you see here were chosen for clarity, readability, and to be easier on your eyes.

Follow the Mouse. You'll find end-of-article "cues" to direct you to online resources, additional features, and more on the *SAMHSA News* home page.

As always, *SAMHSA News* provides highlights of SAMHSA's priority programs, such as suicide prevention and services for returning veterans as well as snapshots of how current grantees are meeting challenges in the field.

In addition, you'll find ordering information for new publications and products, including the latest findings from SAMHSA's National Survey on Drug Use and Health and other Agency data sets.

We appreciate your feedback! **Please add your comments** on page 14 and fax to *SAMHSA News* at 301-984-4416 or send us an email online using the "feedback" button in the right-hand column on our current issue's home page.

We hope our new bells and whistles will help you connect to additional information available on *SAMHSA News* online at **www.samhsa.gov/samhsaNewsletter.**

SAMHSA News online mirrors *SAMHSA News* in print.

SAMHSA's eNetwork: Are You Connected?

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If you haven't signed up for SAMHSA's eNetwork yet, now is the time! You'll be among the first to find out about new programs, campaigns, grant awards, publications, and statistics. And, you'll know right away when a new issue of *SAMHSA News* is available online.

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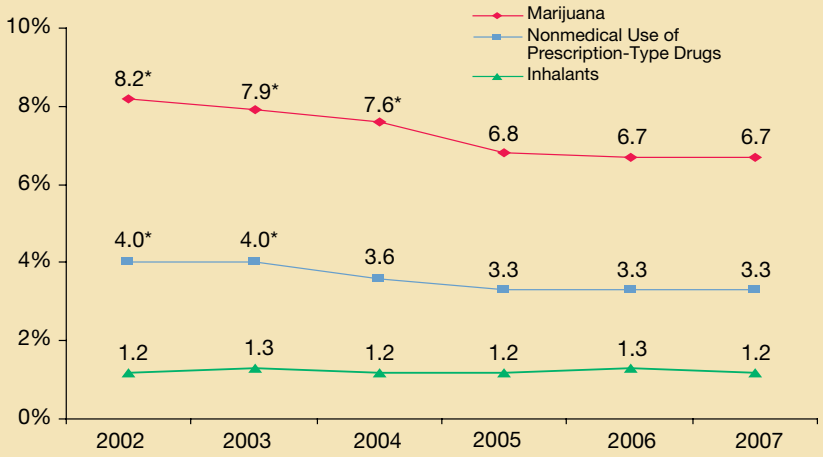
Sign up today by going to **www.samhsa.gov/enetwork.** **Get connected!**

Trends at a Glance: Youth Substance Use 2002 to 2007

Marijuana, prescription drugs, and inhalants are showing a drop in use by young people compared to 2002 levels. Read the full report at **www.oas.samhsa.gov/2k8/youthtrends/youthtrends.pdf.**



Source: SAMHSA, Office of Applied Studies. (December 4, 2008). *The NSDUH Report: Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007.* Figure 2: Percentages of Adolescents Using Selected Illicit Drugs in the Past Month: 2002 to 2007. Rockville, MD.

There's More

Go online to read more from *SAMHSA News* at www.samhsa.gov/samhsaNewsletter.

Read about . . .

Self-Help Groups

Recovery from substance abuse problems is a lifelong commitment. Millions of people attended self-help groups in the past year.

Drug Testing Guidelines

Find out the new revisions that establish scientific and technical guidelines for the Federal workplace drug testing programs.

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Fax: 301-984-4416 (Attention – Kristin Blank)

Phone: 1-888-577-8977 (toll-free) or 240-221-4001 in the Washington, DC, metro area

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Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockville, Maryland 20857